Trauma, Borderline Personality Disorder, and Self-Harm: A Counselling Psychology Perspective

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Declaration

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A. Preface

A.1. Preface to Portfolio of Work

This portfolio comprises three sections: a critical literature review, an empirical research project and an extended case study. Each piece was completed during my training at City University and together demonstrates my competence as a Counselling Psychologist. This portfolio provides evidence of my knowledge and skills within research and practice, demonstrating critical and independent thought at a doctoral level.

The first section of this portfolio opens with a critical review of the literature, exploring the link between borderline personality disorder (BPD), dissociation and childhood trauma. This review aimed to integrate the research evidence on childhood trauma and dissociation, establishing whether links could be found between the constructs and whether BPD could be understood as a trauma-related disorder. This was considered an important area for Counselling Psychologists, as we are highly likely to encounter the affects of trauma within our work, especially if we reframe diagnostic categories of symptoms in terms of 'trauma related distress'; additionally, recent research has highlighted a highly significant link between dissociative disorders and suicidality, making it a priority for research and treatment. This review begins with a discussion of the theoretical speculations on the relationships between trauma, dissociation and BPD, before reviewing the empirical investigations into these relations. The review supported a view of BPD and dissociation as trauma-related disorders; it clearly demonstrated that dissociation and BPD are intimately associated with each other, but exactly how remains unclear. The evidence strongly points to their existence as separate constructs with a shared link with early childhood trauma, but a lack of interaction between specific childhood trauma variables for both DD and dissociative symptoms and BPD suggests they have different causal pathways. This study calls for further well-designed and prospective studies to explore this area further. It concludes by reminding us that debates over aetiology should not obscure the pressing need for the development of effective treatment interventions for this client population.

The second section consists of an empirical piece of research informed by Foucauldian, social constructionist and critical, feminist ideologies. The study aimed to examine the

role of language and how self-harm is constructed in contemporary western society. This is seen as especially pertinent for the profession of Counselling Psychology, as these constructions have far-reaching implications for practice, research and the therapeutic relationship. This research employed a form of Foucauldian Discourse Analysis to explore how health professionals and people who self-harm make sense of self-harm behaviour: specifically, how both people understand and construct self-harm through the use of language, and how these constructions impact on their subjectivities (thoughts and feelings) and behaviours. This involved an in-depth qualitative analysis of expert texts, such as documents, publications and leaflets, to map out the discursive resources available for the construction of self-harm, and the use of semi-structured interviews and focus groups with a community sample of people who self-harm and health professionals who came into therapeutic contact with those who self-harm. Such an intensive and focused qualitative approach was deemed necessary given the lack of knowledge and previous research in this area. This research generated strong discourses of morality and pathology, constructing self-harm as indicative of internal dysfunction, as an external and abnormal 'other', risk/danger and/or morally deviant behaviour. Participants who self-harmed were seen to struggle within largely disempowering discourses: using psychological discourse provided a valid reason for self-harm, constructing it as genuine as opposed to attention-seeking, and resulted in more compassionate behaviour from others; but it also created a tension when it resulted in being attached to the person as a label, and as indicative of permanent internal dysfunction and damage. Finally, constructions of self-harm as risk and danger were strongly resisted by participants; however, they were also utilised to construct the behaviour as needing to be taken seriously by health professionals, therefore 'genuine', subsequently allowing access to treatment. The research concludes by drawing attention to the need for psychologists to adopt a depathologising approach to therapeutic care and distress, by paying more attention to the social and contextual factors involved, and develop a critical awareness of the powerful impact that language can have upon people's experiences.

The final section of this portfolio demonstrates my professional practice through the inclusion of an extended case study. This case study represents my developing interest as a psychologist in chronic pain and offers a critical reflection of my practice within this area. This work was carried out as part of a placement within a department specialising in pain management. I came to realise that the area of chronic pain related to my

wider interests in trauma, and that trauma can manifest itself in many different presentations: pain that persists following a physical trauma (such as whiplash, road traffic injuries, falls or, as in this case, a dental procedure) is just one of these. Such pain vividly demonstrates the unhelpfulness of attempting a mind/body split in a therapeutic approach: the mind and body are intricately enmeshed with past trauma affecting both cognitive and physical aspects of functioning. In this sense, chronic pain is not proposed as being a simple result of trauma: instead, trauma can be seen as having various cognitive, emotional and physical effects that result in pain becoming chronic and persistent. This work demonstrates my broadening knowledge of trauma and the various manifestations it can take, as well as highlighting how my professional career and personal interests have subsequently been shaped. In addition, it demonstrates my broadening practice and understanding of CBT and the incorporation of social constructionist influences.

These pieces of work are presented in order to demonstrate my competencies within the various different areas of Counselling Psychology practice, but hopefully they also demonstrate my development of skills and knowledge in both practice and research, and my growing interest within the areas of social constructionism, trauma and trauma-related disturbances, which may manifest themselves in many different forms. Particularly, I hope it highlights my dedication towards psychological practice that can empower without pathologising those that come for our help.

B: Critical Literature Review

Borderline Personality Disorder: Integrating Our Understanding of Dissociation and Childhood Trauma

B.1. Introduction

Borderline Personality Disorder (BPD) is a condition that has resulted in much controversy over the years and has sometimes been viewed as lacking in scientific credibility; as a diagnosis it is often hidden from clients and, when given, instils little cause for hope (Castillo, 2003). If left untreated, BPD is believed to remain stable over time, and a quick cure is not thought possible; mental health professionals have a tendency to report these clients as 'untreatable' and 'difficult', and their self-destructive behaviours are often viewed as 'manipulative' and 'attention-seeking' (Castillo, 2003). Such reports highlight a lack of understanding among health professionals as to the aetiological roots, degree of suffering experienced and genuine lack of coping skills evidenced in people with BPD; and yet I believe this understanding is necessary if we are to develop effective treatment services and empathic therapeutic relationships.

Grouped in Cluster B of the DSM Axis II personality disorders (PD) classification (APA, 1994) – along with anti-social, histrionic and narcissistic PD – BPD was formally recognised in 1980. This condition is relatively rare in the general population (1-2%), but BPD has been estimated to account for 10% of outpatient populations and 20-25% of inpatient populations (Kraus and Reynolds, 2001); and it is thought to be increasing in prevalence in recent decades (Ryle, 1997). According to research by Herman and van der Kolk (1987), people with BPD tend to experience disturbance in five key areas: affect regulation; impulse control; reality testing; interpersonal relationships; and self concept or identity. Similarly, the DSM-IV requires five out of the following nine criteria for a diagnosis of BPD: unstable, intense relationships; affective instability; inappropriate intense anger; frantic efforts to avoid abandonment; identity disturbance; impulsivity; suicidal and self-mutilating behaviour; chronic feelings of emptiness; transient stress-related paranoid ideas and dissociative symptoms (APA, 1994).

It has been reported that 75% of people diagnosed with BPD are female, and 90% meet the criteria for at least one other PD (Kraus and Reynolds, 2001). There is often a high co-morbidity with other Axis I disorders such as depression, post-traumatic stress disorder (PTSD), eating disorders, substance abuse, somatisation disorders and

dissociative symptoms (Ryle, 1997), which creates a high demand on mental health services. Unfortunately, despite this demand, Bell (2003) reports that people with BPD rarely respond well to conventional treatment. Paris (2007) suggests that even though there is now more acceptance of this condition, clinicians can still be reluctant to make the diagnosis, mainly due to the complexity and high level of 'overlap' with Axis I disorders.

The aetiology of BPD remains controversial, but certain factors are generally agreed within the literature to contribute to its cause. The role of childhood trauma has been well established in the literature and extensively reviewed, with between 60% (Meares *et al*, 1999) to over 90% (Zanarini *et al*, 1997) of borderline patients reporting a history of childhood trauma. Stewart and Harmon (2004) state that, compared to the general population, people who have experienced neglect and abuse are four times as likely to develop a PD. It also appears that compared to clients with other PD, those with BPD report higher rates of childhood trauma, which may include emotional, physical and/or sexual abuse (Sansone *et al*, 2005). Bell (2003) proposes that those who go on to develop BPD will have usually experienced persistent forms of abuse and neglect in childhood. Some researchers, such as Herman (1992), Courtois and Ford (2009), and van der Kolk and colleagues (1996), have called for the re-labelling of BPD as 'complex trauma', or 'complex PTSD' in recognition of the role of childhood trauma in the development of symptoms consistent with that of BPD. Similarly, Blizard (2008) and Howell (2008) call attention to BPD as a form of 'chronic relational trauma', recognising the presence of childhood trauma and dissociative symptoms in such populations. However, reports of childhood trauma are common to a number of other disorders, including Dissociative Identity Disorder (DID) (e.g. Krakauer, 2002), substance misuse, depression and eating disorders (e.g. Ross, 1997), and not everyone with BPD reports childhood trauma (Bell, 2003).

Until recently the presence of dissociation in BPD, and its differentiation from other dissociative disorders (DD) such as DID (formally known as Multiple Personality Disorder), has been relatively ignored in the literature. The DSM-IV (APA, 1994) added 'dissociative symptoms' to the diagnostic criteria for BPD, providing recognition of the high levels of dissociation experienced in this disorder, which has been backed up by recent research (e.g. Korzekwa *et al*, 2009). This sparked a resurgence of research interest in dissociation and its relationship with psychological trauma and various forms

of ‘trauma-related distress’ (Gershuny and Thayer, 1999). Recent research has focused on the comorbidity of dissociation with BPD and their shared link with early childhood trauma. Some of this research has turned towards an exploration of the psychobiological and neurological, as well as environmental, factors involved in these relationships.

Dissociation is defined by the DSM-IV as ‘the disruption of the usually integrated functions of consciousness, memory, identity, or perception of the environment’ (APA, 1994). It can be understood as a failure in the integration of experience (Panzer and Viljoen, 2004), and has been used to describe a range of responses from non-pathological to pathological, although this idea of a continuum of response has not been universally accepted (Krakauer, 2002). Dissociative symptoms are not uncommon and, according to Gershuny and Thayer (1999), although their cause and development are debated, they appear particularly prevalent in those who have experienced a trauma. Some researchers, such as Herman (1992), argue that dissociation can be viewed as a core component of trauma reactions, but note that a diagnosis of PTSD does not adequately cover the full range of posttraumatic reactions, including dissociation. Dissociation does however appear within some form within various disorders listed in the DSM-IV-TR, including acute stress disorder, somatization disorder, panic disorder, schizophrenia, depression and BPD (APA, 2000).

Dissociation as a psychological concept was introduced in the 18th century, but did not become widespread within psychiatry and medicine until the end of the 19th century, mainly thanks to the pioneering work of Pierre Janet who proposed the first trauma-based model of dissociation (Midgley, 2002). Following a brief period of popularity, Janet’s work and the concept of dissociation was mostly forgotten (Midgley, 2002). The subsequent neglect of trauma and dissociation in the literature has been hypothesised to be partly due to Freud’s rejection of the seduction theory, and the subsequent emphasis on intrapsychic conflicts (Ryle, 1997). That is until the late 1960’s, when the diagnosis of PTSD became recognised and the women’s movement brought a realisation of the reality and prevalence of child abuse, in what Armstrong (1978) termed the ‘Age of Validation’. However, a resulting overemphasis on traumatic aetiology led to the ‘Age of Backlash’ which began in the 1990’s, bringing about the ‘recovered memory’ debate: an argument that recovered memories of childhood trauma are false as a result of unethical therapeutic practices (Krakauer, 2002). Such debates throughout the years

have obviously influenced the perceived legitimacy and popularity of the notions of dissociation and traumatic stress in psychological literature and practice, and consequently DID and BPD remain highly controversial diagnoses (Gillig, 2009).

There has evidently been a recent resurgence of research in the area relating to dissociation and trauma, and between dissociation and various forms of 'trauma-related distress'. An extensive literature search could find only one comprehensive literature review looking at the relations between psychological trauma, dissociative phenomena and trauma-related distress, by Gershuny and Thayer (1999). They defined trauma-related distress as including disorders such as PTSD, BPD and bulimia; however, the current review will focus primarily on BPD, with the other categories of trauma-related distress falling outside the scope of this review. Gershuny and Thayer's (1999) review found a strong relationship between these constructs, demonstrating that trauma was positively linked to dissociation, and dissociative symptoms positively related to levels of trauma-related distress. The current review aims to look critically at the literature published since this time and to integrate the research evidence on childhood trauma and dissociation, establishing whether BPD can still be understood as a trauma-related disorder.

I believe this area is of great importance to Counselling Psychologists as we are highly likely to encounter the effects of trauma within our work, especially if we reframe diagnostic categories of symptoms in terms of 'trauma related distress' as suggested by Ross (1997) and more recently by Herman and colleagues (e.g. Courtois and Ford, 2009). Additionally, recent research has highlighted a highly significant link between dissociative disorders and suicidality, making it a priority for research and treatment (e.g. Foote *et al*, 2008; Ozturk and Sar, 2008). Many clients with BPD will present to psychology departments complaining of depression or anxiety, so a more complete understanding of this disorder will offer the clinician a better understanding of the entire person, not simply the presenting symptoms (Kraus and Reynolds, 2001). This idea of holistic treatment is more pertinent to Counselling Psychology which emphasises working collaboratively with their clients in an effort towards empowerment. It should also be noted that recent research has indicated that symptoms of BPD may decrease over time and 'that psychotherapy can accelerate this process' (Brown and Shapiro, 2006, p.403), which offers more hope to people with this condition and a greater call for the intervention of Counselling Psychology. This review will firstly discuss the

theoretical speculations on the relationships between trauma, dissociation and BPD, before reviewing the empirical investigations into these relations. Finally, a discussion will be presented to summarise the main findings of this review with suggestions for future research.

B.2. Trauma, Dissociation and BPD: Theoretical Discussions

As mentioned earlier, the work of Janet has been 'integral to the conceptualization of traumatic dissociation' (Gershuny and Thayer, 1999, p.639). Van der Hart *et al* (2004) have elaborated on Janet's work to define dissociation as a structural division of the personality; a division that was further elaborated on by Charles Myers following World War I, into the 'apparently normal' and the 'emotional' personalities that represented the 'insufficiently integrated' personality (van der Hart *et al*, 2004, p.907). Janet's observations postulated that two or more separate 'streams of consciousness' coexist within an individual, 'each existing in isolation from the others' (Nemiah, 1999, p.7), and that this dissociation is the result of 'a fundamental constitutional flaw in psychological functioning' (Nemiah, 1999, p.10). He believed that dissociation occurred in response to traumatic experiences, and conceptualised this process as a way of coping with trauma (Gershuny and Thayer, 1999). Janet saw the dissociated aspects of the self as functioning independently, and symptoms arose through indirect disturbances of the body; Freud, on the other hand, explained the symptoms of dissociation as arising from intrapsychic conflicts and repression, resulting in consciously experienced dysfunction (Nemiah, 1999). These ideas of dissociation of personality and psychological conflict have now come full circle and been restored to modern-day thinking in the 'revival of a traumatic model' (Nemiah, 1999, p.18).

Janet believed that not only was dissociation a way of coping with trauma, but that people who continued to dissociate would 'become emotionally constricted and develop various forms of psychopathology' (Gershuny and Thayer, 1999). Work by van der Kolk, van der Hart and Marmar (1996) shows that dissociation in response to early trauma increases the probability that this will be used as a coping strategy in the future when faced with stressful situations. Mollon (1997) explains this as a progression to a process of denial on the part of the repeatedly traumatised child, which is in part conscious and deliberate. This has been extensively supported by research papers, which have portrayed dissociation on a conceptual spectrum ranging from non-pathological 'daydreaming' to the severely pathological 'psychosis' of DID, depending on the severity

of childhood trauma experienced: with more severe trauma resulting in more severe dissociative symptoms (Briere and Muntz, 1988; Mollon, 1997; Ross, 1997; Krakauer, 2002; Whewell, 2002). This type of dissociation is seen as serving an adaptational purpose: as a defence against negative emotions resulting from traumatic experiences (Putnam, 1993); to remove oneself from an experience which may be too distressing (Rodin *et al*, 1999); and a technique to enable survival in the face of extreme environmental events (Panzer and Viljoen, 2004).

Unfortunately, this may come at a very high price: it may provide immediate protection, but also can result in an inability to reintegrate the self (Bentovim, 2002). Panzer and Viljoen (2004) report that when dissociation occurs frequently the individual's neural network becomes impaired, resulting in numerous developmental problems involving memory, affect and motivation, to name a few. Research by Stewart and Harmon (2004) is along similar lines, stating that people may not learn how to regulate emotions as a direct result of childhood abuse and neglect. This suggests an interplay of biological and environmental factors, which Janet believed existed, resulting in an inability to regulate emotions. This all ties in with the work of the neurologist, Hughlings Jackson, who introduced the concept of 'the self' in medical literature in the 19th Century (Meares, Stevenson and Gordon, 1999). His work, which undoubtedly influenced that of Janet, proposed that the maturation of the self depends on both genetic biology and the provision of a facilitative environment, and that psychological maturation will be impaired when this environment is lacking (Meares, Stevenson and Gordon, 1999).

Arntz (1994) proposed that chronic levels of abuse would result in 'the development of almost unshakable fundamental assumptions about others (dangerous and malignant), about one's own capabilities (powerless and vulnerable) and upon one's value as a person (bad and unacceptable)' (p.419); thus reflecting a cognitive theoretical viewpoint on the influence of childhood trauma on development. Psychoanalytical research has also looked at the impact of childhood trauma on attachment, suggesting that trauma results in insecure and disorganised attachment, which adversely affects the development of the infant. For instance, Cozolino (2006) describes BPD as an 'interpersonal disorder' with early attachment that was 'highly traumatic and sometimes life-threatening' (p.256). Blizard (2001) stated that in order to maintain attachment with the abusive primary caregiver, the abuse must be dissociated, but the need for

attachment must also be denied in order to protect the self from abuse, which can result in disorganised attachment. This is seen as a 'survival strategy' that is almost unavoidable if any kind of relationship is to be sustained (Coleman, 2002). This reflects much of the work of Ronald Fairbairn in the 1940s on the sense of self and the unconscious splits in self as a result of childhood trauma, instigated by the 'internalisation and repression of a bad object representing the abuser' (Whewell, 2002, p.166). However, as feminist critiques of mental illness (such as Warner and Wilkins, 2003, and Reavey, 2003) have illustrated, this paints a relatively bleak picture for the person who has suffered abuse: in that they may now be viewed as permanently and irrevocably damaged by their experience.

Other DD share this developmental history of abuse with BPD, particularly DID. This has led some authors to conclude that they are related conditions (Meares *et al*, 1999), as suggested by the work of Janet, and Bremner *et al* (1999) propose the existence of trauma-related disorders as lying on a continuum. Meares, Stevenson and Gordon (1999) draw a parallel with 'chronic hysteria' stating that this was essentially dismantled by the DSM-III into its component parts: a distinction that may be somewhat unnatural. Research has appeared to suggest that traumatic events can result in specific but related symptoms (Meares, Stevenson and Gordon, 1999). The work of Herman (1992) similarly suggests that such complex symptom presentations, which are seen to follow prolonged and repeated trauma, have not been formally recognised, despite the recognition of PTSD in 1980. It has been suggested that these traumas should be categorised into Type I and Type II trauma, with the former being the result of a single trauma and the other, prolonged and repeated trauma (Terr, 1991). This would suggest that these different 'symptom clusters' result in different surface diagnoses, depending on which was most prominent at the time of diagnosis, even though they are representing a common underlying trauma-related disturbance.

Not everyone agrees with this theoretical viewpoint, and it has been noted that not everyone who has suffered childhood trauma experiences dissociative symptoms, and not everyone with BPD has reported childhood trauma (e.g. Bell, 2003). Therefore, it is unlikely that a simple connection between childhood trauma and both dissociation and BPD exists. Putnam and Carlson (1999) note that although trauma and dissociation are significantly related, only moderate correlations can be found between them, suggesting that another factor remains to be accounted for. A genetic or neurological vulnerability

factor has been proposed; although there has been little evidence that BPD is genetically transmitted (Meares *et al*, 1999). It may equally be that a dysfunctional family environment is the key factor in the development of BPD, and this has been supported by research (Goldman *et al*, 1993; Golomb *et al*, 1994; Bandelow *et al*, 2005). Little research has been conducted on the cognitive dimensions of BPD, and Judd (2005) states that neurocognitive impairments may moderate the relationship between parenting style and insecure attachment and pathological dissociation in the development of BPD. This is a promising area and neuropsychological research into BPD has found 'frontal and temporal lobe dysfunction', as well as 'abnormalities in size, activation patterns and neurochemical levels in several brain regions' (Cozolino, 2006, p.260-1). Goodman *et al* (2004) also propose that environmental factors such as childhood trauma and familial factors interact with inherited vulnerability in the development of BPD. This work supports that of Jackson and Janet, and Meares, Stevenson and Gordon (1999) developed a 'Jacksonian theory' of BPD, proposing that it results from a failure of the environment which impairs the development of neural networks in the brain; thus suggesting a crucial interplay of biology and environment.

B.3. Trauma, Dissociation and BPD: Empirical Investigations

i) Childhood Trauma, BPD and Dissociation

The link between BPD and dissociation has continued to be an area of interest to many researchers in recent years. This research has looked at the relationships between childhood trauma, dissociation and BPD, risk factors associated with, and predictors of, dissociation and BPD, and the history of early childhood trauma in BPD. Studies by Timmerman and Emmelkamp (2001), and Simeon *et al* (2003), explored the relationship between childhood trauma, dissociation and BPD, specifically comparing dissociation with BPD. The former study used a sample of male forensic patients and prisoners to distinguish between the effects of different types of childhood trauma, finding that reports of childhood sexual abuse (CSA) were significantly associated with BPD, but not with dissociation in the forensic patients. This same relationship was also found in the male prisoners, but only for incidents of CSA occurring within the family. This study suggests that CSA is associated with borderline pathology, but not dissociation. This is an interesting finding, and lends support to the theory that BPD and dissociation are two separate concepts, rather than aspects of the same disorder, with different causal pathways. However, comparisons between these sample groups must be interpreted

with caution, as the samples are small and differing in size, with 39 forensic patients compared to 192 prisoners. Also, as the study was only conducted on males, it may be difficult to generalise these findings to the BPD population, especially given the female gender bias in BPD diagnoses.

The latter study by Simeon *et al* (2003) compared 20 people with BPD with 24 'healthy' controls, and found that the BPD group reported greater levels of dissociation and childhood trauma, and that only the emotional neglect scores (rather than total childhood trauma) were significantly related to dissociative symptoms. This finding replicates those of a study by Draijer and Langeland (1999), which found childhood neglect to be of prime importance in the aetiology of dissociation. Simeon *et al* (2003) also found that dissociation was associated, although not significantly, to 'fearful attachment' and 'immature defences' within the BPD group. This study did not investigate the relation of trauma variables to borderline pathology, and the sample size was only small, meaning that any conclusions drawn need to be cautiously interpreted. However, it does indicate that certain aspects of childhood trauma may contribute to the development of dissociative symptoms, and highlights the need for further investigations into this apparently complex relationship.

Two further studies have looked at these relationships in patients with borderline diagnoses. Goodman *et al* (2003) used taxometric analyses, a statistical method devised to specifically identify *pathological* dissociation, to examine these relationships. Their study looked at 95 people with a personality disorder (37% of whom had BPD), recruited from the community via an advertisement and clinician referral. This study found the moderate presence of dissociative symptoms, but that pathological dissociation, as defined by their use of taxometrics, was not associated with personality disorder or any of the variables of childhood trauma. They did find, however, a significant relationship between 'fear of abandonment' and pathological dissociation, which they suggested form the basis of future research investigations. This again reflects the potential importance of attachment in the development of dissociative symptoms.

It is important to note that this study, unlike the majority of those conducted in this area, used a sample of people from the community as opposed to psychiatric inpatients. This may well account for the lack of pathological dissociation found (only 15 of the 95

subjects), and subsequent lack of associations between these variables and childhood trauma. It may be that trauma levels experienced had not been as severe in this group, and so had not resulted in pathological levels of dissociation. Goodman *et al* (2003) do suggest childhood trauma may be related to the development of less severe dissociative symptoms, which in this community group may well be true; they also suggest that environmental factors may be more influential than childhood trauma in the development of pathological dissociation. It should also be noted that only a relatively small percentage of the sample had BPD and, of particular importance, those with substance abuse were excluded from the study. Given the high percentage of BPD comorbidity with substance abuse (20% of respondents had lifetime history of substance abuse), this is important factor to take into account. It also indicates the potential role that substance abuse plays in the development and experience of pathological dissociation, which warrants further investigation. Again, the sample size was relatively small, and no control group was used, both of which limit the statistical findings from this study.

The second study was conducted by Watson *et al* (2006) and investigated 139 outpatients with BPD; they found that levels of dissociation increased with levels of reported childhood trauma, providing support for a causal link between the two within BPD. Like many other studies, they assessed childhood trauma with the Childhood Trauma Questionnaire and dissociation with the Dissociative Experiences Scale (DES), both of which are well-researched, reliable and valid measures (e.g. Bernstein *et al*, 1994; van IJzendoorn and Schuengel, 1996). Like the study by Timmerman and Emmelkamp (2001), this study failed to find a link between CSA and dissociation and, like Simeon *et al* (2003), discovered the strongest relationship was between dissociation and emotional abuse; however, it would be useful to see if these relationships could be replicated by using interview measures in addition to the questionnaires. One problem with this study was that they were unable to control for comorbid diagnoses, and they note that the percentage of sample with PTSD was unknown and may have impacted on the results found. They suggest that their findings demonstrate that dissociation can be seen to share childhood trauma as an aetiological factor, rather than existing as an intrinsic part of BPD as suggested by the DSM-IV. This is an interesting assertion, but one that is not clearly demonstrated in their study; the inclusion of a control group may be one way of establishing direction of causality. However, it does justify further studies to examine the complex interaction of dissociative symptoms and BPD.

Two prospective studies (the first a 7-year follow-up study, the second being a 2-year follow-up) examining predictors of outcome in BPD found: that CSA is linked to BPD, and it is CSA that predicts poor outcome following deliberate self-harm, rather than the BPD diagnosis itself (Soderberg *et al*, 2004); and that higher levels of BPD pathology and a history of childhood trauma predict poor outcome, with current relationships offering a protective function (Gunderson *et al*, 2006). A well-structured and rigorous study by Zanarini *et al* (2000) used the DES and semi-structured interviews to assess childhood trauma and dissociation within BPD. They identified 'inconsistent treatment by a caretaker', 'sexual abuse by a caretaker' and 'witnessing sexual violence as a child' as significant risk factors for dissociation, and all were significantly related to the level of dissociation reported (Zanarini *et al*, 2000). Most strikingly, Zanarini *et al* (2000) found that once they entered an Axis II comparison sample, BPD joined the other risk factors, implying that something inherent to the borderline diagnosis makes it a risk factor for dissociation. This supports other studies that have shown higher levels of dissociation in BPD compared to other PD, and suggests a combination of environmental and internal factors in the development of dissociation in this client group. A key finding of this study highlights the impact of CSA committed by a caretaker, rather than CSA in general, on levels of dissociation within BPD.

Finally, three recent studies have identified specific childhood trauma variables associated in the development of BPD: Bierer *et al* (2003) found that childhood emotional abuse and neglect, not CSA, were significantly associated with BPD in an outpatient sample, but interestingly only for men; Bandelow *et al* (2005) reported the significance of CSA, parental separation, familial psychiatric disorders and negative parenting style, indicating the multifactoral nature of BPD aetiology; finally Sansone *et al* (2005) stressed similarly complex relationships finding that, in a sample of inpatients, rates of childhood trauma (sexual, physical and emotional) and multiple Axis I disorders were higher among those with BPD than those without.

Summary: These studies generally found a significant link between childhood emotional abuse and neglect and dissociation, and between CSA and BPD, in borderline samples. Interestingly, a link between CSA and dissociation was found, but only when using interviews as opposed to self-report questionnaires. Gender also appeared to influence findings with emotional abuse and neglect, rather than CSA, significantly linked to BPD in men only. Levels of dissociation and childhood trauma were higher in

BPD compared to healthy controls and other PD, and levels of dissociation increased with severity of trauma experienced. One taxometric study found no link when measuring pathological dissociation with BPD and childhood trauma, although this was a community sample with mainly male respondents, which omitted those with substance abuse. The overall findings suggest a complex interplay between environmental and psychobiological factors in the development of dissociation within BPD.

ii) Childhood Trauma, BPD and Dissociative Disorders (DD)

Close relationships were found between BPD and DD in all the studies, indicating a shared link with childhood trauma. A group of studies conducted by Sar and colleagues found high comorbidity rates between the two, and differential effects for different aspects of childhood trauma: for instance, one study found that childhood emotional and sexual abuse, physical neglect and total childhood trauma were significantly related to BPD, whereas emotional neglect was significantly related to DD (Sar *et al*, 2006); another found that only emotional abuse significantly influenced dissociation scores (Sar *et al*, 2004). They state that this lack of interaction between BPD and DD compared with types of childhood trauma suggests they are separate constructs with different aetiological factors, rather than aspects of a single disorder, and that many Axis I DD are under-diagnosed in the BPD population (Sar *et al*, 2006); also that the high comorbidity levels call for a revision of the DD criteria in DSM-IV (Sar *et al*, 2007). Sar *et al* (2004) state that their studies provide support for the concept of BPD and dissociation existing on a spectrum of adaptation to trauma. Lipsanen *et al* (2004) and Ross (2007) also found these high comorbidity levels, particularly between BPD and DID, and pointed out the need for further clarification as to when to diagnose DD in the presence of a PD; Ross (2007) also stated that the dissociative criteria added to BPD in the DSM-IV did not adequately describe the evidently chronic and complex nature of this comorbidity.

Three studies also examined associations between childhood trauma, BPD and DD in substance and alcohol abuse samples. They reported that emotional and physical, not sexual, abuse were linked to BPD and that multiple types of abuse were related to increased severity of PD, independent of drug use (Haller and Miles, 2004). DD were linked to female gender, childhood emotional and sexual abuse, neglect and BPD in alcohol-dependent inpatients, and comorbid DD were more frequent among this group (Evren *et al*, 2005). Interestingly, one study reported a modifying effect of substance

abuse on these associations: with significant links between dissociation and childhood trauma for female participants with BPD, but not for those with BPD and substance abuse (Van Den Bosch *et al,* 2003).

Summary: Studies in this area found high comorbidity of DD with BPD, including those samples with substance abuse. DD and BPD were significantly related, and both had a shared link with childhood trauma, although it appears that different trauma variables influenced DD and BPD suggesting they are different constructs. One study using female substance abuse participants found no link between CSA and BPD, and that the severity of PD increased with reports of multiple trauma types. Finally, the potentially modifying effect of substance abuse rendered previously significant links between BPD, dissociation and childhood trauma insignificant.

iii) Psychobiological research

There has been a growing body of research investigating the neurological and psychobiological factors involved in the development of BPD and dissociation. There is only space in this review to mention a couple of these promising research papers, and it should be noted that given the preliminary nature of many of these studies, they all have very small sample sizes. Schmahl *et al* (2004) compared psychophysiological differences between PTSD and BPD subjects (all with a history of childhood sexual or physical abuse) and found greater skin conductance responses to abandonment scripts in the BPD group. Although it reported only modest effects, this study suggests differences between PTSD and BPD that may be linked to different types of childhood trauma. Vermetten *et al* (2006) used magnetic resonance imaging to measure hippocampal and amygdalar volumes in DID. This important study indicates that people with DID have significantly smaller volumes than healthy controls, and that these biological differences are also found in people with BPD (with early onset trauma) and PTSD. Reinders *et al* (2006) reported psychobiological differences between 'dissociative identity states' (DIS) within DID. They distinguished separate states within DID termed 'neutral' and 'traumatic' identity states, the former of which inhibits access to traumatic memories, while the latter has access and responses to these memories (Reinders *et al,* 2006). They subsequently found different psychobiological reactions to traumatic memories between DIS, providing evidence for the structural division of personality within dissociation that Janet originally proposed. Finally, it may be possible that dissociative symptoms in BPD indicate an increased biological vulnerability to

environmental stress (Simeon *et al*, 2007). These studies have all generated exciting implications for our understanding and need to be followed up with further, larger scale studies.

iv) Memory, dissociation and BPD

Merckelbach and colleagues have conducted various studies relating to dissociative symptoms, childhood trauma and 'fantasy proneness' (Merckelbach and Jelicic, 2004; Merckelbach, 2004). They describe fantasy proneness as a personality trait that refers to a 'deep, profound and long-lasting involvement in fantasy and imagery' (Merckelbach *et* al, 2005, p.181); and they propose that dissociation overlaps with this trait. A preliminary study conducted on clinical samples reported that this overlap is seen in samples with BPD and schizophrenia (Merckelbach *et al*, 2005). They found significantly higher levels of dissociation in BPD compared to other PD, as other studies have, but they believe that this reflects differences in temperament (reflected by correspondingly higher levels of fantasy proneness), which they see as having a primarily genetic cause. Hence, this study asserts that the group differences in dissociation are possibly explained by differences in personality temperament. A study by Pekala *et al* (2001), using multiple regression analyses, also suggested that dissociation could be predicted as much by fantasy proneness as by childhood trauma, using male substance abuse populations.

Merckelbach *et al* (2005) suggest that 'high fantasy-prone' people have a tendency to 'overendorse bizarre items' (p.183) – although they make this point in reference to other studies not through their own measurements – remember vague rather than specific trauma items, and are 'better story-tellers' (Merckelbach and Jelicic, 2004). This is important, as they are suggesting that an intrinsic part of this trait is a tendency to 'positively report', which they claim puts question to self-reports of childhood trauma; they also question the accuracy of subjective reports of high dissociators for the same reason (Merckelbach *et al*, 2005). They fundamentally argue against the acceptance of a trauma-based theory of dissociation, and instead point towards an internal, personality-based explanation. This is a controversial argument, related to the false-memory position, and is based on very small samples (e.g. 20 patients with BPD) while relying on self-report measures alone. There also appears to be an overlap between how the constructs are defined: with daydreaming-type behaviours measured by both the DES and the Creative Experiences Questionnaire, used to measure fantasy

proneness (both used in this study). Nevertheless, it is an interesting view, which potentially indicates the involvement of a personality trait in the development of dissociation in PD.

Interestingly, a recent study conducted by Geraerts *et al* (2006) into dissociation and fantasy-proneness in women with recovered, repressed and continuous memories of CSA, reported that all groups had higher levels of dissociation than controls, but that those with repressed and recovered memories scored higher on dissociation. However, they found that all the groups had higher levels of fantasy proneness, which they concluded could not support the idea that dissociative symptoms can be fully accounted for by fantasy-proneness; this also suggests that fantasy proneness is not associated with only repressed and recovered memories of abuse. Research by Kremers and colleagues also demonstrated that a sample group with BPD remembered specific items from their childhood, and these memories were unrelated to levels of childhood trauma or dissociation; they found that only the group with comorbid depression had trouble remembering specific events (Kremers *et al*, 2004). In another study they found that self-reports of childhood trauma in BPD did not change in a sample of 50 patients following 27 months of therapy (Kremers *et al*, 2007). Both of these studies support the accuracy of self-reports of childhood trauma in BPD, but of course, this cannot be proved without prospective studies corroborating incidents of childhood trauma. Indeed in those prospective studies that have examined childhood trauma memories, childhood survivors were more likely to forget or deny traumatic events than fabricate them (Krakauer, 2002).

Summary: Fantasy proneness is described in the literature as a personality trait that has been linked to dissociation within BPD and other PD, with a greater tendency to positively report childhood trauma on self-report scales and be better 'story-tellers'. Increased levels of 'fantasy proneness' are found with increased dissociation and, as such, caution is advised when interpreting self-reports of childhood trauma in highly dissociative groups. The authors of these studies have proposed that dissociation is likely to be caused by both childhood trauma and fantasy proneness. However, specific memories of childhood trauma have also been reported within BPD, unrelated to levels of dissociation or trauma, and these memories appear to remain stable over time and after therapy. Prospective studies have indicated that those with traumatic childhoods

are actually more likely to forget or actively deny traumatic memories from their childhood.

B.4. Discussion

This results of this review clearly demonstrate that dissociation and BPD are intimately associated with each other, but exactly how is still not clear. The evidence strongly points to their existence as separate constructs, with a shared link with early childhood trauma. The lack of interaction between specific childhood trauma variables for both DD and dissociative symptoms and BPD suggests they are different concepts with different causal pathways, although the results from current research need to be replicated with large-scale studies. Nevertheless, the under-diagnosis of DD within BPD needs to be addressed, and clinicians need to be aware of this high comorbidity and to know when to diagnose Axis I DD in PD. There is clearly a need for the DSM to elaborate on these relationships and to describe the common comorbidities in more depth, providing more guidance on when to make which diagnoses. This comorbidity has led some researchers to propose that the categories be reclassified in terms of trauma related disturbances: "reflecting common underlying problems in posttraumatic self-dysregulation and attachment disorganisation" (Ford and Courtois, 2009, p.20).

A complex relationship evidently exits between these constructs and further studies are needed to help clarify the situation. The research reviewed demonstrates that childhood trauma variables alone are not explaining the whole picture, which suggests that something still needs to be accounted for in the development of dissociative symptoms and BPD. Current research into both environmental and familial factors is very promising, as are investigations into psychobiological and neurological factors. It would be useful to investigate the different aspects of trauma as well as the child's environment, parenting style and family life, and their interactions with neurobiological factors in pathological development. The research plainly indicates that increased childhood trauma levels correlate with increased dissociation and severity of pathology, which provides support for the notion of a trauma-based spectrum of disorders. The evidence, backed up by psychobiological research, also points to a structural division of the personality within dissociation, as originally suggested by the work of Janet.

The work into memory, fantasy proneness and dissociation needs to be considered. Even though their own research indicates that fantasy proneness is not completely

accounting for levels of dissociation, Merckelbach and colleagues' theory of personality needs to be explored further. It is certainly plausible that some accounts of childhood trauma are false, and it sounds logical that high dissociators would also experience high abilities to fantasise and imagine, especially if dissociation is seen as an escape from a painful reality. But even so, a good aptitude towards creative story telling does not directly imply that severely traumatic childhood memories are fabrications. As Krakauer (2002) points out, people are more likely to forget or deny such memories than make them up. It is interesting to note that semi-structured interviews are more likely to identify significant associations between CSA and dissociation than self-report measures alone, which may suggest that people may be reluctant to divulge such personal information on paper. Still, this research highlights the need to be careful and not to automatically assume a trauma exists when it may not. I believe that part of our role as therapists is to understand how our clients histories have impacted upon their current distress and difficulties; however, it is equally important to avoid making assumptions, and in doing so convey the message that abuse makes problems in later life inevitable (Kennerley, 2000). Similarly, it becomes the task of the therapist to achieve a balance between the extreme responses of 'uncritical endorsement' (of traumatic memories) and 'rigid dismissal', and instead encourage exploration without jumping to conclusions (Krakauer, 2002, p.38).

Returning to the investigation of dissociation, Van der Hart and colleagues (2004) make an important point when they call for the need for conceptual clarity. They believe that the 'imprecise' definitions of dissociative symptoms used within current literature prevent real progress being made on our understandings of trauma-related dissociation. Reviewing the literature highlights that this may well be the case, with different studies using different conceptualisations: some distinguishing high from low dissociation, others focusing on pathological and non-pathological, while others disregard bodily sensations of dissociation, and focus purely on the mental elements. Hence, a 'fundamental conceptual vagueness regarding the use of the term dissociation remains' (Loffler-Stastka, Szerencsics and Bluml, 2009, p.82). Without universal clarity, a comparison between papers and theories is not possible. It therefore becomes a prime target to work towards developing an accepted definition of dissociation. Van der Hart *et al* (2004) state that viewing dissociation as a structural division of personality may essentially resolve these problems, as everyday alterations in consciousness, such as daydreaming, are not seen as dissociative symptoms, whereas positive and bodily forms

of dissociation are reintroduced. Accepting this conceptualisation of dissociation would have implications for treatment and, given the supporting body of research, this does not seem an unreasonable proposal.

Despite these general conclusions, several important limitations of the current research need to be addressed. Firstly, the studies were often conducted using small sample sizes and either clinical or non-clinical samples with no control groups. Many used standard and well-validated self-report measures, such as the DES, but did not back this up with different types of measures, such as semi-structured interviews. A majority of the studies were cross-sectional in design, which made presumptions about directions of causality; as such, large-scale, prospective studies are urgently needed in this area to clarify these issues. Many of the studies classified dissociative symptoms in different ways, as mentioned above. Finally, the gender differences indicate an interesting avenue for further exploration, as it may be that females dissociate more readily than males, or that childhood trauma variables result in different responses according to gender: clarifying these relationships would assist our understanding in this area. Similarly, the use and influence of substances and alcohol are important areas for further research, especially given the high comorbidity within BPD.

This review has generally replicated the findings of Gershuny and Thayer (1999) and supported a view of BPD and dissociation as trauma-related disorders. The link between the two is far from clear, however, and further research is called for to further our understanding. Most importantly, there now appears to be a strong need for well-designed and ethically sound prospective studies with children and adolescents; not just to help increase our understanding of the factors involved in dissociation and PD, but also since, if the root of these disorders do lie in childhood, then preventative research and treatment is surely a first priority. As Counselling Psychologists we owe it to our clients to at least try to understand and listen to their stories. When we are either assuming a traumatic childhood or denying one, then we have stopped listening. Regardless of their childhood, these clients need to be given an equal standard of therapeutic care, and debates over aetiology should not obscure the pressing need for the development of effective treatment interventions.

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C: Empirical Research

"My label is not a self-harmer.. I'm just someone who happens to hurt themselves sometimes": Pathology and morality – constructing self-harm at the turn of the 21st century.

C1. Abstract

This research study aims to explore how self-harm is being constructed within available discursive resources in contemporary western society. A Foucauldian Discourse Analysis was conducted on a sample of professional documents on self-harm and interview transcripts: these included 6 interviews with people who self-harm (or have self-harmed in the past), and a focus group with 5 health professionals working within a residential unit for people who self-harm. The analysis generated three major discursive themes in relation to the object of self-harm within expert text and discourse: pathology (external 'other' and internal dysfunction); risk and danger; and choice, addiction and morality. Participants who self-harmed were seen to struggle within available discourses, most notably between utilising a discourse of confession and keeping the behaviour secret within a wider moral discourse of recovery. Using psychological discourses provided a valid reason for self-harm, constructing it as genuine as opposed to attention-seeking, and resulted in more compassionate behaviour from others; but it also created a tension when it resulted in being attached to the person as a label, and as indicative of permanent internal dysfunction and damage. Finally, constructions of self-harm as risk and danger were strongly resisted by participants; however, they were also utilised to construct the behaviour as needing to be taken seriously by health professionals, therefore 'genuine', subsequently allowing access to treatment. The struggles evident in the participants' constructions of their self-harm behaviour were strongly apparent, resulting in a constant shifting between discourses, as each subsequent position was found to be disempowering. Ideas for future research and developments with Counselling Psychology practice are discussed in light of this analysis: particularly the need for psychology to adopt a depathologising approach to therapeutic care and distress, by paying more attention to the social and contextual factors involved, and develop a critical awareness of the powerful impact that language can have upon people's experiences.

C2. Introduction

Self-harm is a complex and little-understood behaviour, yet it poses a great challenge to health service providers within the UK. It is generally considered to have a poor response to treatment interventions and has been reported as 'one of the most treatment resistant behavioral disorders in psychiatry' (Tuinier and Verhoeven, 1996, p.521). Research has identified self-harm as one of the highest risk factors for suicide (Hawton, 2004; Didham *et al,* 2006; Singh *et al,* 2002; Kapur, 2005; NICE, 2004b), as a behaviour that has been increasing over recent years (e.g. Plante, 2007; Fortune and Hawton, 2005), and as a burden upon health services, causing high levels of distress to those who live with it (Boyce, 2004). Despite the implementation of national guidelines to aid in the management of self-harm, there still remains a reported stigma and negative stereotyping of this behaviour amongst those who are on the 'front-line' of treatment provision (Kapur, 2005; Warm *et al,* 2002; Greenwood and Bradley, 1997), and a high level of dissatisfaction with services among those who self-harm (O'Donovan, 2007; Persius *et al*, 2003; Hume and Platt, 2007).

There are also debates as to what exactly treatment should be aiming for (prevention or management), with some research questioning the ethics of preventing a behaviour which may be providing a way of coping (Arnold, 1995). Such debates indicate a potential conflict between how people who self-harm understand their behaviour, and how the professionals involved in their care do. Despite a recent increase in qualitative studies and books dedicated to self-harm, there is still a lack of understanding into how both health professionals and service users construct and make sense of self-harm, and how these constructions impact on their subjectivity and behaviour. Exploring self-harm from the perspectives of both people who engage in this behaviour and health professionals is important in terms of understanding and evaluating treatment interventions, and also for the development of more effective management strategies.

This study adopts a social constructionist framework and is particularly interested in the role of language and how self-harm is constructed in contemporary western society. This is especially pertinent for the profession of Counselling Psychology as these constructions have far-reaching implications for practice, research and the therapeutic relationship.

This chapter will begin by exploring definitions of self-harm within the literature, before looking briefly at the cultural and historical differences in understandings, outlining the epidemiology of self-harm and how it appears within diagnostic classifications, with corresponding implications for policy and politics. The aetiology of self-harm will then be explored within various different models of understanding, which inform different approaches to treatment, both biomedical and therapeutic. Finally a review of other qualitative research in the area will be presented before outlining the current aims for this research study.

C2.1 Definition

The definition of self-harm can be quite confusing and different terms are used throughout the literature, including: self-injury, cutting, self-mutilation, deliberate self-harm, self-wounding, parasuicide, self-inflicted violence and self-injurious behaviours; see Table C1 for a list of behaviours that can be understood as self-harm. Self-harm is often defined as the deliberate harming or injuring of one's own body 'without suicidal intent' (Klonsky, 2007, p.226); and whereas some researchers see self-harm and suicide as similar constructs (e.g. of self-destructiveness: Linehan, 1993), others see self-harm as the opposite – as an active way of surviving (Babiker and Arnold, 1997) or adaptive alternative (Solomon and Farrand, 1996). However, despite this, much of the research undertaken has been on self-harm as presented to A&E hospital departments, where the line between self-harm and suicide has for the large part been blurred. The term 'non-fatal' self-harm was developed to clarify a distinction between self-harm and completed suicide (McMillan, Gilbody, Beresford and Neilly, 2007; Kapur, 2006a; Kapur *et* al 2006). Interestingly, this still conveys connotations of risk. Even without apparent suicidal intent, Farber, Jackson, Tabin and Bachar (2007) noted that self-harm may still be life threatening, which makes a construction of 'risk' possible without needing to acknowledge the person's intentions.

Much of the research in this area has constructed self-harm as indicative of 'risk' for suicide: a dangerous, pervasive and perplexing behavioural problem (Craigen and Foster, 2009; Nock, Teper and Hollander, 2007; Prinstein, 2008) and growing public health concern (e.g. Hawton *et al,* 2007; Best, 2005; Kapur, 2005; Sinclair and Green, 2005; Hawton, 2004), particularly among young people in the UK (Fortune, Sinclair and Hawton, 2008). As a result, it has become of increasing concern to health professionals as a clinical condition and topic for research, prompting the production of national

clinical guidelines and policy documents which inform and impact upon the treatment of people who self-harm. However, research figures tend to be based on hospital presentations, which are more often indicative of suicide attempts than repetitive self-harm in the form of cutting: a report by the BBC identified that such populations tend to keep their behaviour hidden, and will avoid seeking help from formal services (BBC, 2000). Turp (2003) has also drawn attention to this, stating that most self-harm is 'hidden' and 'low key' as opposed to the more dramatic and severe examples seen by clinical practitioners, believing this former group to be neglected in current literature.

Types of self-harm
Cutting
Burning or scalding
Bruises and banging
Scratching, picking, scraping or biting
Inserting sharp objects (under skin or into body)
Tying ligatures (strangulation)
Pulling out hair
Bathing in bleach
Swallowing sharp objects or harmful substances (poisoning)

Table C1: Types of self-harm behaviour (adapted from Sutton, 2007)

In an attempt to address these conceptual difficulties, the Department of Health's National Institute for Clinical Excellence (NICE) produced clinical guidelines (2004a) defining self-harm 'irrespective of the apparent purpose of the act' (p.7) and dropped the word 'deliberate' as a prefix to self-harm. Similarly, the Royal College of Psychiatrists' (2004) clinical assessment guidelines recommended the term 'deliberate' be dropped due to objections from service users that this implied blame, awareness and conscious intent (Sutton, 2007). Fox and Hawton (2004) agreed, viewing self-harm as the result of impulse rather than conscious deliberation, and Kapur (2005) supported this move but maintained a link between self-harm and suicide, reinforcing the construction of self-harm as indicative of 'risk'.

In direct contrast, Motz (2009b) stated that self-harm *should* be recognised as a deliberate and conscious act, with its meaning being of paramount importance: 'to deny this is to disregard its communicative function and its role as an expression of hope, not

simply despair' (p.16); as do Schoppmann *et al* (2007), who see self-harm as a form of 'self-care'. Favazza (1996) also constructs self-harm as a symbol of hope:

> *"It is easy to forget that dripping blood may accompany birth as well as death. The scars of the process are more than the artless artefacts of a twisted mind. They signify an ongoing battle and that all is not lost"* (p.322)

Here, self-harm can be seen to be constructed as a positive act of communication, hope and survival.

A wider definition of self-harm may encompass more socially acceptable behaviours, such as: excessive drinking, smoking, dieting, body piercing and tattoos, compulsive shopping and working, and plastic surgery. Few clinicians and researchers include these more socially acceptable forms of behaviour under the rubric of 'self-harm', although Babiker and Arnold (1997) comment upon the similarities of 'body enhancement' behaviours (such as piercing, tattoos, plastic surgery, hair removal and wearing corsets) to self-injury, differing only in their 'total social acceptance.. seen as serving as testimony to someone's level of functioning and consideration of themselves as 'worth' the effort and expense' (p.3). Some researchers have proposed a view of self-harm as existing on a continuum (e.g. Turp, 2003; Douglas *et al*, 2004), from the less physically harmful and more acceptable behaviours (compulsive shopping or decorative body piercing) on one end, through 'compromised self-care' and 'mild self-harm' (Turp, 2003, p.29), to severe self-harm and suicide at the other. It appears that western society at the beginning of the 21st century understands 'self-harm' as forms of injury that are not socially condoned (Babiker and Arnold, 1997), and therefore seen as 'a problem' (Turp, 2003).

The terms 'self-harm' and 'self-injury' are often used interchangeably, while some researchers emphasise that they 'may refer to different behaviours with different meanings' (Claes and Vandereycken, 2007, p.137); for instance, Duffy (2006), Sutton (2007), and Lilley et al (2008) describe self-injury as distinct from self-harm in terms of type of behaviour, being most often defined as cutting. Babiker and Arnold (1997) distinguish between self-injury, self-harm, self-destructive behaviours, body enhancement, factitious disorders (previously known as Munchausen syndrome) and other, marginal self-injurious behaviours, but acknowledge that these are all linked by

the harm they cause to the body. Sutton (2007) proposes that 'self-harm' and 'deliberate self-harm' are terms most commonly used in the UK, whereas 'self-injury', 'self-mutilation' and 'self-inflicted violence' are more common in America; however, this may be changing through the increased sharing of language and information through the Internet.

More recently, researchers have employed the term 'non-suicidal self-injury' (NSSI) to distinguish self-harm behaviours, such as cutting, from a broader conception of self-harm which may include suicidal behaviours, such as overdose (e.g. Klonsky and Muehelnkamp, 2007; Armey and Crowther, 2008; Prinstein, 2008; Klonsky, 2009; Nock and Favazza, 2009, Ross, Heath and Toste, 2009; Walsh, 2007); however, this is not without its criticisms and researchers and clinicians remain dissatisfied with current definitions which are seen to prevent a common shared understanding and therefore hamper research progress. For instance, it is difficult to compare findings across studies when different definitions have been used, as these are potentially studying different behaviours with different meanings and functions (Brown, Comtois and Linehan, 2002). Research has supported such distinctions amongst constructs and found that different types of self-harm (e.g. suicide versus NSSI), 'have different base rates, correlates, courses, and responsiveness to treatment' (Nock and Favazza, 2009, p.11).

Cultural and historical influences

Self-harm has evolved over history and cultures, often bearing both religious and spiritual significance, and can be seen in such practices as: foot binding in China, circumcision in many African countries, self-flagellation in Shiite Moslems, and various acts which demand suffering as a form of religious cleansing and redemption and which view self-harm as a step to greater wisdom and enlightenment. For instance, in the Gospel of Mark, a man believed to be possessed by the Devil cuts at himself repeatedly with stones (Favazza, 2009). Body mutilation and 'blood-letting' have been seen as important healing practices in many societies, and are often associated with identity and rites of passage within communities (Babiker and Arnold, 1997). Body modification rituals have been well-documented 'culturally sanctioned behaviours' across the world for more than 20,000 years, linked to 'healing, spirituality, and social orderliness.. woven into the fabric of social life' (Favazza, 2009, p.21). Quite plainly, self-harm has existed for many thousands of years, but has not always been viewed as an illness, disorder or negative behaviour.

In 1938, Menninger was the first researcher to focus upon self-harm as a distinct presentation within mental health, but his work did not gain popularity and self-harm remained unstudied until the 1980's (Favazza, 2009), when a recorded increase in self-harm behaviours in the 1960's and 70's prompted renewed interest (Favazza, 1998). Self-harm has received growing media attention in recent years, along with a proliferation of Internet chatrooms dedicated to this behaviour. Behaviours that were once considered 'deviant' are also now more common (such as tattoos and piercing) indicating a growing social acceptance of self-harm, particularly among young people (Favazza, 2009). Unfortunately, time constraints and word limits make a full exploration of the historical and cultural significance of self-harm impossible for this study, which will focus primarily on contemporary western constructions; the interested reader can find more information in Favazza'a comprehensive book, '*Bodies Under Siege*' (1996).

C2.2 Epidemiology of self-harm

The 'escalating epidemic' (Plante, 2007, p.xiii) of self-harm is viewed as costly 'in terms of both individual distress and also service provision' (Boyce, 2004, p.868). Research has demonstrated a high risk of repetition and suicide following previous episodes of self-harm (Hawton, 2004; Didham *et al,* 2006; Singh *et al,* 2002; Kapur, 2005), and self-harm and suicide are reported as 'the third leading cause for life years lost following cancer and heart disease in all age groups' (NICE, 2004b). Given the sensitivity surrounding the behaviour and lack of clear definitions, its prevalence is difficult to determine, but estimates have ranged from anything between 6.9% and 39% of adolescents in community samples (Duffy, 2006; Nock and Prinstein, 2005), and between 21% and 61% of clinical samples (Prinstein, 2008), with adults between the ages of 18-25 identified as 'the highest risk group for engaging in (self-harm)' (Rodham and Hawton, 2009, p.46). It is one of the most common presentations to Accident and Emergency departments of hospitals across the UK (Bolton, 2006; Boyce, 2004; Hawton *et al,* 2007; Kapur, 2005), with overdose being the most common reason (Hawton, 2004), and it is believed to be increasing, particularly among young people (Fortune and Hawton, 2005). An anonymous questionnaire study by Hawton *et al* (2002) found that as few as 12.6% of teenagers who self-harmed actually presented at hospital, suggesting that the true prevalence rates may actually be much higher than hospital-based figures suggest.

Self-harm is often believed to occur more frequently in females than males (Sutton, 2007; McAllister, 2003) and in people under the age of 30 (McAndrew and Warne, 2005), with one large-scale community study of 14-15 year olds finding reports of self-harm as 4 times higher among girls (Hawton *et al*, 2002). Studies have also reported a similar gender split among adults (e.g. Ogundipe, 1999; Suyemoto, 1998). However, research has been inconsistent and recent studies have demonstrated comparable rates across gender (Hawton, 2004; Gratz and Chapman, 2007; Kapur, 2006a; Marchetto, 2006). A large monitoring study assessing self-harm presentations in six general hospitals across the UK found that 57% of cases were female and 62.9% were under 35 years of age; it also found that the female to male ratio decreased with age (Hawton *et al,* 2007). Despite these findings, the majority of research to date has focused on self-harm in females and adolescents; possibly because self-harm is believed to begin in adolescence in many cases (Klonsky, 2007; Rodham and Hawton, 2009), with children being viewed as a more vulnerable population group. It may also be more difficult for men to admit to self-harming (Wedge, 2007), or it may be that destructive/aggressive behaviours (such as contact sports, fighting and high-speed driving) are more socially acceptable in males than females and so provide channels for anger while not being classed as 'self-harm' (Sutton, 2007).

Self-harm has been studied in specific populations and has been found to occur in a disproportionately high number of females in prison (Short *et al*, 2009), a population described as 'mentally ill' and 'chronically disturbed' (Lord, 2008, p.928), and people in young offenders institutions, where it has been related to more severe mental health problems, childhood abuse and psychological distress (Kenny, Lennings and Munn, 2008). Recently, a meta-analysis and systematic review conducted by King *et al* (2008) reported a higher risk of self-harm among lesbian, gay and bisexual people. Recent studies and a systematic review looking at ethnic and cultural differences in self-harm have shown higher rates amongst South Asian women in the UK, compared to South Asian males and white females, indicating a need for further research and more culturally sensitive assessments (Ahmed, Mohan and Bhugra, 2007; Husain, Waheed and Husain, 2006; Bhui, McKenzie and Rasul, 2007).

C2.3 Diagnostic classifications

Within the American Psychiatric Association's *Diagnostic and Statistical Manual* (DSM IV TR, 2000) and the World Health Organisation's *International Classification of Diseases* (ICD) diagnostic manuals, self-harm does not appear as a separate diagnostic category in its own right, despite there being calls for this since the 1980's: e.g. 'The Deliberate Self-Harm Syndrome' proposed by Kahan and Pattison (1984) delineated clinical features (a typical pattern of onset in late adolescence, multiple recurrent episodes, low lethality, harm deliberately inflicted upon the body, and extension of the behaviour over many years) separating self-harm out from other 'self-destructive behaviours', which they believed justified its separation as 'a diagnostic syndrome'.

Favazza and Rosenthal (1993) called for self-harm to be recognised as 'a syndrome of repetitive superficial or moderate self-mutilation (which) should be regarded as an axis I impulse disorder' (p.134). Indeed, other authors have also called for its inclusion as a separate diagnosis within this category (e.g. Fox and Hawton, 2004; Turner, 2002 – who proposes that self-harm be reclassified as 'self-injurious behaviour syndrome' within this category), with moves to include it within the DSM-V, due to be published in 2010 or later. Self-harm does appear as a criterion for and is associated with various mental health diagnoses, such as learning disabilities (e.g. 'self-injurious behavior syndrome', 'stereotypic movement disorder' and autism: Harris, 1998). Adler and Adler (2007) note that it most often features as a symptom of others disorders that are mainly to do with impulse control, such as: borderline personality disorder (BPD), antisocial personality disorder, histrionic personality disorder, depressive disorders, dissociative disorders and psychosis.

Trichotillomania (hair-pulling), substance abuse and eating disorders could also be viewed as forms of self-harm, although Babiker and Arnold (1997) distinguish the latter two as 'self-destructive behaviours' rather than 'self-injury'. Sutton (2007) labels eating disorders, substance abuse, risk taking and the more accepted forms of behaviour, such as gambling, excessive work and smoking, as 'non-direct self-harm' with the view that, unlike self-injury, causing harm to oneself is not usually the direct aim of this behaviour. Labelling self-harm as a distinct 'disorder' comes with its own problems, however, and can result in negative stereotyping as seen in the diagnosis of BPD (Babiker and Arnold, 1997). Many people who self-harm are given a diagnosis of BPD regardless as to whether they meet other symptoms listed by the DSM (APA, 2000), and such labelling

can lead to negative attitudes among health professionals (McAllister, 2003; Turp, 2003).

C2.4 Policy and politics

NICE (2004a) have recently published guidelines to aid in the prevention and management of self-harm which, although generally welcomed, have also been criticised for not having an adequate evidence-base (Kapur, 2006b). The main recommendations stemming from the study involve treating service users with the same level of care and respect as any 'patient', offering appropriate training to staff who are in contact with those who self-harm, assessment to all people presenting at hospital following an act of self-harm, and treatment based on a full and comprehensive assessment (NICE, 2004a). In accordance with these guidelines there has been a recent change in emphasis from risk- to needs-assessment, focusing more on the precipitating 'psychosocial factors that might explain an act of self-harm' than the individual's risk of suicide (Kapur, 2005, p.498). This emphasis reflects a formulation-driven approach to treatment, which has been recommended by research (Duffy, 2006), and highlights a potential evolution from a construction of self-harm purely as 'risk' to one of 'need', with self-harm as a behaviour that can be explained and understood, and as an illness to be treated. This can be seen to reflect a medical discourse with identification of problem, explanation of causation and application of treatment.

Despite these recent guidelines, several studies have suggested that the attitudes of mental health professionals responsible for providing care still need to change (Kapur, 2005; Warm *et al,* 2002). Kapur (2005) states that there remain people who view those who self-harm as an undeserving population who 'divert resources from those with 'serious' physical or psychiatric illness' (p.498), with them often being perceived as 'difficult patients' (Schoppmann *et al*, 2009). The responses and actions of A&E doctors are seen as crucial in decreasing the risk associated with self-harm (Hadfield *et al*, 2009), and according to Duffy (2006), 'positive attitudes to the self-injurer' are a vital aspect of treatment (p.263), yet such attitudes are not commonly reported. An interesting finding by Hume and Platt (2007) suggests that people in their sample who self-harmed wanted services that acknowledged that self-harm may be *managed* without necessarily being *prevented*. This is in line with previous research, which suggests that the very notion of treatment to reduce or prevent self-harming behaviour is controversial, with such constraints being seen as potentially detrimental to the

individual being treated (Arnold, 1995). This is in direct contrast to most current treatment ideals established within medical discourses, highlighting a potential conflict over goals for treatment: a conflict that may subsequently impact negatively on treatment outcomes and undermine their success. If effective interventions are to be developed and utilised, there needs to be a greater convergence of understanding between mental health professionals and those who self-harm.

C2.5 Aetiology

In trying to understand and explain self-harm, psychological models have proposed an interaction of various contributing factors (biological, psychological and environmental), and Turp (2002) has warned against attempts to find one single, unified understanding of the causes, functions and meanings of self-harm, in respect of its complexity. Self-harm has often been linked to childhood trauma (e.g. Bierer *et al*, 2003) (particularly childhood sexual abuse and/or physical abuse): '(it is) at once to speak and not speak.. (of) unspeakable secret' (Babiker and Arnold, 1997, p.1)), and symptoms of post-traumatic stress disorder (PTSD) have been proposed as mediators between this trauma and subsequent self-harm (Horne and Csipke, 2009). Structural changes within the brain have been indicated following trauma, which have implications for the processing of emotions and memories (Sutton, 2007), creating a biological 'vulnerability' to self-harm. Within the cognitive-behavioural model, this trauma or underlying vulnerability may be seen to predispose a person to self-harm, but the development of the behaviour will depend on other factors such as personality, resilience, social environment, core beliefs surrounding the self and others, low self-esteem, negative thoughts, unhelpful coping and perfectionism (e.g. Sidley, 2006).

Psychodynamic models have also focussed upon early childhood years and explained self-harm through theories of disrupted attachment and consequences of neglect and loss, with self-harm constructed as an expression of 'intrapsychic conflict' (Gardner, 2001, p.107) or psychic pain. Alternatively, self-harm is seen as a paradoxical attempt at creating a secure base (Holmes, 2001) and regulating the internal world (Shaw, 2002), and people engaging in self-harm as possessing lower levels of internal structural and interpersonal integration (Boeker *et al*, 2008). From this position, self-harm may also be viewed as a form of punishment and/or gratification of repressed feelings (Shaw, 2002).

Sutton (2007) reports that childhood trauma may lead to an inability to express emotions, which has also been linked to diagnoses of BPD and PTSD, resulting in the development of self-harm. Dissociation is also linked to childhood trauma, and self-harm has been proposed as a way to break this numbness and bring the person back to 'reality' (Babiker and Arnold, 1997), or alternatively to induce dissociation when feelings are overwhelming (Horne and Csipke, 2009). However, not everyone who engages in self-harm has experienced childhood trauma, and likewise, not everyone who has experienced childhood trauma will go on to self-harm (Sutton, 2007).

In most of the psychological models, self-harm is constructed as a symptom of an underlying problem or distress. It is constructed as a maladaptive or problematic coping mechanism (e.g. Ogle and Clements, 2008) or the result of some deficit or dysfunction residing within the individual, often as a response to something external, such as a trauma. Self-harm has been explained as meaningful and serving a function: a behavioural response to stress and way of coping with difficult and negative emotions, decreasing affective arousal and promoting calm (Klonsky, 2009); a 'morbid form of self-help' that provides relief from disturbing emotions (Favazza, 2009, p.32), or a way of transferring 'emotional pain into physical pain' (Sutton, 2007, p.34). This can be seen as a type of emotion regulation (Gratz, 2007; Kleindienst *et al*, 2008), avoidance of/distraction from specific emotions (such as anger) (Babiker and Arnold, 1997), or 'experiential avoidance' (Armey and Crowther, 2008; Chapman, Gratz and Brown, 2006). It has been described as a form of communication and expression of psychological distress, and punishment (to self and others) (Horne and Csipke, 2009).

Biological and neurological models have proposed an influence of hormones and neurotransmitters on self-harm behaviour, and the presence of self-harm amongst some primates has been taken as evidence in favour of a biological component (Sher and Stanley, 2009). With the release of endorphins, behavioural psychology has explained self-harm as bringing immediate rewards and reinforcement, such as decreased stress and increased relaxation, understanding self-harm as an addictive and formed habit. Findings of reduced levels of serotonin in people exhibiting impulsive and aggressive behaviours have led some researchers to explain self-harm as resulting from a biological deficiency or dysregulation (e.g. Sher and Stanley, 2009). Sher and Stanley (2009) propose a 'homeostasis model', explaining self-harm as an attempt to restore reduced endogenous opioid levels to normal through 'stress-induced analgesia', constructing self-

harm as serving a biological function (p.107). Similarly, genetic factors have been identified which may mediate the link between childhood trauma and self-harm, suggesting a biological 'predisposition' and 'vulnerability' to self-harm behaviours (Sher and Stanley, 2009).

C2.6 Treatment

Biomedical approach

There is no single agreed upon treatment for self-harm, but the medical approach typically goes about 'fixing' (reducing or eliminating) the identified problem, healing the physical wound and preventing 'abnormal' behaviour, bringing it under control so it is no longer causing damage (Babiker and Arnold, 1997). Treatment for self-harm usually follows assessment (including risk) and may involve prescription of psychotropic medications (such as antidepressants or anxiolytics), pumping the stomach and administering intravenous fluids (Sandman, 2009, p.293), hospitalisation, residential treatment and/or behavioural management and psychological therapy; however, some people presenting to A&E have also reported experiencing 'increased observation, seclusion, and restraint' (Weber, 2002, as cited in Craigen and Foster, 2009, p.78). There is wide spread disagreement over which drugs to prescribe, and Sandman (2009) refers to 'a somewhat chaotic pharmacological approach' to the long-term treatment of self-harm in the community (p.293). There have been no studies to date evaluating the efficacy of medication in reducing self-harm behaviour (Klonsky and Muehlenkamp, 2007).

The clinical management of self-harm has generally been reported as inadequate, with hospitals not being 'appropriately organised to care for these patients' despite being the most frequent first point of clinical contact (Boyce, 2004, p.868). Douglas *et al* (2004) note that the high suicide risk accompanying deliberate self-harm is 'not reflected in clinical management' (p.263) and research has highlighted a significant number of presentations at A&E who are discharged without any proper assessment or follow-up (Greenwood and Bradley, 1997). Assessment is seen as a crucial aspect of patient care following incidents of self-harm, and a full assessment of the person's physical and mental health is recommended before the person is discharged (Owens, 2006). Hume and Platt (2007) state that interventions should acknowledge the diverse needs of self-harm patients and should therefore be tailored to individuals rather than adopting a blanket response. Although this situation does seem to be improving, there still remains

'uneven standards of care for people who attend hospital because of self-harm.. in the UK and elsewhere' (Owens, 2006, p.271).

Effective interventions targeting self-harm are portrayed as representing 'one of the best opportunities for suicide prevention worldwide' (Kapur, 2005, p.497), and Gask and Morriss (2006) see 'the ability of health professionals.. to assess and respond appropriately' as key (p.266). Singh *et al* (2002) recommend that emergency medical staff need education in the management of self-harm, and Greenwood and Bradley (1997) state that doctors and nurses within A&E need to be 're-educated to dispel their prejudices in order to improve the way in which the patient is assessed and treated', and 'so that they are better able to understand the needs of these patients' (p.136). Similarly, Hawton (2007) recommends that general hospitals should have separate designated services available for the management of self-harm. Residential treatment centres are increasingly being seen as a preferable and 'cost-effective alternative to inpatient care' and although the number of people, particularly adolescents, being treated in such centres has increased, research on their efficacy has been notably absent (Walsh and Doerfler, 2009, p.272).

Therapeutic approaches

Like the medical approach, therapeutic treatment has generally focused on preventing and/or reducing self-harm and suicide. Researchers have only recently begun to evaluate the efficacy of interventions, measuring success in terms of reduction in frequency of self-harm behaviour, with varying levels of success (Walsh and Doerfler, 2009). Therapeutic approaches to self-harm include CBT, dialectical behaviour therapy (DBT), problem-solving therapy (PST), feminist therapy and psychodynamic therapy. Muehlenkamp (2006) states that DBT and PST (both falling under the umbrella of CBT) have been the most extensively studied in relation to self-harm, with DBT showing promise in successfully reducing self-harm behaviours, although 'the effectiveness of PST is inconclusive' (p.170). A randomised control trial found evidence in favour of time-limited CBT (Slee *et al*, 2008b), and a study by Weinberg *et al* (2006) reported that a manual assisted form of CBT reduced self-harm frequency and severity. Boyce's (2004) study in Australia and New Zealand found that CBT, PST and the provision of emergency contact cards (listing contact details in case of emergency, such as feeling suicidal) did not reduce the repetition of self-harm; in the UK, Evans *et al* (2005) also found no benefit of emergency coping cards. Variations of CBT derived from the work

of Aaron Beck have been developed (e.g. Berk *et al*, 2004; Rudd *et al*, 2001), involving a focus on crisis plans and restructuring beliefs, with self-harm itself as the primary target of treatment. Although these models show some promise, further evaluation is needed (Slee *et al,* 2007). Prinstein (2008), Warm, Murray and Fox (2002), Johnston, Cooper and Kapur (2006), Bosman and van Meijel (2008) and NICE (2004a), all highlight the lack of evidence for treatments targeting self-harm, with no one therapy being demonstrated as more effective than another.

This mixture of results and general lack of demonstrated effectiveness has led self-harm to be labelled as a treatment-resistant behaviour (Craigen and Foster, 2009), although it could instead be highlighting a misalignment of therapeutic goals (between therapist and client), leading some researchers to call for an alternative outcome measure to self-harm repetition, one that is perhaps of more relevance to service users (Allen, 2007). Nevertheless, this translates to a potentially frustrating and negative encounter for the therapist, who is failing to make an impact on the 'problem' behaviour, which may affect their empathic capabilities, which in turn may have very negative 'psychological and emotional effects upon self-injuring clients' (Craigen and Foster, 2009, p.77) and leave the therapist feeling powerless and inadequate (Gardner, 2001). Especially since the therapeutic relationship is seen as a key component for success (Cooper, 2008; Trepal and Wester, 2007; Walsh, 2007; Nafisi and Stanley, 2007). The few studies measuring satisfaction with treatment amongst service users have found a diverse range of experiences, with many expressing dissatisfaction, especially with medical and psychiatric treatments (O'Donovan, 2007; Persius *et al*, 2003; Hume and Platt, 2007).

Dialectical Behaviour Therapy (DBT: Linehan, 1993) is one treatment that has shown the most promise in reducing self-harm and suicidal behaviours within BPD (e.g. Linehan *et al*, 2006; Stanley *et al*, 2007), receiving positive responses from both therapists and clients alike with decreased treatment drop-out rates (Perseius *et al*, 2003), but its application to self-harm in non-clinical populations has not been extensively measured. DBT involves weekly individual and group therapy sessions, and combines behavioural skills training, exposure and cognitive restructuring. The overall aim is to achieve emotional stability and safety for the client, with decreased self-harm and suicidal behaviours, as a first stage before working to reduce PTSD symptoms through narrative exposure to traumatic life events, and a structuring of life goals and increased self-esteem. Skills are actively taught by the therapist, who uses validation,

problem solving and contingency management to reinforce helpful adaptive behaviours (as alternatives to self-harm), and intensive telephone support is made available to the client 24 hours a day (Linehan, 1993). Interestingly, a randomised controlled trial assessing CBT for self-harm found that it was changes in emotion regulation difficulties that mediated much of the change in self-harm behaviour, leading to recommendations for treatment to target emotion-regulation (as in DBT) (Slee *et al*, 2008a).

Feminist therapy takes a different approach, preferring to eschew individual pathology and instead construct self-harm as a way of coping with and resisting abusive and disempowering environments and oppressive relationships (e.g. Brown and Bryan, 2007; Shaw, 2002), relocating the problem from the internal, individual level to an external, social level (Craigen and Foster, 2009). In this way self-harm behaviours are seen 'as attempts at solutions that work more or less well' (Brown and Bryan, 2007, p.1123). The aims of such therapy would be to work on empowering the individual by helping them connect to their emotional experiences, increase their ability to self-soothe and safely contain their feelings. Importantly, this would be done without presumption that the person wishes to stop self-harming and an equal, non-coercive relationship would be of paramount importance (Brown and Bryan, 2007). It is this determination not to impose assumptions as to therapeutic goals that separates this approach from others (such as DBT) that also enhance emotion regulation skills. Unfortunately, there has been very little research to date measuring the application or outcomes of therapy adopting such a postmodern framework to self-harm (Craigen and Foster, 2009).

Psychodynamic treatments are also not well researched, however, some studies have begun to demonstrate their effectiveness in reducing self-harm (e.g. Bateman and Fonagy, 2001). Like DBT, much of this therapy was originally developed to treat people with BPD (e.g. mentalization-based treatment (Bateman and Fonagy, 2004)), but self-harm is still often a specific target of treatment (Klonsky and Muelenkamp, 2007). Although there are many different forms of psychodynamic-oriented treatments, common aims tend to be: working through past relationship patterns and the use of interpretations and the therapeutic relationship to build new, more positive relationship patterns; increasing the strength of internal objects and self-image; and increasing emotional awareness and healthy expression (Klonsky and Muehlenkamp, 2007). The therapeutic relationship and the ability to contain the (unconscious) intrapsychic conflict - 'previously held by attacking the body' – within the countertransference is seen as key

(Gardner, 2001, p.107). Research by Korner *et al* (2006) found this type of therapy to be successful in improving interpersonal relationships, symptoms of distress, self-harm and frequency of mental health service use among outpatients. Like DBT, cognitive-analytic therapy (CAT: Ryle, 1995) was developed for the treatment of people with BPD, and has also shown promise in reducing self-harm behaviours in this population, while also improving general functioning and decreasing levels of distress (Martens, 2006).

Owens (2006) stated that the implementation of effective interventions following self-harm 'is an uncertain business because the evidence base is scant and equivocal', however, 'the brief forms of psychological therapy' provide the best evidence for benefit (p.271). As well as reduced incidence of self-harm, benefits here also refer to: 'improvements in mood, hopelessness and problems experienced' (Owens, 2006, 271). In the UK, Hawton (2007) believes that 'there is good evidence that psychological therapy is effective' (p.565). However, Kapur (2005) warns that the results from research to date on treatment efficacy are difficult to generalise, due in part to the tendency to target certain 'sub-groups' of individuals and reliance on the repeat presentation to hospital as the main outcome measured.

C2.7 Research on self-harm

The majority of research in this area consists of clinical studies investigating the management and prevention of suicide and self-harm, from the clinicians' rather than clients' viewpoints. Prior to 2000, research largely focused on the treatment of self-harm and self-harm in people with learning disabilities, particularly focusing on the role of reinforcement in this behaviour (e.g. Murphy *et al*, 1999; Derby *et al*, 1998) and treatment with medication (e.g. Cohen *et al*, 1998; Hellings, 1999). Studies since 2000 have broadly focused on: the epidemiology of self-harm (e.g. Hawton, 2004; Hawton *et al*, 2007; Kapur, 2006b); causal factors and links with childhood trauma and emotion regulation difficulties (e.g. Armey and Crowther, 2008; Boeker *et al*, 2008; Chapman, Gratz and Brown, 2006; Spinhoven *et al*, 2009); cultural differences and implications (e.g. Ahmed, Mohan and Bhugra, 2007; Bhui, McKenzie and Rasul, 2007; Husain, Waheed and Husain, 2006); relationship with suicide (e.g. Chan, Draper and Banerjee, 2007; Douglas *et al*, 2004, Hawton and Harriss, 2008); assessment and treatment (e.g. Boyce, 2004; Brown and Chapman, 2007; Burns *et al*, 2005; Crawford *et al*, 2007; Evans *et al*, 2005; Gask and Morriss, 2006; Slee *et al*, 2007); and occurrence across diagnoses such as personality disorder (e.g. Bierer *et al*, 2003; Commons and Lewis,

2008; Daffern and Howells, 2009), psychosis (e.g. Addington *et al*, 2009), eating disorder (e.g. Ross, Heath and Toste, 2009), chronic pain (e.g. Sansone, Sinclair and Wiederman, 2009), substance abuse (e.g. Jenkins, 2007), depression/bipolar disorder (e.g. Parker *et al*, 2005; Jones and Tarrier, 2005) and domestic violence (e.g. Sansone, Chu and Wiederman, 2007).

There has been an increase in research on adolescents and children in the past few years, particularly focusing on the prevalence, functions and treatment of self-harm within this population (e.g. Nock, Teper and Hollander, 2007; Whitlock, Muehlenkamp and Eckenrode, 2008). There has also been a small but noticeable increase in studies exploring self-harm dedicated Internet forums (e.g. Baker and Fortune, 2008), the experiences of teachers, parents and carers of young people who self-harm (e.g. Sansone, Wiederman and Jackson, 2008), and of self-harm within lesbian, gay, bisexual and transgender (LGBT) communities (e.g. King *et al*, 2008).

Studies have mostly used clinical cases in hospital or presentations to A&E departments but, as Hawton (2004) points out, many cases of self-harm occur in the community. There has also been a noticeable lack of engagement of service users and of qualitative studies in general. The NICE (2004a) guidelines report a need for further qualitative studies and Kapur (2005) concurs that alternative qualitative study designs may be of benefit to our understandings. Such qualitative enquiry would enable a more in-depth exploration of meaning and experience, particularly from the perspective of people who self-harm, a perspective which is sorely lacking.

C2.8 Qualitative research

Qualitative studies conducted since 2000 have looked at various aspects of self-harm, from the perspective of people who self-harm, health professionals and parents/carers of young people who engage in self-harm behaviour:

C2.8.1 Perspective of people who self-harm

i) Experiences, meanings and functions of self-harm

Harker-Longton and Fish (2002) used a phenomenological case study to describe one woman's (with learning disabilities) experiences of self-harm, particularly focussing on the functions of this behaviour. Crouch and Wright (2004) analysed interview transcripts

using Interpretative Phenomenological Analysis (IPA) with 6 adolescents within a residential unit to identify the processes involved in self-harm. Their study incorporated observational notes taken from the unit's team meetings and they identified self-harm as occurring in response to conflict and distress/anger, leaving others with feelings of upset and a sense of being burdened by the behaviour. Self-harming as 'genuine' and as 'attention-seeking' was also identified as sub-groups of the behaviour, with a desire to be seen as genuine, which resulted in people harming in secret. Schoppmann *et al* (2007) analysed interviews and emails with women who self-injured using a thematic analysis, describing their experience of 'alienation' and self-harm as 'a form of self-care' that could stop this 'painful experience' (p.587).

Redley (2003) conducted a qualitative interview study on 50 people categorised as having repeatedly taken overdoses, exploring their sense of agency and the 'over-reliance' on risk factors within treatment (p.348). McAndrew and Warne (2005) conducted a feminist exploration of the meanings of self-harm utilising a case study methodology. They used psychoanalytic theory to explain the behaviour in terms of intra-psychic conflicts, portraying self-harm as a form of communication of these issues. Horne and Csipke (2009) utilised grounded theory to develop a 'non-paradoxical theory' of the functions of self-harm, from the perspective of it serving an emotion regulation purpose (between feeling 'too much' and feeling 'too little'). Their theory described self-harm in terms of being 'a body-based experience', which served to resolve 'psychosomatic suspension' as seen in dissociation (p.655).

Subjective experiences of the 'self' were also explored by two studies (Adams, Rodham and Gavin, 2005; Walker, 2009) with young people who self-harm and women with diagnoses of BPD. The sense of self and identity were both affected by self-harm and the responses received from others, with an emphasis upon a desire to be validated. Scourfield, Roen and McDermott (2008) and Alexander and Clare (2004) explored experiences of LGBT women and young people (utilising focus groups and interviews within IPA and thematic analyses), conveying self-harm as both a way of coping with an invalidating and abusive social environment and strategy for dealing with distress.

ii) Satisfaction with and perceptions of treatment interventions and health professionals, and views on preventing self-harm

Warm, Murray and Fox (2002) employed a qualitative, Internet survey study to explore help seeking and levels of satisfaction with services among people who self-harmed (mainly female and in their early 20s). They reported that people were most dissatisfied with treatment by medical personnel, and most satisfied by specialist self-harm services. Hume and Platt (2007) utilised grounded theory on 14 interviews with people admitted to hospital as a result of self-harm. They remarked upon a clear preference within this group for specialist interventions provided within the community which acknowledged that treatment did not have to result in prevention of the behaviour. A study by Perseius *et al* (2003) analysed 10 interviews with people with BPD, to explore their perceptions of receiving DBT for their self-harm behaviour. This analysis showed very positive experiences of therapy, describing it as 'life saving' and making their situations 'bearable', valuing the therapist's understanding and respect as well as the CBT elements of the therapy.

Harris (2000) conducted a correspondence study with 6 people who regularly self-harmed, who described health professionals as viewing their behaviour as illogical and irrational; however, a qualitative exploration described self-harm as possessing a logic to the person, which does not necessarily appear rational to others. Craigen and Foster (2009) describe a qualitative study involving 10 young women with a history of self-harm, exploring their experiences of therapy; this study emphasised the importance of the quality of a collaborative and trusting therapeutic relationship, with the women finding directive and behavioural approaches to the self-harm unhelpful (such as behavioural replacement strategies and no harm contracts), preferring instead to explore 'underlying issues'. Finally, Fortune, Sinclair and Hawton (2008) explored adolescents' views on potential treatments approaches to self-harm, using thematic analysis on nearly 3,000 students aged 15-16. However, self-harm was conceptualised within this study as suicidal behaviour, and young people were asked what could be done to prevent this. The respondents identified friends, family and teachers over external source of support as the people to prevent suicidal behaviour, which the authors concluded pointed to a need for the provision of school-based support programmes.

iii) Views on starting and stopping/resolving self-harm

Sinclair and Green (2005) conducted an interview study with 20 people who previously self-harmed to explore how they resolved the behaviour, identifying that this involved resolving 'adolescent distress' and recognising the role of alcohol in maintaining the behaviour and self-harm as a symptom of deeper untreated illness. This study recruited participants who had previously presented to hospital with self-poisoning, which suggests the findings perhaps may be more linked to suicidal behaviour. Deliberto and Nock (2008) focused upon factors associated with NSSI, and analysed motivations for starting and stopping the behaviour in a sample of 64 adolescents in the community (compared with 30 adolescents who did not self-harm). They reported that young people who self-harmed sometimes started by getting the idea from friends and most gave at least one reason for wanting to stop the behaviour, but that less than half were receiving treatment.

Kool, van Meijel and Bosman (2009) utilised grounded theory to study the processes of stopping in 12 women who no longer self-harmed. They identified 6 stages in stopping self-harm, with an emphasis on developing a connection with the treatment provider. They recommended that health professionals focus on building a connection with the people they are treating, helping them to develop a positive self-image and learning alternative behaviours in place of self-harm.

iv) Help-seeking behaviour

Howerton *et al* (2007) reported, in this qualitative interview study with 35 male offenders, aged 18-52, that they were reluctant to seek medical help for their self-harm behaviours, mainly due to lack of trust and fear of receiving a diagnosis of mental illness, and the related stigma associated with this.

v) Self-harm as a long-term effect of childhood sexual abuse (CSA)

Denov (2004) conducted in-depth interviews with male and female respondents to explore their experiences of CSA (by female perpetrators), and found that they reported long-term difficulties with self-harm and suicidal behaviour as a result of the abuse.

vi) Functions and understandings of self-harm dedicated Internet forums

Rodham, Gavin and Miles (2007) conducted a qualitative study exploring the interactions on a 'nonprofessional' self-harm message board. They reported that

people using these message boards and forums were very positive about them, 'and appeared to feel that their needs for support, venting, and validation were being met' (p.422); however, these authors expressed their concern over the forums as allowing a potentially serious minimisation of risk and a normalisation of behaviour, which could serve to reinforce and maintain the behaviour.

Baker and Fortune (2008) also explored websites dedicated to self-harm and suicidal behaviours, by employing a discourse analysis of 10 young people who used these sites and engaged in self-harm and suicidal behaviours. The users constructed the websites as providing a source of community support, empathy and understanding, and as a way of coping and forming positive identities. In contrast to the study above, the authors of this study called for health professionals and researchers to adopt 'a more balanced view', and to 'not focus solely on the possible risks associated with using these sites,' in order for services to understand the people using these sites 'and engage them in their services' (p.118).

C2.8.2 Professional perspective

i) Perceptions and experiences of people who self-harm

Anderson, Standen and Noon (2003) explored nurses' and doctors' reported perceptions of young people who engaged in suicidal behaviours within a grounded theory analysis, which highlighted experiences of frustration towards, and barriers in relating to, people who self-harm. The authors concluded with calls for an improvement in communication between health professionals and the young people in their care. O'Donovan and Gijbels (2006) explored through content analysis the views of 8 psychiatric nurses towards their practice with people who self-harm (distinguished here from suicide). They found that the nurses, however, did not differentiate between self-harm with or without suicidal intent, and that their practice was largely inconsistent, seen as reflecting a lack of policy and treatment guidelines in respect to self-harm. They reported viewing their duty as preventing self-harm and 'providing a physically safe environment' (p.191). Wilstrand, Lindgren, Gilge and Olofsson (2007), and Thompson, Powis and Carradice (2008), also explored psychiatric nurses' experience of caring for inpatients who self-harmed. They found that the nurses were concerned with managing risk and professional boundaries, plus being burdened by the work along with feelings of fear, stress and lack of adequate support.

Brown and Bryan (2007) utilised a case study to illustrate the practice of feminist therapy with a woman who self-harmed (described here as self-inflicted violence). The authors highlighted the challenges inherent in therapy with this population, of balancing the encouragement of empowerment with ensuring client safety. Best (2005), and Simm, Roen and Daiches (2008), explored the perceptions of child and adolescent self-harm in teachers and educational staff, who often expressed a lack of understanding of self-harm, which was often not recognised or acknowledged in training or practice. Many expressed fear and emotional distress when faced with self-harm, often making links with attempted suicide, with a desire to refer the pupil on to external agencies.

Short *et al* (2009) administered semi-structured interviews to explore the attitudes of prison staff towards self-harm behaviour in prisoners. The prison staff, including officers and healthcare staff within a female prison, perceived self-harm as either genuine or non-genuine and viewed the latter as conscious manipulation, creating feelings of resentment. Many expressed feeling unsupported and lacking confidence in dealing with self-harm, with conflicting roles of 'welfare' and 'custody'.

ii) Responses to self-harm and approach to care

Studies by O'Donovan (2007), and Hadfield, Brown, Pembroke and Hayward (2009), explored a psychiatric nursing approach to care in a psychiatric admission ward, and responses to self-harm among A&E doctors, where both helpful and unhelpful behaviours were identified within a medical context where relational aspects of care were often neglected.

C2.8.3 Perspective of parents and carers

i) Experiences of self-harm in children and adolescents

McDonald, O'Brien and Jackson (2007) employed hermeneutic phenomenological methodology to describe experiences of 6 parents (mainly mothers) of young people who self-harm. Byrne *et al* (2008) used a focus group to explore the experiences of 25 parents and carers whose children had engaged in suicidal behaviour, recruited from Paediatric A&E departments, child and adolescent mental health services (CAMHS) and family support services. Oldershaw, Richards, Simic and Schmidt (2008) utilised IPA to describe experiences and perspectives of 12 parents of adolescents who self-harmed, who were receiving treatment in community CAMHS. These studies described parents

feeling guilt and shame over the behaviour of their children, emotional dilemmas over responsibility and the best course of action to take, and a need for further support, advice and information on self-harm and suicidal behaviours, with parents often struggling to understand self-harm. One study explored the experiences of families whose close relative had a diagnosis of BPD and history of self-harm (Giffin, 2008): this constructed self-harm as serving an emotion regulating function and families as chronically and traumatically stressed, with strained relationships between family members and mental health services.

At the time of writing only one study was found that employed discourse analysis (Baker and Fortune, 2008), which explored understandings of websites dedicated to self-harm and suicidal behaviour among young people (from the user perspective). One study was also found to adopt a social constructionist perspective in a theoretical consideration of the challenges facing healthcare professionals, 'to achieve a more informed and effective response when working with someone who self-harms' (Allen, 2007, p.172). This paper suggested that the common understanding of self-harm as a pathological label (e.g. as a 'self-harmer', rather than 'someone who self-harms') should be challenged as 'dehumanising', and the issue of language be considered of paramount importance in subsequent approaches to treatment. This paper also challenged the construction of self-harm as indicative of suicidal risk, and emphasises a need to prevent 'an overprotective and paternalistic approach' in treatment to avoid a resulting disempowerment (p.174).

Research on self-harm has been increasing recently, particularly those using a qualitative methodology, but a more in-depth understanding is still lacking: 'this understanding would inform treatment and provide a meaningful context for research' (Klonsky, 2007; 227). The research has been mostly of adolescents and/or samples presenting to hospitals, and of medical staff (such as doctors and psychiatric nurses). There is a distinct lack of research on community samples and professionals other than medical staff who provide treatment (such as therapists and psychologists), both of which are recommended as targets for future research (Hume and Platt, 2007; Klonsky, 2007).

C2.9 Foucault and feminism: Relevance to this research study

The work of Foucault is of great importance to this study, not only in informing the type of analysis undertaken but also in the applicability of his ideas to modern day psychological practice. Of particular relevance are his theories on control, power and surveillance, and how such control permeates culture in socially acceptable forms. His work on *Madness and Civilisation* (1971) outlined an account of how madness has been constructed through history, an account that involves psychiatry in the regulation and surveillance of society. Foucault proposed that inherent in this regulation is the idea of 'confession', as a type of self-surveillance more powerful than any direct oppression, as it remains invisible and therefore not obviously enforced. In self-surveillance, people are willingly subjugating themselves to certain actions that are considered to be socially acceptable and correct. Foucault developed this idea of self-surveillance in his work *Discipline and Punish* (1977), where he described the Panopticon: a circular prison with a central tower, allowing for maximum observation of prisoners. The crucial point being that prisoners acted *as if* they were being watched, even if the warden in the tower could not be seen, hence:

> *"discipline then moves from something inflicted on others to something which becomes internalized and we move from regulation by others to self-regulation" (Parker et al, 1995, p.60).*

Foucault further extended this notion of confession within regulation in his seminal work, *The History of Sexuality* (1981). Here Foucault introduced the idea that psychotherapy serves to reinforce the moral demands of confession, setting up a process of observation, comparison against social norms, and subsequent regulation.

Foucault's ideas have had great importance in the movements against psychiatry and in questioning dominant understandings and taken for granted 'truths', especially concerning madness and diagnoses. By drawing upon his ideas, researchers have been able to deconstruct and question this everyday knowledge and, in doing so, attempt to improve the situations and actions made possible for those people positioned by society as 'mad'.

Feminism also has an important history within our understanding of self-harm. As Parker *et al* (1995) suggest, if Foucault can be seen as interested in 'the

development of a medical discourse about madness', then feminism can be seen to further add 'discourses about femininity' to this equation (p.41). Specifically by exploring how female experience has been medicalised and pathologised (e.g. Turner, 1987). Feminist writers such as Proctor (2007), Warner and Wilkins (2004) and Johnstone (2010) have all drawn attention to the social context of women's experience in accounting for common 'female' diagnoses/pathologies, such as BPD, self-harm and eating disorders, particularly highlighting the conflicts within assumed gender roles and power differentials present in society.

Both Foucault and feminism attempt to shift the focus from the individual to the social contexts the individual is embedded within. By doing so, the wider processes involved in power and control can be observed, and a greater attention can be given to the *meaning* of behaviour (for that individual within their social context) as opposed to separation and categorisation as 'mad'. Both these ideologies are highly relevant for my study, which attempts to explore such complex social dynamics by paying attention to current and dominant constructions.

C2.10 Aims of current research

This study aims to explore how health professionals and people who self-harm make sense of self-harm behaviour through the use of Foucauldian Discourse Analysis (FDA) (Parker, 1992; Kendall and Wickham, 1999; Willig, 2001): specifically, both how people understand and construct self-harm through the use of language, and how these constructions impact on their subjectivities (thoughts and feelings) and behaviours. This involved an in-depth qualitative analysis of expert texts, such as documents, publications and leaflets, to map out the discursive resources available for the construction of self-harm, and the use of semi-structured interviews and focus groups with a community sample of people who self-harm and health professionals who came into therapeutic contact with those who self-harm. Such an intensive and focused qualitative approach was deemed necessary given the lack of knowledge and previous research in this area.

The *objectives* were to: examine if the two groups (health professionals and people who self-harm) hold similar understandings and constructions of self-harm; explore which discourses are being mapped out within expert texts and how self-harm is being constructed within these; how health professionals are utilising the available

constructions and how they are positioned within the available discourses; how people who self-harm are utilising these available constructions and how they are positioned, identifying any space for resistance; and exploring discursive positioning and the implications for possible behaviour and subjectivity.

The main *research questions* being used to guide the research:

1) How do people who self-harm construct and make sense of their behaviour?
   - i) How is self-harm constructed within the available discourse?
   - ii) What resources (such as expert discourse) are they drawing upon to shape their constructions?
   - iii) What functions do their constructions serve?
   - iv) How is their discourse positioning them in relation to others?
   - v) How are their constructions shaping their subjectivity and behaviours?

2) How do health professionals construct and understand self-harm?
   Same questions as above.

C2.11 Personal reflexivity

My personal background in psychology began with the study of a rather mainstream degree, with a heavy emphasis on cognitive and positivist psychology. I undertook a quantitative research project and found the entire learning experience quite flat and uninspiring. It was not until some five years later, when I returned to study an MSc in health psychology, that I encountered social constructionism and critical psychology. This way of thinking was at first a frustrating and alien concept to me, but I was also intrigued. Through reading and conversations with my brother, who had long been a fan of the work of Foucault, I began to understand and appreciate this philosophy, and a radical shift in my worldview took place. What I had initially seen as a somewhat pedantic argument became an increasingly freeing and welcome contrast to my original, unchallenging study. It was not until my current training in counselling psychology that I began to realise the exciting possibilities of applying this viewpoint to my research. Although quantitative research appealed to the more 'orderly' part of me, qualitative research, and FDA in particular, appealed to my more 'rebellious' nature. I found

something very satisfying about questioning the status quo and something incredibly important about deconstructing the power relations inherent within the profession of mental health, and the effects of these upon the people we are supposed to be helping. This study grew out of an interest in the use of labels and diagnoses, and the impact of these upon both the service users and the mental health professionals involved in their care. Underlying this was a sense of injustice in the way self-harm was being viewed and stigmatised, and indeed in the whole concept of mental illness, and the dilemma and implications involved for myself within a profession founded on such notions.

"Everybody thinks that we are harming ourselves to get attention, but we are not, we are harming ourselves because life hurts so damned much"
(Respondent quoted by Perseius, Ojehagen, Ekdahl, Asberg and Samuelsson, 2003, p.223)

C3. Method

C3.1. Research Framework and Rationale

Aims and Design

This study aims to explore how health professionals and people who self-harm make sense of self-harm behaviour through the use of Foucauldian Discourse Analysis (FDA) (Parker, 1992; Willig, 2001), and in doing so, hopes to gain a deeper understanding of how people construct self-harm through the use of language, and how these constructions impact on their subjectivities (thoughts and feelings) and behaviours, with corresponding implications for practice within counselling psychology.

FDA, through its emphasis on social processes and constructions, can analyse a wide variety of materials. In order to understand the resources that people who self-harm draw upon to shape their constructions it is important to gain an understanding of expert discourses. As such, official documentations regarding self-harm, such as publications, research papers and leaflets, were sourced and analysed in addition to interviewing health professionals working in this area. However, the main focus of this study rested on understanding how individuals construct meaning (as opposed to social and institutional structures), so the data was gathered mainly from interviews (Willig, 2001).

Semi-structured interviews were conducted with self-harm participants, while a focus group was conducted with the health professionals. The aim was to offer a variety of methods (to improve the quality and range of the work), and to enable the health professionals to talk more openly about their experiences; it also allowed a unique opportunity to understand the process of group discourse within this sample. My concerns were that an interview situation would constrict discourses surrounding views of self-harm, especially given my situation as a researcher in this area, and that they may become less inhibited with their views in a group of other health professionals. Research has shown that focus groups are 'well-suited to exploring 'sensitive' topics, and the group context may actually facilitate personal disclosures' (Wilkinson, 2008, p.187). I felt that health professionals might have been more inhibited than people who self-harm when talking 'one-on-one' to another health professional, and more aware of how they were being represented, especially when discussing a potentially controversial topic. However, this may not have been the case and a focus group could equally have been conducted with a group of people who self-harm. On reflection, it would have been interesting to see how this may have impacted upon discourses of this sample. The decision was taken, however, based upon the reasoning described above, as well as inevitable constraints on time and a desire not to overload myself with too much data.

Rationale for a Qualitative Approach

A literature review found very few qualitative studies that looked at the meanings and functions of self-harm from the perspectives of those who self-harm and health professionals. At the time of writing, I found only one research paper in this area that employed any form of discourse analysis (Baker and Fortune, 2008). Research on self-harm has been increasing recently, particularly those utilising a qualitative methodology, but further in-depth, exploratory studies would help improve our understanding: 'this understanding would inform treatment and provide a meaningful context for research' (Klonsky, 2007, p.227). Given the lack of knowledge and previous research in this area, such an intensive and focused qualitative approach was considered important. Quantitative (and indeed other qualitative) approaches were deemed unable to answer the type of research questions posed by this study. For instance, discourse analysis attempts to go beyond the lived experience of an individual, as explored by phenomenological methods, and towards finding explanations (Willig, 1999b), which potentially has important implications for the practice of counselling psychology.

Social Constructionism and the Turn to Language

Social constructionism is a theoretical orientation indicating a radical shift away from mainstream beliefs of knowledge and truth, offering an alternative, critical framework of understanding. The Enlightenment period brought with it modernist understandings, which undermined royalty and religion as 'autocratic rule' (Gergen, 1999, p.7), pushing instead towards science and rationality. Methods of observation and reason were employed to uncover structures in a search for an objective and definable truth, and in doing so, the focus became increasingly individualistic: a new totalitarianism was established, with science heralded as the new source of knowledge and power (Gergen, 1999).

In response, the postmodern movement began to question these commonly held assumptions about the nature of reality and the search for truth. Rather than viewing knowledge as an objective truth to be discovered and held, something that existed in an external reality, it was being portrayed as 'at least in part a product of human thought' (Burr, 2003, p.12). This had important implications, as it was presenting a very different understanding of our selves and the knowledge held to be true. Our identities, and how we made sense of the world, were seen as continually constructed between us through social interaction (rather than existing and residing within us), and so language was viewed as particularly important in this process.

Social constructionism has had a varied background, influencing humanities, art, literature as well as sociology. It did not emerge within psychology until the 1970s, accompanying a 'crisis' in social psychology, with Gergen in the US and Harré and Secord in the UK arguing for a new vision of psychology with an emphasis on language (Burr, 2003). Burr (2003) and Potter (1996) both postulate that there is no single way of defining social constructionism. However, broad areas of agreement or consensus can be seen to link those who call themselves 'social constructionists' (Burr, 2003; Cromby and Nightingale, 1999):

1. <u>Knowledge is the product of social processes</u>: this focus represents a shift from the individualist, essentialist notions of an inherent or inbuilt nature, to the importance of social interaction (and language in particular) in the construction of our worlds, our selves and our relationships. This opposes the

view that language is merely a vehicle for the expression of our thoughts, instead seeing language as 'a pre-condition for thought' (Burr, 2003, p.7).

2. Our understanding is historically and culturally specific: in that no one way of understanding can be seen as 'right', and instead will change and fluctuate depending on the prevailing ways of making sense of the world available to us in our culture and particular time in history.
3. Knowledge and social action are interlinked: knowledge and language are intimately linked to consequences and action. By creating knowledge that we take as the truth about the world, we inevitably create positions that make certain actions possible, while restricting others.
4. The adoption of a critical stance: primarily towards the mainstream, positivist notions that 'facts' about the world can be gathered by an objective, impartial observation.

Despite these general commonalities, the movement led to the development of different strands of theory and methodology that were couched under the umbrella of social constructionism, such as: critical psychology, discursive psychology, deconstructionism and FDA, and constructivism (Burr, 2003). Essentially, while allying themselves with the key assumptions of social constructionism, they hold different views and interpretations regarding: research focus and methods; realism/relativism; embodiment; materiality; and power (Burr, 2003; Cromby and Nightingale, 1999).

Discursive Psychology and Foucauldian Discourse Analysis (FDA)

There currently exist two major forms of social constructionism: what Danziger (1997) labelled as 'light' and 'dark', or what Burr (2003) preferred to label 'micro' and 'macro'. The 'light' focus of discursive psychology is upon the micro structures of language use, whereas the 'dark' focus of FDA is upon the macro structures of our social and psychological lives (Burr, 2003).

Discursive psychology (Harré, 1995; Edwards and Potter, 1992; Potter and Wetherell, 1987) is the most popular area of social constructionism. Generated from the ideas of ethnomethodology and conversation analysis it has a focus on the role of everyday language and social interaction (Willig, 2001). Although language here is not regarded as a simple representation of internal emotions and thoughts, the existence of such cognitions are not necessarily denied; instead this debate is viewed as essentially

unnecessary to their aims (Burr, 2003). The emphasis is instead upon the *action* component of language, how people use language to do things and to build specific accounts of events (Crossley, 2000). Therefore, the primary focus is on 'the performative functions of language' (Burr, 2003, p.17).

FDA (Parker, 1992; Willig, 2001) is heavily based upon the work of social theorist, psychologist and philosopher, Michel Foucault. Rather than viewing language as an individual action and creation, FDA widens the focus to consider the historical and cultural influences of knowledge, and the relationship between knowledge, social action and power (Hook, 2001; Burr, 2003). Although not interested in discovering an objective 'truth', FDA is interested in exploring how truth is established and attained within discourses (Hook, 2001). This is because truth and knowledge are viewed as inextricably tied to power, making discourse a politically laden exercise through which dominant institutions and structures reproduce their power and influence (Crossley, 2000).

Foucault saw power as permeating every level of social interaction, and was especially concerned with the way people 'willingly subjugate themselves to subtle forms of power', through accepting as normal, and therefore without question, everyday rituals, practices and expectations (Gergen, 1999, p.38). According to Foucault, discourse was seen as a critical component in such power relations. The term 'discourse' here refers to 'patterns of meaning', which are not purely restricted to language (Parker, 1999, p.3), and 'practices that systematically form the objects of which they speak' (Foucault, 1972, as cited in Parker, 1999, p.3).

In contrast to the discursive focus on individual action, FDA is more concerned with the *discursive resources* available within society, and how discourse constructs subjectivity and the self; specifically, how discourses *position* people in society, what kinds of *objects* and *subjects* are constructed and what 'ways-of-being' are made available or possible (Willig, 2001, p.91). The key focus of such work is therefore upon the power effects of discourse and the subsequent implications for subjectivity, experience and action. An important point to bear in mind is that not all researchers see such a sharp distinction between these approaches as necessary or even desirable (e.g. Potter and Wetherell, 1995 and Wetherell, 1998) instead arguing for a combination or 'synthesis'

between the two, with a preferred focus on both 'discursive practices *and* resources' (Willig, 2001, p.91, emphasis in original).

Rationale for choosing FDA

FDA was considered the most appropriate methodology in this study as it enables the exploration of experience and subjectivity though the analysis of discourse. This emphasis on construction and understanding of personal experiences is an important part of this study and so FDA was used in preference to other forms of discourse analysis which do not aim to address such experiences. Discourse analysis, as opposed to FDA, with its focus on the use of language as communication would question the very notion 'experience', conceptualising the term as a construction of discourse used by speakers to 'validate their claims' (Willig, 2001, p.122). This study is primarily interested in the relationship between the constructions generated through discourse, an individual's subjective experience and their subsequent behaviours: FDA is a perfect method for exploring and analysing these relationships. The use of FDA allows an open, exploratory approach of the subject and is interested in locating discourses within wider society and exploring related issues of power, legitimisation and subjectivity (Willig, 2001).

Critical Realism and Implications for Research

A key belief of social constructionism is that individuals cannot be separated from their social, cultural, material and historical worlds, but at the same time there are questions over the extent to which this means we have to reduce people entirely to these processes (Nightingale and Cromby, 1999). Social constructionism is aligned with a relativist philosophy which problematises the existence of an ultimate and objective 'truth' or 'reality', instead proposing that reality is constructed between us, inevitably influenced by historical and cultural understandings of 'truth' (and therefore what can be understood as 'knowledge').

By adopting a relativist standpoint, discourse analysis faces several problems. Firstly, this position excludes subjectivity and the notion of 'the self' essentially disappears (Cromby and Standen, 1999). Although allowing for the exploration of how constructions may impact upon subjectivity, it does not explore the more dynamic aspects of the self that Foucault (1988) termed 'technologies of the self'; in other words, 'how an individual acts upon himself' (p.19, as cited in Willig, 1999b, p.39). This

fails to account for why people choose to use certain constructions over others that are available to them (Willig, 1999b). It also dismisses embodiment and the existence and influence of the physical aspects of our bodies upon our experience and 'as a site of meaning-making' (Burr, 1999, p.125), termed by Burr (1999) as the 'extra-discursive', so that:

> *"all bodies (young/old, male/female, able-bodied/impaired) must be comparably write-able, so similar as to drop out of the equation, sufficiently malleable and homogeneous that bodily discourses may write over or through them as though they were not there"* (Nightingale, 1999, p.169).

Another area of disagreement relates to materiality, which refers to the 'elemental, physical nature of the world in which we are embedded' (Cromby and Nightingale, 1999). Relativism often espouses Derrida's controversial, yet often misinterpreted, notion of nothing existing beyond discourse. As Searle (1995) has pointed out, this essentially alludes to the theory that nothing has *meaning* outside of our constructions, rather than an outright denial of a material and physical world existing. Nevertheless, it can be argued that the physical world puts constraints upon, as well as creates opportunities for, the constructions we make and therefore the actions we take, suggesting that such materiality cannot be reduced purely to text (Cromby and Nightingale, 1999).

Related to the above, the common criticism aimed at purely relativist research is that deconstruction is all that can be achieved, with no move to consider how things could be different. Although some relativists deny this charge, claiming that a position can be taken up as long as it is remembered that all positions are inevitably value-laden (Potter, 1998; Gergen, 1999), Willig (1999b) calls for a need to explain 'why things are as they are and in what ways they could be better' (p.38). If we purely describe the power processes inherent in our discourse, and fail to ground such discourse in a 'material, embodied context', we run the risk of being unable to fully address the power identified (Cromby and Nightingale, 1999).

To address the above concerns and undertake research that not only describes constructions but also begins to explore more dynamic subjectivities and potentialities of discourse, taking into account the material and social structures involved in the maintenance of power, calls for the adoption of a *critical realist* approach. Critical

realism (Parker, 1992; Willig, 1999b) can be seen to take a middle ground combining epistemological relativism and ontological realism, arguing that while language constructs our social realities, such constructions are limited by the material world. In other words, social conditions can be seen to offer a range of possible ways-of-being, which are then 'appropriated by the individual' (Willig, 1999b, p.41). The key focus of such an approach then lies upon the availability of discursive resources within a society, the positions made available, and the social, psychological and physical effects of taking up such positions; ultimately exploring the links between discourse, subjectivity, action and 'the material conditions within which such experiences may take place' (Willig, 2001, p.107).

C3.2. Recruitment and Sampling

Participants

Research to date has focused primarily on adolescents and/or samples presenting to hospitals, and of medical staff, such as doctors and psychiatric nurses. There is a distinct lack of research on community samples and professionals other than medical staff who provide treatment (such as therapists and psychologists), both of which are recommended as targets for future research (Hume and Platt, 2007; Klonsky, 2007). The sample in this study was not restricted by gender, given the research trend towards studying females, and focused upon people who have self-harmed on more than one occasion. Given the research bias towards adolescents, this study included only adults over the age of 18 years.

The sampling process followed an idiographic form of enquiry, aimed at detailed understanding of individual cases rather than seeking generalisations across populations. Rather than trying to find a representative sample, I employed purposive sampling to find: 'a more closely defined group for whom the research question will be significant' (Smith and Osborn, 2008, p.56). Respondents were excluded from the study if they were under the age of 18, and although English as a first language was not a prerequisite, given the focus on discourse they needed to be able to speak English well enough to converse about their self-harm experiences.

Location of Texts

The aim was to source a variety of texts to gain a range of expert discourses available on self-harm within society, particularly focusing on how self-harm was being

constructed and conveyed to others. Practical constraints on time meant that these texts had to be limited in number and carefully selected, especially given the more central analysis of interviews. Given the focus upon expert discourses, three sources were selected that were viewed to have an influence on training and policy within mental health, and two documents were taken from each source. The sources were: the Royal College of Psychiatrists; Government; and core health professional training texts.

To find appropriate documents within each source, searches were conducted on the Internet and in libraries. For *Government documents*, Internet search terms: 'Government self-harm UK' was used. This located '*Truth Hurts'*, a two-year national inquiry conducted in 2004 by the Mental Health Foundation and the Camelot Foundation in partnership with the government, to investigate self-harm amongst young people in the UK. The executive summary document of their findings was located on the Mental Health Foundation website (www.mentalhealth.org.uk), under 'campaigns: self-harm inquiry', as a PDF file. The second document was taken from the *National Institute for Clinical Excellence* (NICE), which is linked to the Department of Health, to provide evidence and national guidelines for good practice in relation to health. They have developed guidance for the management and prevention of self-harm, which was accessed via their website (www.nice.org.uk) under 'clinical guidance'.

A search was carried out on the *Royal College of Psychiatrists'* website (www.rcpsych.ac.uk) for 'self-harm' which produced a number of results, including information on the 'better services for people who self-harm' programme (under 'Clinical and Services Standards: Centre for quality improvement: Self-harm project'). This was designed to review and improve the emergency services offered to people who self-harm. In this section, under the link: 'Change interventions and training materials', the document '*Working with people who self-harm: information for staff in emergency services*' was located (under staff education and training materials). Secondly, a leaflet (printable version) called '*Help is at hand: self-harm*' designed for 'patients, carers and mental health professionals' was sourced.

Locating suitable training texts proved a more difficult task. After searching in libraries, on library databases and an Internet search engine, it became apparent that the more general medical and nursing texts did not contain any reference to self-harm and if

mentioned, would be within chapters on 'suicidal patients' and 'risk assessment'. Because of this focus on risk and suicide, I decided to narrow my search to include these terms. A search in my university library resulted in finding the '*Handbook of Emergency Psychiatry*' (Petit, 2004), which contained a chapter on suicidal ideation/attempts (again the only reference to self-harm). This same trend became apparent when searching within training texts in counselling and clinical psychology. Self-harm was either not mentioned, or mentioned as a reference to (and as part of) suicidal behaviour. Searching within my own textbooks in counselling psychology training, I found a chapter on 'self-harm' within the text: '*Case formulation in cognitive behaviour therapy: The treatment of challenging and complex cases'* (Sidley, 2006).

C2.3. Procedure

Recruitment

To recruit the self-harm participant sample, adverts (Appendix 1) were placed in the community (as opposed to hospitals), via support groups and online self-harm forums. These adverts contained information about the research and details of how to get in contact. The search terms 'self-harm' and 'self-injury' were typed into an Internet search engine to find organisations and websites related to self-harm in order to access this community. Many self-help or charity websites contained resource sections that listed support groups and other helpful contacts in the community. A number of organisations were approached including counselling/mental health organisations, Internet websites for either self-harm or childhood abuse, and organisations that produced newsletters for people who self-harm. Those that produced responses were two self-harm Internet forums and a national website for people affected by childhood abuse, which had a separate research appeals section.

To avoid confusion, this study used 'self-harm' as a generic term to encompass all aspects of self-injury, poisoning or mutilation, with or without suicidal intent, but not referring to cases of completed suicide. I purposefully did not define a list of self-harm behaviours, as I was more interested in recruiting participants who considered themselves to self-harm and to explore their constructions rather than limiting the study to my definitions of what this may be. All of the participants referred to self-harm and self-injury interchangeably when referring to the same behaviour, which was primarily cutting, throughout their interviews.

A total of 22 people expressed an interest in the research and requested further information. An information sheet and informed consent form (Appendix 2 and 3) were given to people who expressed interest, and they were asked to reply if they were still interested in taking part. There was quite a large dropout rate from the point of contact to actual interview (73%), mainly due to people failing to respond after receiving further information; however, 3 participants who positively responded were judged to live too far away for reasonable travel, 1 participant cancelled after arranging an interview, and 1 failed to turn up to interview. The majority who expressed an interest in the research were female, only 2 being male. A total of 6 participants were finally interviewed: these were mainly British, white females with only one male participant (also British, white), and the age range varied from 19 to 40 years old. Attempts were made to select participants with a range of characteristics, such as gender and geographical location; however, this was evidently limited by who agreed to participate.

Once consent had been given, semi-structured interviews were undertaken face-to-face with each individual at a location of their choosing. Most participants were interviewed within a room at the researcher's university; two participants were interviewed in their own homes. Each interview was tape-recorded and a flexible agenda used to guide the process (Appendix 4); this remained a tentative guide with open-ended questions to enable the participant to tell their stories as much as possible. To facilitate open discussion and exploration, general questions were used to start off the interview in order to 'break the ice' and allow the participant to feel more at ease. These led into more sensitive areas concerning self-harm behaviour and the feelings and thoughts surrounding these. The questions generally focused on helping the participant talk about their experiences of self-harm, how they understood their behaviour, how they experienced other people's responses to their behaviour, and how they felt and behaved in response to this. Following each interview, an opportunity was given to de-brief and process the interview experience, and a resource pack was offered providing details of support organisations, websites and helplines.

To recruit the 'health professionals' sample, a search was conducted on the BPS, BACP, UKCP and BABCP contact lists. Those therapists (12 overall) who listed self-harm or trauma as an area of interest were contacted by email. However, after a disappointing response, an Internet search for treatment facilities identified a specialist residential unit for young people who self-harm. Five mental health professionals (2 psychiatric nurses,

1 psychological therapist, a service manager and occupational therapist) who worked together at the unit expressed an interest in attending a focus group. Further information on the research was provided, including an ethics approval form, informed consent and information sheets. This took four months to set up, and eventually one meeting took place at a location of their choosing.

For the focus group, my position was as group facilitator rather than interviewer, and a series of questions was used to help shape the group discussion (Appendix 5). These were tentative and the schedule flexible to allow participants to discuss their experiences and understandings as much as possible. The questions were purely to help keep the discussion 'on track', and all participants had seen a copy of this schedule beforehand. My role as facilitator was in: 'posing the questions, keeping the discussion flowing, and encouraging people to participate fully' (Wilkinson, 2008: 187). The group discussion was tape-recorded and, in order to keep track of the research process, detailed process notes were kept, including aspects of activity such as decisions made, activities undertaken, motivations, experiences of respondents and revisions and developments of interview questions, as outlined by Heath (1997). Following the group, all participants were given an opportunity to debrief, discuss the interview process and raise any issues they may have had.

Methodological Reflexivity

When placing adverts I emphasised that I wanted to give people who self-harm a voice, in the hope that this would motivate people to take part. I was pleased with the response rate, although two points should be made at this stage. Firstly, it may be that in phrasing the advert in this way, I effectively recruited people who felt that they did not have a voice, and potentially had experienced more oppression and prejudice than others. Secondly, the majority of people were recruited from a website for people abused in childhood, and it may be that this population have different experiences than others who self-harm in the community. Both of these points may have implications for the final analysis and so need to be kept in mind. I feel that my prior experience of facilitating groups was useful, providing me with the skills to manage the focus group situation well, guiding discussion without imposing too much of myself. I also think my skills and experience as a counselling psychologist in training placed me in a good position to conduct the interviews, enabling me to deal sensitively with the topic, listen and respond empathically, and encourage a 'contained' exploration of sensitive material.

However, I noticed in the first two interviews that I had a tendency to interrupt the participant and impose my own understandings, something that I tried to address in subsequent interviews. Because I was viewing this as 'research' as opposed to 'therapy', I got a bit carried away with the prospect of bringing more of myself into the encounter, which inadvertently led to a failure in allowing the participant to lead the process. Each participant chose the location of interview, which I saw as very important in establishing a safe environment given the sensitivity of discussion, and also in an attempt to address the power imbalance of interviewer and interviewee; however, I balanced the interviewee needs with my own, and put measures in place to ensure my own safety in this process.

Data Handling, Coding and Transcription

Each interview was tape-recorded and then transcribed verbatim using a system of Jefferson Lite (Parker, 2005). This style of transcription indicates certain speech emphases, points of interruption and overlap, hesitation, delays and pauses (measured in seconds), and other non-verbal events which are considered important in any analysis as they can affect meaning (Willig, 2001). Adopting such a style allowed key elements to be retained, including certain non-lingual aspects, without the complexity and depth necessary for conversation analysis (Appendix 6: transcription key). All transcripts were made anonymous and certain identifying details changed to protect confidentiality of participants. Each interview was between 50-75mins in length, and transcription occurred at a ratio of 5/60 (5 minutes of text took approximately one hour to transcribe), with 6 interviews overall. The focus group took longer, as it was 1hour40mins in length and there were more people speaking which made the transcription process slightly slower. Transcription times are detailed in Appendix 7.

Back-up copies of recordings and transcriptions were made and stored securely in a different location. Given the number of participants involved in the focus group, this interview was transcribed as soon as possible after the event so the details were fresh in my mind (Wilkinson, 2008). Interview notes were taken both before and during the interviews, to help me note down aspects of the process to help guide the transcription and later analysis.

To prepare the transcriptions and texts for analysis, each sample was coded in an attempt to make the data more manageable. The expert discourse texts were divided

into three sources, and each source was assigned a letter: the Royal College of Psychiatrists' papers (P); the Government documents (G); and core training texts (T). Each sample within a source was then assigned a number, for example, 'The Truth Hurts' government document was labelled G1. Interview transcripts were assigned a letter (I) and also a number, for example, I3. For each sample, every page was numbered and divided into sentences, each of which was given a number (Appendix 8: full coding table).

Analytic procedure

The analysis process was guided by the stages laid out by Willig (2001). There are a number of different analysis procedures available, such as the 20-step analysis described by Parker (1992); however, I chose this method as it focuses on linking discursive constructions to an individual's subjectivity and behaviour, while also exploring the wider social implications of resources and positioning (Willig, 2001). So although not a 'full' Foucauldian analysis, I believe that the 6 steps detailed below are sufficient for the aims of this study. It is also important to note that these steps were utilised as a 'roadmap' and guide rather than as set in stone, and the final analysis evolved as the process unfolded. Harper's (2006) adaptation of Billig's (1997) stages also helped guide the analysis.

Stage 1: Discursive Constructions

This stage involved looking for ways in which self-harm was being constructed, by highlighting all text that referred (directly or indirectly) to 'self-harm': such as, for example, references to self-harm as 'it' ("it's something I've been involved in for years now"), or references to behaviour that wider literature constructs as self-harm, such as suicidal behaviour.

Stage 2: Discourses

This stage aimed to identify different types of constructions by locating them within wider social discourse. These discourses were noted in different coloured ink on the transcripts and enclosed in a box, to help separate them out.

Stage 3: Action Orientation

This stage involved examining the function of constructing self-harm in that particular way at that particular moment within the text. I asked

myself, what is the participant doing with their discourse at that moment and how does it relate to other constructions within the text?

Stage 4: Positionings

This refers to the location of a person within a discourse in relation to others, making available certain 'ways-of-being' in the world and positions within 'networks of meaning that speakers can take up (as well as place others within)' (Willig, 2001, p110).

Stage 5: Practice

This stage involved exploring how the constructions and positionings afforded by the participant's discourse allowed or restricted 'opportunities for action' (Willig, 2001, p.111), and how these actions in turn legitimised the constructions held.

Stage 6: Subjectivity

This final stage explored how discourse constructed psychological, as well as social, realities. The discursive positioning will influence how a person can then view the world, which will influence 'what can be felt, thought and experienced' (Willig, 2001, p.111).

The first phase in this procedure was to familiarise myself with the texts and transcripts by reading and re-reading them. Each sample was then annotated with detailed analytic notes relating to the stages identified above. Summaries of these analytic notes were made for each sample, labelled as 'AnSum' followed by the appropriate sample code: e.g. AnSum.FG for the focus group note summary. Each summary contained chapters for each analytic stage as detailed above, plus a final section for additional thoughts and comments, and a summary of overall impressions presented at the beginning. The section for 'discursive constructions' contained initial construction code labels generated with corresponding excerpts from the text, which were identified by page number followed by line number in brackets (e.g. all text which constructed self-harm as 'stigma' were listed under this code label and identified by page and line number, such as 20(5), which would identify a quote on page 20, line number 5). The expert text documents were then merged to form summaries for each source (e.g. 'Government' texts). These merged summaries were labelled CSum, followed by the source code: e.g. Csum.T for the training texts' summary. The overall aim being to produce a comprehensive list of identifiable constructions and discourses for each source, and eventually outline key analytic themes.

Evolution of the analytic procedure

This study started out with intentions of conducting a discourse analysis informed primarily by the work of Foucault. Although this very much remained the case, as the analysis began I became increasingly influenced by Feminist writers in this area; particularly those with interests in constructions of childhood abuse and female pathology, such as Reavey, Warner, O'Dell, Gavey, and Burman and colleagues (e.g. Reavey and Warner, 2003; Burman *et al*, 1996). This reading enabled me to make sense of the data, particularly within the second section of analysis (interviews with people who self-harm), providing a framework for understanding the analysis. The work of Parker *et al* (1995) and Rose (1998) also influenced me, particularly through informing my understanding of discourses surrounding mental illness and 'madness', the internalisation of pathology and individualisation of psychology. I found myself wanting to write more upon the historical development of modern day discourses, to explain how certain constructions and social structures have been made possible, which would be more in line with a Foucauldian analysis; unfortunately, time and word constraints, along with a requirement for an applied focus, resulted in this study focussing instead upon the *consequences* of utilising constructions, as opposed to how these constructions became known as truth and knowledge in the first place. The interview data collected within this research were viewed as cultural stories rather than as reflecting reality, and through a deeper exploration of an individual's account of their experiences, we become able to explore that individual's reaction to and possible 'resistance to dominant discourses, and the emergence of alternative subject positions as well as subversive practices' (Willig 2000, p.554).

Improving the quality of the research

Research standards often call for reliability and validity to be demonstrated in order to offer some benchmark of evaluation. However, these terms reflect a positivist, empiricist approach (Burr, 2003; Yardley, 2008), as opposed to the constructionist, qualitative piece of work undertaken here. This approach has no interest in making claims to establish any objective or identifiable 'truth', making measures to match our findings to the 'real world' irrelevant. For instance, due to the small sample size in this study, and characteristic of all small-scale qualitative research, generalization from the findings of this study is limited. However, the aim is not to generalise but instead gain detailed understandings of selected samples that are currently neglected in research; the hope is that such detailed study may increase our current understandings, inform further

research and point the way for improvements in practice. Additionally, since I am interested in the availability of discourses to participants, large numbers were not deemed necessary: if a discourse is available to one person, it will potentially be available to others too. Nonetheless, this research still needed to demonstrate its quality, and assure readers that it was conducted in a rigorous and coherent way (Burr, 2003). Several ways of improving the quality of qualitative research have been proposed, and guidelines by Henwood and Pidgeon (1992) and Yardley (2008) were incorporated into this study. Specific details of how this was achieved have been reserved for the conclusion section of this thesis (see section C.5.5 Evaluating the research).

C3.4. Ethical Considerations

As with any research study, it was necessary for certain ethical considerations to be borne in mind when designing the research to be undertaken. Since this research concerns a sensitive and potentially emotive topic such as self-harm, such considerations become even more salient. Steps were taken to ensure that participants were as fully informed about the aims and procedures involved in the study as possible, to ensure that participants understood what to expect from the study and what it was attempting to do. Participants were de-briefed at the end of the interview, to allow them to talk about their experience of the interview and to raise any concerns that they may have had, and were given a debriefing pack which included resources (such as 24-hour helplines, websites and counselling services) to enable rapid access to support if required.

Upon agreeing to participate, it was emphasised that they could stop the interview at any time and refuse to answer any questions that made them feel uncomfortable or that they did not want to answer. They were informed they could withdraw from the study at any time, without prejudice, and that confidentiality would be maintained throughout: all recorded data was kept anonymous and coding used throughout, including research notes kept, transcripts and computer storage of recordings. The tape recordings were digitally stored and locked by a password to maximise security and prevent accidental loss of data in case of theft, and recordings were kept until the research thesis had been examined before being securely destroyed. For the focus group, I set 'ground rules' at the beginning of the session to establish a group understanding of confidentiality and to agree not to discuss any information or details discussed outside of the group context:

'participants should be requested to respect and preserve the confidentiality of others' (Wilkinson, 2008, p.192). An opportunity for de-briefing was also provided to participants, as in the interviews.

It was important to make clear to the self-harm participant group that the interviews constituted a research endeavour and therefore should not to be viewed as therapy. Talking about self-harm experiences in depth could be seen as potentially upsetting to participants, however, talking to someone who was interested in listening to deeply personal experiences could also be very positive, and even prompt someone to seek out and engage in personal therapy. Contact details of counselling organisations and emergency psychiatric services were available, but this did not turn out to be necessary for any participants. Details were given out to ensure participants could contact my supervisor or myself at any stage after the interview regarding any issues that may have arisen as a result of the process. In order to further protect the rights of potential participants, ethical approval was granted for this study from the Psychology Department at City University.

C4. Analysis

C4.1 Setting the scene

The research process involved the analysis of information from three different sources: 'expert' documents (such as health professional training texts, information leaflets, reports and guidelines); a focus group transcript with health professionals who work with people who self-harm; and transcripts from interviews conducted with people who self-harm. This analysis could have been presented in a number of ways, but it was decided that separating the data into two chapters (by data source) would make more sense and make the section more manageable. The first chapter (C4.2) presents the themes generated from both the 'expert texts' and health professional focus group, with an aim of mapping out available discourses and constructions, and demonstrating how health professionals utilised this. The second chapter (C4.3) presents analysis from the interview transcripts to highlight how people who self-harm understand their behaviour and draw upon available constructions, including any possibilities for resistance.

The constructions identified within the analysis are grouped within wider discursive 'themes', a collective descriptive term used to delineate related constructions and

discourses. The main constructions are identified within each theme, which includes commentary on how these have been achieved and what function they appear to serve. Excerpts from the data sources appear in quotation marks, followed by their source of origin (e.g. G1), as illustrative examples. Consideration is also given to subject positions made available by constructions, and the possible effects these are likely to have on subjectivity and action. The identified themes should not be seen as static categories existing independently from one another, they are fluid and overlap, and examples from the data can be seen to appear in several themes. As noted by other qualitative researchers (e.g. Allwood, 1996; Harper, 2003), my analysis and interpretations are one out of many possible alternative readings. My own interests, political views and motivations have inevitably caused me (consciously and unconsciously) to focus on aspects of the texts that I found of greatest relevance. Since a social constructionist framework informs this research, I have not attempted to achieve any scientific and objective 'neutrality' but instead striven towards transparency and reflexivity in the analysis process, to increase the quality of the work and enable readers to make their own informed decisions regarding my analytic reading.

At this point, it is important to say something about the nature of the 'struggles' that I describe within the next two chapters of analysis. Participants are described as struggling with different discourses, at times utilising and then resisting conflicting constructions of self-harm. I see these struggles as representative of the dilemmatic nature of social thinking, as described by Billig *et al* (1988), and explore the often conflicting and contradictory nature of everyday speech when individuals struggle between ideologies: e.g. "on the one hand.. but then on the other..". These dilemmas remain socially constructed, however, and when analysing these interview transcripts, I noticed an increased tendency towards attributing intentions to individuals in their speech (as conscious and purposeful). Other DA researchers have noted this tendency towards 'individualistic intentionalist rhetoric' (Parker, 1997, as cited by Harper, 1999, p.92), which serves to locate functions of discourses as originating within individuals. Rather than becoming entangled in debates over individual agency (or free will and choice) or social determinants of action, I have taken a similar approach to Harper (1999), who challenges a need to take such a dualist approach to analysis (i.e. by discussing either individual intentions or the wider social affects of discourse), by viewing DA as an approach that sees that: "acts of an individual are *at the same time* social and have social consequences (and *vice versa*).. (and) that effects occur at

multiple levels and that meaning is in a very real sense overdetermined" (Harper, 1999, p.88).

In this way, I have attempted to avoid descriptions of individual discursive intentionalism, with an understanding that discourse is complex and dynamic: an individual both positions and is positioned, and the positions made available depends upon the individual's relation to others (in terms of power) within a wider social system. An individual may both utilise and resist discourses, and take up or refuse to take up subsequent discursive positions, but the effects that follow go far beyond individual intentions. Individuals cannot be separated from the wider social and institutional structures that they are embedded in; hence, I am more interested in analysing the *consequences* of discursive utilisation than accounting for such consequences in individualistic terms.

I have included a diagram to summarise and simplify the main themes that were generated from the data and described below (Fig C1).

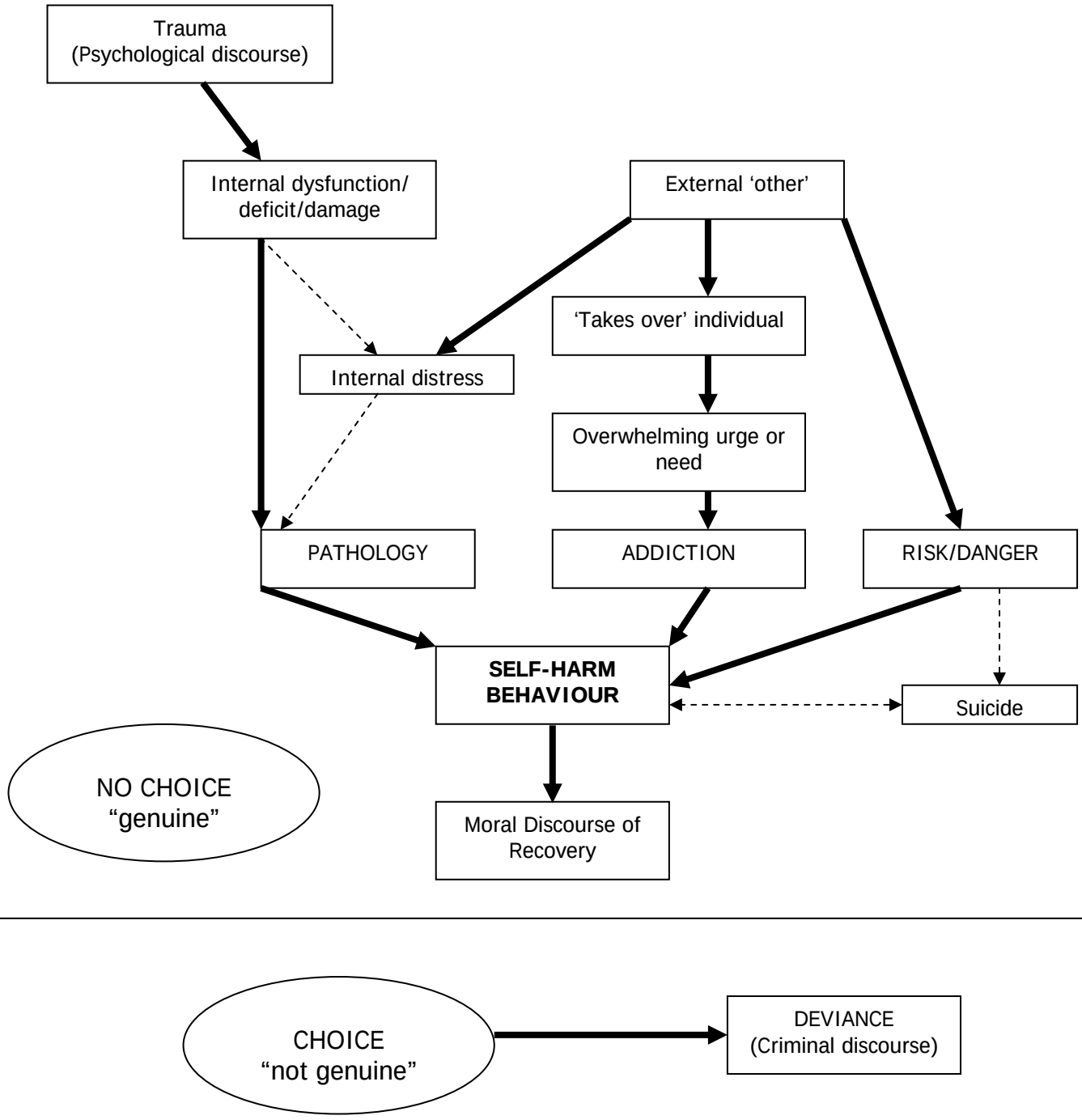

Fig C1: Diagrammatic summary of main discursive themes

The expert discourse will now be presented, firstly introducing the three overarching discursive themes, including a brief explanation of definitions and quotation use, before exploring each theme in detail.

C4.2 Expert discourse

Mapping and mobilising the discursive territory

The analysis generated constructions that were grouped into three major discursive themes:

- **Discursive theme 1**: Pathology
    - *i. external 'other'*
    - *ii. internal dysfunction*
- **Discursive theme 2**: Risk and danger
- **Discursive theme 3**: Choice, addiction and morality

Definitions and clarification

'Expert texts' and 'texts' refer to the documents analysed (such as training texts, leaflets, guidelines and policy documents), whereas 'expert discourse' or 'focus group' refers to the health professional focus group. Most sections begin with analysis generated from the texts, before bringing in the expert discourse to show how the constructions are being mobilised. Self-harm was referred to as specific types of behaviour that cause physical harm and are directed towards the self (such as 'overdoses.. lacerations, cuts, and wounds; 'wrist cutting behaviour' T1; 'hair pulling' G1; 'poisoning' G2; 'burning oneself.. jumping from a height, inserting things into one's body.. self-strangulation or many other actions' P1). Some distinguished self-harm from suicide whilst others referred to them as the same, or linked together on a continuum or as a risk for suicide. Some documents therefore refer to 'parasuicide patients', 'suicidal populations' and 'parasuicides' when talking about people who self-harm, and suicidal ideation and attempts when referring to self-harm behaviour. This is discussed in further detail in the chapters below, but an introduction was deemed appropriate for making sense of quotations and examples. The focus group mainly referred to young people when talking about self-harm, however it should be noted that they worked within a self-harm unit for young people. Quotations from the focus group have been adjusted to increase readability; for instance, punctuation has been added and

emphasised speech underlined, and some minor speech omitted if deemed irrelevant. Two full stops indicate a pause in speech, whereas three within a bracket (...) indicate omitted speech.

Theme 1: Pathology

A strong medical/disease discourse was evident in the texts allowing for constructions of self-harm as *illness* and *pathology*. This medical discourse discussed self-harm in terms of prevalence, hospital admissions and diagnosis, as part of the symptom profile for disorders of complex PTSD and BPD. One document also described an "average age of onset (of) 12 years old" (G1). Self-harm was constructed as an observable occurrence that could be measured and assessed, predicted, prevented and managed through formal interventions, with an overall aim of stopping or reducing the behaviour. Such interventions were split into physical and psychological treatments, representing the mind/body split characteristic of the medical model:

> *"Self-harm: The short term physical and psychological management and secondary prevention of self-harm in primary and secondary care" (G2)*

> *"In an ED (emergency department), suicidal ideation should be initially assessed at triage so that the necessary precautionary procedures are instituted. Primarily, the emergency physician should manage patients with overdoses or with lacerations, cuts, and wounds requiring more involved medical care, with psychiatry consultations as necessary" (T1)*

One document described self-harm as a *'suicidal process' (T2)* consisting of various phases, and self-harm was variously referred to as existing on a *continuum*, ranging from less to more severe behaviours depending on the extent of physical injury, with more severe self-harm being more closely linked to suicide: *"suicide must be conceptualised on a continuum from passive ideation to completed act" (T2).* See theme 2 and 3 for a more detailed exploration of self-harm's link with suicide.

Interestingly, some of the texts focused more heavily upon the physical consequences (such as wounds and poisoning) and medical treatment of these (for instance in the NICE guidelines and psychiatrist training text) than others, which utilised a stronger psychological discourse to construct self-harm as a symptom of underlying mental

health problems and trauma (for instance, in the mental health policy document (G1) and information texts for the public and health professionals (P1/2)). This reflects a split between the medical treatment of self-harm (physical), and the psychological treatment of underlying distress and dysfunction. This split was also reflected in the focus group, where the nurse practitioner focused upon the physical aspects (such as tending to wounds) when asked about treatment, whereas the others were more concerned with the psychological aspects:

P5: I mean I'm very into like making sure wounds are clean, but I think that's 'cos I'm a nurse(…)

C: how does everyone else feel about erm, the general approach to the treatment of self-harm?

P3: I suppose I, I mean.. I suppose I never, I always think of the wound last, I suppose I wanna try and think about erm.. the motivation for the, what has caused the injury

This construction of illness/pathology was observed as being discussed in two separate, but related ways: either separated out from the self as external 'other', or referred to as an internal dysfunction. These concepts shall now be discussed further:

i) External 'other'

Self-harm within the medical discourse was constructed as an *illness* – frequently referring to people who self-harm as 'patients' – and growing *public health 'epidemic'* that people are 'at risk' from, and can be 'vulnerable to' in the future. Here, policy discourse was evident within documents, constructing a need for implementation of policy to tackle the problem, which was now constructed as a public health issue:

"Self-harm among young people is a serious public health challenge that everyone in contact with young people must rise to(…) (there are) a wide range of services and interventions, many of which hold great promise in tackling this hidden epidemic(…) United Kingdom Health Departments should give overall leadership for developing policy in respect of self-harm in recognition of the fact that self-harm among young people is a significant public health issue" (G1)

This is constructed as highlighting a change in society that indicates something is wrong:

> *"there's also a massive shift in society as well, y'know in terms of, er.. when I was small, erm I'm not aware, it was the same at school, I wasn't aware that kids had a social worker y'know, and I wasn't aware there were kids that actually self-harmed (P5: no, same here), but I've got a friend who's a doctor now and nearly every other person that comes through his door is self-harming, and an increase in boys as well, erm (laugh) young men, so for me, there's also societal change there, and I don't, y'know somewhere in society you've got something wrong, this is how we're managing our daily lives" (FG)*

Certain populations are considered more 'at risk' than others, such as: young people; women; gay, bisexual and transgender people; people in prisons (particularly young females); and people with 'chronic physical and psychological conditions' (P1). Cultural factors are also seen as important, with 'South Asian women' appearing more at risk too (P1). So it appears that age, gender, culture, sexuality and existing underlying conditions all increase the risk from self-harm, with young females particularly at risk. Interestingly, constructions of increased self-harm among boys and young men (quoted above) were used to account for the growing disturbing social trend: the 'fact' that males were also self-harming suggested that this was somehow even more serious (positioning males as inherently more 'reasonable' in comparison to the 'irrational' female). The expert discourse also referred to young people as particularly vulnerable, positioning them as vulnerable and impressionable:

> *"there's something about erm.. young people today that are, that are influenced by something" (FG)*

These discourses of illness, risk and vulnerability convey suggestions of *contagion*, that self-harm can in some way be 'caught'. Following on from this, the NICE guidelines (G2) made numerous references to 'staff who have contact with people who self-harm' and 'staff that come into contact with self-harm', which holds a resemblance with contagious disease. References were also made to people (particularly young people) harming together in groups, and that being in contact with self-harm increases a person's chances of developing the behaviour:

"Sometimes groups of young people self-harm together – having a friend who self-harms may increase your chances of doing it as well" (P2).

This construction of contagion was strongly evident in the focus group, who explained that working with self-harm led to the development of 'immunity', including normalisation and minimisation of the behaviour; however, despite this immunity, numerous references were made to self-harm as *not normal*:

"it's interesting though actually how it becomes just a normal part of your life, I remember my other half said to me one day, y'know Sophie, that stuff you do at work, it's not normal" (FG)

"we forget, anyone who's worked there for a while will forget, the fact that like you say, we treat it as normally, so we'll walk away at the end of a shift and you just go home and I, I said to Julie, please after that shift that night, please stop us if anything, you want to talk about it, I said, because you know, until you see certain things you will be quite freaked by it and y'know, and we'll minimise it" (FG)

P3: it's not normal
P4: it ain't normal
P5: (laughs)
P3: and no [and.. it's not normal you must remember that
P4: no it's not actually.. y'know]
P3: it's not normal
P5: it's true yeah
P4: you actually do [forget that it's not normal
P3: what these, what these] young people do
P4: hmm
P5: is totally abnormal, yeah

In this way self-harm is emphasised as an abnormal *'other'*, something that exists *externally* to and separately from the individual, and that is capable of causing harm:

"self-harm blights the lives of young people and seriously affects their relationships with families and friends" (G1)

"cutting can give you permanent scarring, numbness or weakness/paralysis of the fingers; (it) can be very damaging physically and psychologically" (P2)

The negative impact of this 'other' is further enhanced through its objectification as a construction of 'horror'. Particularly graphic language and imagery was observed in the focus group when asked to recount any experiences that had stood out for them:

"I've been with a person that started to cut.. and when you're in a quiet room.. and there's no sound, you can hear the flesh cut into, and if you're there and there's nothing else, and I was trying to explain to them, actually it does sound and, if there's no other interference you can smell the blood as well" (FG)

This discourse of harm splits the external 'other' from the person, separating and objectifying it as a source of distress and horror, but then translates it into a cause of *internal damage*, which affects everything from: *"their relationships, the clothes they wear, their interactions with friends and their sense of self-worth" (G1)* (see below for further discussion of internal damage).

This external 'horror' is described as causing panic and revulsion, shock and distress in people who are 'in contact' with it:

"Health professionals should provide emotional support and help if necessary to the relatives/carers of people who have self-harmed, as they may also be experiencing high levels of distress and anxiety" (G2)

It is also constructed as emotionally demanding for the health professionals providing treatment and care. Health professionals are positioned as needing to manage this distress, in order for them to continue working in the area and prevent damage being done to them. In addition to normalising and developing 'immunity', this management also included staff supervision, a sense of humour, and maintaining emotional distance from the people in their care (to create a boundary):

"you can actually talk things through and, erm, I think sharing it with peers as well, sharing with the team, talking with the team in brief, in supervision.. y'know, the consultant psychotherapist comes and the psychologist comes in, actually sharing that stuff is very important, vitally important"; "you minimise it don't you, you laugh about it, it's a really sick sense of humour because that is the only way you get through"; "most people don't spend their whole day in that situation.. and I think it does mess us up" (FG)

The maintenance of this professional boundary was seen as vitally important, to prevent emotional over-involvement and distress:

"I've gone home really distressed(…) got very caught up in some situations with some of the people that I've worked with, and knowing that I shouldn't be doing that(…) I would never ever do that or let that happen ever again" (FG)

This boundary also separated out self-harm, keeping it safely contained, which further reinforced it as 'other' and 'abnormal':

"the idea is you leave it behind when you go don't you, y'know, you lock the door behind you, you leave the unit and that's it" (FG)

By constructing self-harm as a harmful and serious public health concern, an external 'other' that we are *all* at risk from, public fear is increased along with a corresponding need for surveillance, monitoring and governmental response. A surveillance discourse was evident, emphasising the need for people (particularly those at increased risk, such as young people) to be monitored in order that self-harm behaviour can be understood, researched and prevented in the public's best interests. Within this disease discourse, health professionals were positioned as potential experts (providing they undertake training), possessing the knowledge to explain self-harm and provide assessment and treatment. They are better able to understand the behaviour than the 'patient' who looks to them for explanations, which suggests that they have a privileged access to knowledge. People who self-harm were positioned correspondingly as patients with an illness (to be treated), or as helpless victims of an external 'other': a harmful contagion that puts people at risk (which they need protection from).

Self-harm was described as a complex and widely misunderstood behaviour among people in general, those who harm themselves, and the health professionals who see them. However, the scientific and medical discourse constructing it as a 'condition' defines that it *can* be understood (through research and investigation). The importance of undertaking further, specialist training (and abiding by professional guidelines) was emphasised in order for health professionals to fully understand and respond appropriately. One of the focus group members resisted self-harm as 'a medical issue', to explain why medical staff do not understand:

> *"it's part of the reason why we have such a dilemma with doctors at A&E and stuff isn't it, because they are so very medical model and.. don't understand" (FG)*

Such staff were seen to respond to the surface presentation, and in doing so missed what was 'underneath'. Here self-harm was constructed within a psychological discourse to access a greater understanding/truth.

ii) Internal dysfunction

Self-harm could also be seen as an indicator of underlying 'psychological dysfunctions', disorder and trauma. Self-harm was also constructed as indicative of 'impaired impulse control' (T1) and mental health problems: it's presence taken as 'a mental health indicator' with treatment required:

> *"It became clear to the Inquiry that self-harm is a symptom rather than the core problem. It masks underlying emotional and psychological trauma and a successful strategy for responding to self-harm must be based on this fundamental understanding" (G1)*

Here self-harm could be seen as both a response to *external* stress, pressure and interpersonal conflict, 'life crisis', loss, trauma and abuse, as well as a symptom of and response to *underlying, internal* distress. When discussed as the latter, self-harm was often constructed as a way of coping with internal distress and turmoil, or as providing a release or expression of this distress. It was also constructed as an attempt to escape or end this internal 'suffering', or as a way of regulating emotions, which may involve reducing emotion: *"self-mutilatory or wrist-cutting behavior are self-soothing acts" (T1)*;

or increasing sensations: "*self-harm 'brought them back to life' and made them 'feel something – alive and real" (G1: emphasis in original).*

In this way, distress and despair become associated with self-harm and subsequently enmeshed and fixed, as if inevitable. Experiences of abuse, particularly in childhood, were given as reasons for self-harming behaviour:

> *"people who self-harm are more likely to have experienced physical, emotional or sexual abuse during childhood" (P2); "80% of people who self-harm have experienced abuse, often in childhood, but also as adults" (P1: bold type in original)*

Although occasionally framed as an understandable response to past traumas, a construction of active survival often became an internalised dysfunction: an abnormal deviation from 'normal' development signifying an internal 'badness', or irretrievable loss and damage. Although the focus group utilised this discourse of internal pathology, they also resisted it at times, constructing self-harm instead as a positive method of survival:

> *"it's always viewed in a negative self-harm, but actually this is what I need to do to live.. actually you know, I mean it's, it's not a negative, this is what's keeping me alive" (FG)*

When discussed as a response to external problems, these were sometimes constructed as distressing (such as trauma, loss and abuse), but they were also minimised as 'normal teenage problems', resulting from the pressures of growing up, which were *"often daily stresses rather than significant changes or events" (G1)*. Within such 'daily stresses' were listed: *"feeling isolated (and) academic pressures",* and also *"suicide or self-harm by someone close to them" (G1)*. The suicide of someone close was minimised as a daily stress, which appears to normalise self-harm as a response to everyday problems faced by teenagers. By doing so self-harm becomes something that could effectively happen to *any* young person, increasing its construction as a public health concern affecting all children (and parents), and increasing the need for surveillance and response. It also has the effect of placing the fault *within* the individual, as a dysfunctional response to normal stress, rather than as lying with the environment, as a normal response to extreme environmental stress. The expert

discourse struggled between these constructions of self-harm as a normal teenage response and as a symptom of underlying distress and trauma.

Regardless, either construction shifts the focus to an internal 'fault' or pathology residing within the individual, who can now be seen as in some way damaged. This construction of damage was particularly strong within the focus group, who made frequent references to working with 'damaged people', who have:

> *"so many different parts that are missing or that are damaged that need work on, it's not just the self-harm, the self-harm is kind of, the end result" (FG)*

This pathology was produced through discourse, taking on relatively stable and fixed characteristics as a 'condition', that can be 'uncovered' and then visible to assessment and diagnosis. Once visible in this way, it can then be categorised and treated. Not only does this have important consequences for how self-harm can be understood and talked about, it also affects the way people who self-harm are positioned. For instance, although it was seen as a way of coping, self-harm was constructed as not desirable or effective, so needs to be resolved with more functional coping skills learnt in its place. The person is subsequently viewed as unable to cope, because they are coping in a 'dysfunctional' and ineffective way, and in need of external help.

The expert discourse made strong use of psychological discourse in the construction of internal pathology. Self-harm was portrayed as a response to internal distress, which was often seen as overwhelming and unbearable, and a way of coping with and managing this. Childhood trauma was constructed as resulting in underlying damage and disorder, which was used to explain self-harm (as an end-product):

> *"I wanna try and think about erm.. the motivation for the, what has caused the injury, I've got a cut at the end of it, or I've got something tied around their neck, or swallowed something but.. y'know, fourteen years ago when they were six months old, what was going wrong that was developing these coping strategies, cos somewhere <u>that's</u> where for me, the self-harm is gonna need treating, some form of symbolic erm, repair"; "(we) deal with the fundamental attachment disorder" (FG)*

This construction enabled them to view the behaviour with compassion and understanding: *"I can have compassion for that 'cos they have been through stuff that I can barely bear to think about" (FG).*

There were also constructions of self-harm as 'madness':

> *"it's not normal to spend your day with crazy people, for want of a better word, for people that are doing dangerous, crazy things" (FG)*

Although this madness and damage was normalised as being common to everyone *("I'm damaged too, we're all damaged")*, people who self-harm were somehow less able to manage and positioned as *more* damaged, separated out as abnormal:

> *"we're very close, all of us, at any given point, y'know to being mad… the only difference between us and the young people we work with is we're able to manage our madness more of the day than they are"; "you just feel saner than they are (laughs)… I'm fairly sane actually" (FG)*

People who self-harm were also constructed within the expert discourse as having very strong emotions, particularly anger, with the act of self-harm constructed as an aggressive and 'brutal' thing to do. Despite being seen as an aggressive act, people who self-harm were positioned as having turned their aggression inwards, an expression of emotion accounted for by personality and gender, which further individualised the behaviour and situated the dysfunction internally:

> *"it was really obvious cos the inward ones, erm were all the ones that did self-harm, and the outward directed ones were the ones that were going round, like you say, punching staff.. punching walls"; "I suppose that's linked to people's personalities what they do with emotions, whether they internalise it or whether they externalise things, and as well we've got women here, girls as opposed to males as well" (FG)*

Some of the texts stated that self-harm was not an illness and that *'people who self-harm are <u>not</u> mentally ill' (P2)*, but these statements were contradicted throughout by the strong use of medical and psychological discourse outlined above. The continual

reference to people presenting with self-harm as 'patients' in need of external management and treatment also served to position them as such, regardless of whether the term 'illness' was formally accepted or rejected. The word 'treatment' was also contested within the focus group, preferring instead a different term: *"I hate this word healing, but erm.. that's just the word that's coming to mind"*; advocating the need for an individual approach: "*whatever approach needs to be individual to each young person, you can't stick them in a box and say just treat them all the same" (FG)*.

By focusing on self-harm as 'an expression of personal distress rather than illness (G2), and on the 'many and various' reasons for self-harm (P2), it can be further individualised as an internal problem, from which the person needs recovery and healing.

This individualisation also illustrated a further process of essentialism within the focus group, who commented upon the attachment of a label to people who self-harm so that they 'became' their behaviour. For instance, being referred to as 'self-harmers', which was constructed as not only defining who they were but also as providing them with a group identity. The focus group utilised tribal and animalistic language when describing this group process, constructing self-harm as 'kudos', being part of a 'code' and as a competition for role of 'top dog' and group 'leader', involving open displays of self-harm scars. This discourse served to separate people out by their self-harming behaviour, positioning them as abnormal and animalistic.

Theme 2: Risk and danger

As can be seen from the previous section, self-harm has already been constructed as a substantial 'risk': as something that people are *at risk from*. In this way, self-harm can be seen as a public health problem, a growing and disturbing epidemic with notions of disease and contagion, with certain populations (such as young people and women) being at higher risk and greater vulnerability than others. Self-harm can also be seen as indicating a *risk for* suicide. As noted in this chapter's introductory paragraph, self-harm and suicide are often closely linked, and while some of the expert texts clearly stated that self-harm is <u>not</u> suicide, others referred to self-harm as 'suicidal behaviour', 'suicidal ideation' (T1), and 'parasuicide' (T2).

When linked to suicide in this way, self-harm becomes an indicator that the person's life is at risk and, as such, needs to be taken seriously:

> *"the risk of killing yourself increases after self-harm. Everyone who self-harms should be taken seriously and offered help" (P2)*

Even when defined as 'deliberate self-harm which is not lethal' (T2: emphasis added), the behaviour is still seen as 'a key risk factor for completed suicide', which also serves to separate people who self-harm from the 'general population':

> *"parasuicide patients being 100 times more likely to kill themselves in the following 12-month period when compared to the rate for the general population" (T2)*

Even when clearly separated from suicide, *all* forms of self-harm were constructed as needing to be taken seriously as potential risk:

> *"they all still need help" (P2: emphasis added); "All people who self-harm should be assessed for risk" (G2)*

This aspect of risk was also seen within the focus group discourse, with the words 'crisis', 'danger' and 'risky/risk-taking' being used to describe the behaviour, with people who self-harm seen as "doing dangerous, crazy things", regularly using A&E services. Self-harm was also perceived as affecting the therapeutic approach, in terms of paying more attention to, and having more responsibility for, their safety:

> *"(I don't think) I would approach someone that self injures, with the exception of the safety aspect, perhaps any differently than I would with any other client"; "I get in early in the morning to make sure they're still there and they haven't done anything" (FG)*

Suicidal behaviour, such as 'overdoses', was mentioned within discussions of self-harm and they were often linked, which became a site for struggle within the group. Some strongly resisted the construction of self-harm as a 'failed suicide attempt':

"I firmly believe that erm, if you want to kill yourself you kill yourself, you don't have a, y'know, a failed suicide attempt"; "if I want to kill myself, I'll think of a way of doing it where actually it's gonna be the quickest way possible" (FG)

They constructed self-harm instead as very different, as a way of surviving with no intention to die; while others continued to link them by an internal ambivalence over wanting to live or die, and as providing relief from internal pain, which served to reposition people who self-harm as suffering an internal struggle with pain, at risk from death and in need of external help:

"people aren't that black and white, absolutely want to die, absolutely want to live, I think there is a huge internal kind of struggle, ambivalence"; "I see suicide, or an attempt at suicide.. as another way to obtain relief" (FG)

Self-harm could be identified as existing on a continuum, with more serious (severe) behaviour linked to suicide at one end, with less serious (superficial) behaviour at the other. The more serious behaviour was constructed as recognisable by observable "Danger signs":

"Those who are most likely to harm themselves badly: use a dangerous or violent method; self-harm regularly; are socially isolated; have a psychiatric disorder" (P2).

So regular and violent self-harm is considered 'a danger sign', as are people who are socially isolated with a mental health diagnosis. This can be seen to position certain populations more at risk for suicide (through self-harming) than others. In addition to those mentioned above, one document noted: *"A study of 200 gay men in Northern Ireland revealed that a quarter of gay men have attempted suicide, two thirds have considered it and 30% have self-harmed" (P1)*, with suicide again separated from, but closely linked to, self-harm behaviour. Another document (P2) also noted that the risk for suicide following self-harm increased with age, being much greater in men. So, age, gender (this time men), sexuality, frequency and severity of self-harm, social isolation and a mental health diagnosis were all constructed as indicating a higher risk for suicide. Interestingly, because the risk for suicide was reportedly greater in men who

self-harm than women, women's self-harm tended to be constructed as 'attention-seeking' (see theme 3: choice).

Within the expert texts, regular use of words such as crisis, danger, 'serious suicide attempt', self-destructive, high risk, life-threatening and 'imminent suicidal behaviour', all emphasised the construction of risk. Responsibility falls on the health professionals to look for and recognise these 'danger signs', and to take any presentation of self-harm as a serious and potential risk for suicide. Self-harm was linked to a lack of safety (increasing its construction as dangerous and out of control), with the health professional's role to provide and ensure this safety:

> *"If a person who has self-harmed has to wait for treatment, he or she should be offered an environment that is safe, supportive and minimises any distress. For many patients, this may be a separate, quiet room with supervision and regular contact with a named member of staff to ensure safety." (G2)*

Correspondingly, the person who has self-harmed is positioned as unsafe, vulnerable and in need of external help and containment: someone to provide them with safety and remove them from danger. This suggests an inability to provide this for themselves, or to control their own behaviour:

> *"What helps(…) Asking if there is anything you can do to help them feel safe (e.g. removing the sharps bin from the cubicle!)" (P1)*

This is also linked to the construction of self-harm as an 'urge' that takes over, causing them to feel unsafe, which contributes to their position as out of control, unstable and powerless. This falls within a wider discourse of addiction (see theme 3), portraying self-harm as something lying dormant within the person ready to be 'triggered' by an external situation. This suggests that health professionals can potentially trigger the behaviour, making it then vital that they both understand and respond appropriately, and take the risk and danger of the behaviour seriously. This was reflected within the focus group, who expressed concern that they could cause harm within the people they cared for and the need for them to provide them with safety as part of their job:

"I'm constantly aware of is this gonna trigger them self-harming, and I feel like I'm continually just trying to walk that line and I don't always know where it is"; "I do want to keep them safe and their safety is a priority"; "if they can stay safe.. in managing their lives, I think we've done a reasonable job" (FG)

This emphasised the struggle faced by health professionals between doing their job (and being therapeutic) and not 'triggering' the underlying behaviour, which also highlighted the client's vulnerability and instability:

"a lot of the girls experience genuine dissociation, there's that fine line in the therapeutic sort of thing as well, erm not pushing anything too overwhelming, but still trying to do some, hopefully, something in that session" (FG)

The link between mental illness and risk was particularly emphasised (and particularly interesting), with important implications for the construction of self-harm behaviour, and for health professionals and people who self-harm: *"The association between suicidal ideation and psychiatric illness is the strongest piece of evidence regarding prediction of suicide" (T1)*. By linking mental illness with more serious self-harm and risk, the positioning of people as unable to make reasonable and rational decisions in their own best interests was strengthened. Those with a mental illness were positioned as at higher risk for suicide, unable to ensure their own safety and therefore, *"require an inpatient psychiatric hospitalization to provide safety" (T1)*. Those who cut 'superficially', with no 'intent to die' were positioned as young and therefore: *"because of their age and their inability to grasp fully the severity of their actions, often pose a serious challenge" (T1)*.

Hence, even when self-harm was seen as non-life threatening they were still positioned as unable to understand the risks in their behaviour, therefore requiring external provision of safety. This risk was constructed as present regardless of the person's underlying intentions, which become irrelevant. This could also be seen in the focus group, who struggled over the intentions of people who self-harm within their care, where an internal ambivalence over wanting to live or die (within people who self-harm and those who commit, or attempt, suicide) could be seen to obscure the relevance of the intentions. The professional's duty subsequently becomes that of providing containment, and they have the power and authority (and ethical obligation) to do so,

preferably with the person's consent, but without if necessary. In this way, health professionals are positioned as able to make reasonable judgements regarding safety, and to forcibly detain people who are considered unsafe and at risk, and therefore unable to make reasonable decisions. This discourse of choice and morality is discussed further next.

Theme 3: Choice, addiction and morality

Self-harm was often referred to in the expert texts as 'self-inflicted', 'planned', 'premeditated' and 'deliberate', while at other times described as 'impulsive' and 'spontaneous'. Even when considered impulsive, it was constructed as a decision nonetheless: *"In many instances of deliberate self-harm, the decision to act is taken impulsively" (T2)*. It was often referred to as serving a purpose for the individual, who self-harmed *with intent* and *for a reason*. However, this suggestion of deliberate choice is contested within the discourse:

> *"It can feel to other people that these things are done coolly and deliberately – almost cynically. But someone who self-harms will usually do it in a state of high emotion, distress and unbearable inner turmoil" (P2).*

Self-harm was constructed as not being a simple response to distress, and the individual often portrayed as having no choice and no alternatives:

> *"the word 'deliberate' unhelpfully blamed self-harm as a reaction to painful feelings(…) these terms are misleading"(P2); "young people who self-harm mainly do so because they have no other way of coping" (G1)*

The emphasis is then shifted from self-harm as a deliberate reaction to external events, to self-harm as a consequence of the individual being highly distressed and internally damaged in some way (see Theme 1: internal pathology). So even though they may have 'chosen' this behaviour, they are positioned as only doing so because of their inability to cope any other way. This positions people as victims of their (damaging) personal histories: not to blame for their behaviour and, correspondingly, not responsible.

A similar pattern can be seen when self-harm is constructed as 'suicidal behaviour'. People are referred to as self-harming with 'intent to die' or 'no intent to die'. They are portrayed as in considerable internal pain and 'suffering', and the suicidal behaviour perceived as their 'only option', highlighting a lack of alternatives. One document (T1) split people into clinical 'profiles' depending upon their self-harm behaviours and corresponding intentions: the 'adolescent/impulsive' and 'angry/impulsive' types were described as harming themselves 'superficially' with 'minimal intent to die' (this was constructed as 'non-lethal' and 'attention-seeking', and most common in young females), whereas the 'despondent/anxious' types were viewed as having psychiatric disorders, and an intention to die resulting from 'intense psychic turmoil'. Although having no intent to die, the first group were described as unable to comprehend the seriousness of their behaviour: *"because of their age and their inability to grasp fully the severity of their actions" (T1)*, whereas the second group harmed themselves as a result of 'character disorders' and 'significant impulse dysregualtion' (T1). Here, people were either positioned as internally damaged and distressed – mentally and/or emotionally unstable and unable to make decisions in their own best interests – or too young to fully grasp the severity and consequences of their behaviour. When constructed in this way, they were no longer held to blame for the behaviour, but they were also no longer able to care for themselves adequately and needed external help.

Self-harm may also be viewed within a discourse of *addiction*, in which case they were positioned as helpless and at the mercy of an overwhelming internal 'urge' or 'need' that caused them to harm themselves. Self-harm was seen to provide a form of relief, which was addictive: *"Because young people often find release or even positives from self-harm it can be difficult to envisage coping with life without it" (G1)*. Once self-harm was repeated over time, it was reconstructed from a one-off behaviour (such as a response to a 'life crisis' (P1)) to an addiction that the person relies upon and needs. This need was considered harmful and only a temporary solution to problems, with the person's life as out of control. This again results in the positioning of people as 'suffering' and out of control, with a need for 'recovery', which was constructed as an often long and slow process, and for treatment to replace their addiction with something less harmful. Any positives gained from self-harm become framed within a construction of addiction, and therefore immediately reconstructed as harmful and negative. The expert discourse additionally used moral discourse to construct any positives felt from self-harm to be experienced as shameful:

"one of the things that erm our clients never talk to us about, and we never really talk to them about is, how much enjoyment they get out of what they do(…) we never get into that"; "it must be awful that they get enjoyment from it.. that they feel they get enjoyment from it, cos how do they then justify that, to themselves, their family and us.. you know.. I actually, enjoy that" (FG).

Within these discourses it becomes difficult, if not impossible, to view self-harm as a behaviour deliberately chosen by someone who is viewed by society as rational and reasonable. This was further strengthened through constructions of self-harm as something shocking, disturbing and dangerous (see theme 1): an external 'other' that people need protecting from. This adds to its construction as abnormal and not socially acceptable, and subsequently stigmatised as morally wrong:

"of course, many people harm themselves to cope with emotional pressures, but in ways in which our society finds acceptable – or at least understandable!" (P1)

By portraying self-harm in this way, it becomes difficult for others not to react strongly and negatively when faced with this behaviour:

"Treating someone who has self-harmed may prompt feelings which you would not experience if their injury was accidental. Staff members have talked about feeling shock, anger, nausea, and bewilderment" (P1)

"The most important thing is to listen to them without judging them, or being critical. This can be very hard if you are upset – and perhaps angry – about what they are doing" (P2)

The expert discourse utilised many of these constructions, referring to self-harm as something that was self-inflicted and as something that served a purpose, such as a way of coping with and expressing unbearable emotions (see theme 1). Self-harm was constructed within a strong discourse of addiction: a behaviour with an "addictive quality", and "very, very strong addictive component" (FG), that needed to be repeated to achieve the same level of relief: *"they get relief initially(…) and then it reduces doesn't it, so that they have to do it more often" (FG)*; and in this way self-harm as a

coping strategy was problematised as an addiction: *"the coping strategy can then become.. y'know, a problem"; "the addiction becomes a problem in of itself" (FG).*

This discourse was used to challenge the idea of self-harm as a deliberate choice, positioning people as having no control over their behaviour, with no alternatives:

> *"if you don't have the understanding of self-harm, as far as you're concerned it can be controlled" (FG)*

Such deliberate choice was constructed as socially unacceptable and stigmatised, resulting in negative treatment from health professionals, especially medical staff, who are positioned as not being equipped to deal with psychological presentations:

> *"I think just generally as a culture we have less compassion or sympathy for anything that presents as being self-afflicted, if someone develops cancer we have more compassion for that than, y'know, if someone's cut their own leg off, there's that element of choice and option"; "A&E is geared up to actually fixing whatever you present through the door, it's not geared up to deal with their, y'know, the two years before or the three years before so, they are gonna get pissed off with (laughs) I guess someone who <u>seemingly</u> they've done this to themselves" (FG)*

So, a person who is seen to deliberately engage in the behaviour without being internally distressed or damaged in some way must then be *choosing* to do something constructed as unacceptable, positioning them as morally deviant. For instance, the self-harm then becomes something that is used for gain and manipulation, or as 'attention-seeking'. This behaviour was no longer constructed as 'genuine', as it was not seen to result from inner distress and genuine need; as a consequence of this moral discourse, the person must then be seen as either 'mad' or 'bad'. Choice was linked to attention-seeking behaviour within the expert discourse, which was constructed as occurring in response to external events, such as being told off. This behaviour was seen in opposition to a construction of coping, positioning people who self-harm as defiant *("then it's not a coping mechanism, it's erm, a defying gesture" (FG)*), and as children having 'temper tantrums' in order to get their own way: *"it's throwing their toys out of the pram"; "a temper tantrum" (FG)*. Some of the group resisted this idea of an

attention seeking temper tantrum, and reconstructed self-harm as a way of coping with unbearable feelings that 'being told off' generated. This served to increase their compassion, simultaneously repositioning people who self-harm as victims in need of help and sympathy:

> *"for some people, possibly being told off, erm, or having a sense of being rejected or not wanted, could be an emotionally incredibly overwhelming experience"; "and actually being told off does produce those feelings which they then can't cope with" (FG)*

This was closely linked within the focus group to the construction of self-harm as a learnt or copied behaviour:

> *"when you're talking to a kid and they're copying behaviours(…) for example, one person seeing how much attention that behaviour sort of got and thinking right, ok, I'm not getting that attention, so I'm gonna do the same sort of thing"; "they mimick one another and they copy one another's behaviour at times" (FG)*

Self-harm is then seen as manipulative and no longer genuine (*"they would say, if you don't let me do so and so, I'm going to self-harm and it was a <u>bribery</u> thing"; "it's not genuine behaviours either" (FG)*), which causes frustration and anger among the staff:

> *"we see a lot of it I think, and it can be frustrating"; "ligaturing because you told her she couldn't have something, the ligaturing part is the issue, that really winds me up"; "it's the way I feel sometimes that we're being played"; "if you say something they don't want to hear, they'll ligature, that frustrates the life out of me" (FG)*

When discussed as manipulation, constructions of self-harm as an expression of internal distress are resisted:

> *P4: "cos it's learnt as well.."*
>
> *P2: "but it's a way to express some internal sense of.. y'know"*
>
> *P5: "but it isn't always that"*

Some of the group resisted this construction of manipulation as deviant, by constructing it as common to all human beings *("I'm sorry as human beings we're all manipulative, y'know, we manipulate all our relationships" (FG)*) and a response to an internal need, rewording it as "goal-oriented behaviours", in order to increase its authenticity and reduce feelings of anger, frustration and blame:

> *"but you've got to get beyond that feeling to.. they've seen what the other person had, so there must be something that they want, that they need" (FG)*

The group struggled over these conflicting constructions, over self-harm as a deliberate manipulation and deviance, and as normalised as a (teenage) behaviour similar to alcohol and smoking:

> *"when I was growing up, the things that we did which were self-harming(…) alcohol, drugs, smoking"; "I remember when I was a smoker that the head rush you get with your first cigarette of the day(…) it's a similar sort of thing when you cut"; "maybe some of the drugs I did as a teenager was the equivalent"; "we all have our equivalents" (FG)*

This was in some way resolved by explaining manipulation and a need for release as normal to humans (particularly teenagers), but self-harm itself was resisted as an acceptable way of doing this. People who self-harm were also separated out from 'normal' teenagers, with an abusive history accounting for the behaviour:

> *"it is tough being a teenager(…) on top of that you also have to cope with the fact that, somebody who is very close to you and who you trusted and who you love actually abused, absolutely everything" (FG)*

A legal discourse was also apparent within the expert texts, constructing self-harm within wider discourses of criminality. For instance, within the Government texts, the Inquiry was positioned within such discourse as 'judge', having the power and authority to 'sift the evidence presented to them', consider 'personal testimony' and weigh the evidence to come to a final conclusion with regards to recommendations for practice and development of national policy guidelines. This legal language was particularly evident in one document, which described the responsibilities of health professionals in

their treatment of people with self-harm, written in small type similar to a legal disclaimer:

> *"This guidance represents the view of the Institute, which was arrived at after careful consideration of the evidence available. Health professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not however override the individual responsibility of health professionals to make decisions appropriate to the circumstances of the individual patient" (G2)*

The expert discourse also utilised such criminal discourse, often comparing the residential unit with prison, and the process of learning to self-harm as similar to criminal behaviours in prison:

> *"I think there's a risk of providing, y'know, it is a bit like in prison isn't it, y'know, you go in as a petty thief and come, and come out as a safe cracker [P5: absolutely] so there is the element of yeah, potentially, they could learn to be more proficient self-harmers in that environment I think" (FG)*

This relates back to the constructions of self-harm as contagion, but also utilises criminal discourse in the construction of self-harm as something (bad) that can be learnt from others (moral deviance).

Whether responsible or not for the actual self-harm, people were however given responsibility for their own 'recovery', which involves stopping, reducing or changing their harmful behaviour, learning new ways of behaving and 'committing to safety' (T1): *"a slow process of resolving past traumas and learning new ways of coping" (P1)*. This appears to provide people with choice but this choice is limited, since if they continue with their behaviour (despite being offered help and alternatives), they are positioned as not wanting to make changes and therefore deviant (or as too young to understand the severity of their behaviour). For instance, a wider moral discourse could be seen to frame constructions of 'recovery', particularly within the discourse of addiction, with a person's ability to stop their behaviour and seek help based upon strength of character, self-control and willpower:

"The feelings of self-harm go away after a while. If you can cope with your upset without self-harming for a time, it will get easier over the next few hours"; "Can I tell myself that I WILL tolerate feelings of frustration, desperation, and fear?" (P2)

Recovery was portrayed as long and difficult and therefore requiring determination and substance on the part of the individual:

"Don't: expect them to stop overnight – it's difficult, and takes time and effort" (P2); "for some people the journey takes months or years – sometimes many years" (P1)

They need to be 'ready' to stop, and must want to do it before they can succeed: *"this can be resolved and you can feel better and you can live your life differently, and I really passionately believe that's possible if someone's motivated to do it" (FG)*.

With responsibility placed upon the person to stop their own behaviour, friends and family were able to distance themselves from this process. Health professionals on the other hand were positioned as having a strong ethical obligation and responsibility to ensure the person's safety, and to reduce, stop or prevent harm. The assessment of whether or not to discharge a person who has presented with self-harm was constructed as *"one of the hardest decisions to make" (T1)* and not to be taken lightly, reinforced as 'essential' (T2), 'imperative', 'crucial' and 'important' (T1). In terms of safety, responsibility and choice was taken away from the person who has presented with self-harm, as they are seen as unable to provide this for themselves: *"a promise to "commit to safety" is not a guarantee of future safety!" (T1)* (see theme 2). Although required to show responsibility by embarking upon their own recovery, the health professional still maintains the responsibility, power and authority to contain the patient if they are unwilling or "unable to commit to safety", when *"further evaluation and inpatient treatment must be considered" (T1)*. Worryingly, even if a person who has a psychiatric diagnosis (while not displaying 'active symptoms') chooses to 'commit to safety', they are still considered a risk that may require continued containment (T1). This strongly reflects the idea of diagnosis becoming part of the person, as an internal and relatively stable dysfunction, despite current symptomatic presentation (refer back to theme 1).

A duty was expressed within the expert discourse to care for and provide help for the people within their unit, but the direct responsibility to stop someone's behaviour and provide a 'cure' was challenged and resisted: *"the over-riding thing for me is that, erm, we are not curing these people, erm we are a small part of their life's journey(…) we are not providing a cure" (FG).* This medical discourse was challenged with a moral discourse of recovery, to position them as providing life skills to 'damaged' people:

> *"our job is hopefully, someone leaves us in a better state than when they joined us"; "if they've got a sense of being able to manage their own behaviours when they leave, I think we've done our job" (FG)*

This positions the young people as responsible for, and having choice over, their own recovery. Within this approach, continued self-harm within the people in their care, despite their help and efforts, was not taken as failure, as the individual was seen as 'not ready':

> *"we'd done lots of work with him over the years, he'd had all sorts of therapies all sorts of counselling and he had always said, I'm not ready to stop" (FG)*

However some of the focus group struggled with this, positioning themselves as responsible for ensuring the young people's safety (and the young people as out of control and unsafe), subsequently finding it difficult not being able to remove objects from the unit or stop the behaviour:

> *"my first shift in here and I've had years of self-harm, working with it, freaks me right out, I really did think oh my god what am I doing, because I'm used to being able to take things away from people so they can't self-harm, whereas here.. it's almost like, I mean(…) there's stuff in there they can self-harm with, every minute of every day if they choose to and I found that really, really odd"; "some of them actually struggle with that because there is almost like, if you were a cocaine addict and(…) if it was available to you, your little thing of choice was available to you all the time, it could feel like a very scary, unsafe place.. if you can't trust yourself, or you can't control yourself that that extent, it must be quite intimidating, overwhelming" (FG)*

Although they emphasised their role was not to forcibly stop people from self-harming, they also stressed that they did not allow or condone it: *"what I get concerned about is some people think our service is a service where we allow people to self-harm, we don't, we have to try and manage it, but we don't give anyone permission to self-harm, or give them clean implements" (FG)*; and the overall aim *was* to stop the behaviour, even if this responsibility was shifted to the person in their care. Self-harm was constructed as harmful and damaging within this struggle, which was distressing for them to witness and not prevent. However, this was repositioned again within a discourse of choice, with them not being able to stop people harming themselves even if they tried to:

> *"but you can't stop them, I've had lads in a room with, almost a padded cell, where there is nothing there to self-harm, clothing, bedding and nothing, and they have, because they still wanted to self-harm.. started biting chunks out of his arm, because he was determined, he felt so stressed and he said, you cannot stop me doing this" (FG)*

Constructions of self-harm as a behaviour that could be triggered led the focus group to express fear about causing this and a pressure not to: *"the pressure of don't you dare say anything bad to me because I actually am gonna harm myself" (FG)*; leading to self-doubt over decisions made and difficulty in doing their job:

> *"the other day I felt like I'd really made the wrong decision because of the way I ended up feeling with this situation, but that was because I knew she was gonna go and (self-harm) later that night when I went home, and she did.. and she did do that, despite us having a conversation about what I thought she was gonna do as well.. she still did it" (FG)*

> *"as a therapist you can either, y'know, gently be confrontative and just calling things as I seen it.. and y'know wandering into more emotional trauma territory, but I'm constantly aware of is this gonna trigger them self-harming, and I feel like I'm continually just trying to walk that line and I don't always know where it is" (FG)*

This self-doubt and fear were resisted, however, by constructing the behaviour as a wilful defiance and attempt to stop them doing their job:

"when I first started working there they used to try and push me quite a lot"; "the fact it's used as a point to try and stop you doing what is right" (FG)

A family discourse evident throughout the group, with references to people within their care as 'our girls' and 'the kids', positioned them within a parental role, with a need to provide firm boundaries:

"I said to them I have kids your age, you can't piss me off, annoy me, upset me, any more or do anything that any one of my kids could do, so throw it all at me because you will get no different response than mine will" (FG)

This position allowed them to continue with their jobs without internal conflict and fear: not tolerating behaviour that was constructed as attention seeking or manipulative, and not feeling guilty about triggering harmful behaviour:

"it never ever crossed my mind, oh my god, I might just have tipped them over the edge to go and do something(…) if they said to us, if you don't do, or I can't have I'm gonna do, we say, you ain't having it, crack on, we'll deal with the end result once you've done it" (FG)

The focus group constructed strong feelings towards the people in their care, when asked how they felt about them: *"sometimes really pissed off with them.. sometimes really angry with them"; "I feel a whole range of feelings that anyone can ever describe from anger, frustration, to pleasure, to happiness, to sadness" (FG)*

Self-harm was not seen as the cause of these feelings, as recovery was acknowledged within the moral discourse to be a long and difficult process; they were instead generated by a lack of engagement by people who were positioned as responsible for their own recovery. This lack of engagement was seen to demonstrate a lack of personal substance and passivity, positioning people who self-harm as irresponsible, childish and deviant:

"the sort of passivity and manipulation and those elements that I've never seen so strongly within a group before and I really struggle with that, the sort of, oh woe is me, and y'know, and the lack of personal responsibility" (FG)

"you've spent hours with somebody and y'know, you're really trying to help them and they really give you the impression they want to help themselves, and two hours later they're.. sticking fingers up at you and it's quite frustrating" (FG)

This 'lack of engagement' was used to account for being positioned as ineffectual professionally and personally:

"I really, really like working with people that do want to make some changes, and they engage and, my history I've mostly been working with my clients, so this group I really haven't been for the most part(…) I do feel personally sort of frustrated, ineffectual, because the level of engagement.. isn't there" (FG)

However, this lack of engagement, and constructed lack of trust, was reconstructed at understandable in light of their damaged pasts, which required them to be patient:

"do you not think there's an element in these clients, I don't know, that we're actually gonna have to do the same thing, y'know, every day for the next four years before we get to a point where someone might trust us(…) it's not a five minute job is it, y'know what I mean, it's their lives"; "it's gonna take a long time for them to trust because of all the people that they did trust who they should have been able to trust, who let them down, so actually it is a really, really long process and.. I don't know, requires a lot of patience" (FG)

People were seen as continuing to self-harm, despite being offered help, because they did not want to face these past issues. The focus then becomes on the person not allowing themselves to recover from the internal damage caused from the past, rather than on the professional's (in)ability to change the behaviour:

"if they were to stop self-harming here, if they were to get better here, if they were to function in a better way, then actually.. we've done something that their family couldn't do(…) the people they care about couldn't do and there is an

element of.. erm, not wanting to er, y'know, spoil that"; "by allowing themselves to get better then they've got to deal with a whole set of other things then" (FG)

In this psychological discourse, forcibly stopping them from self-harming was reconstructed as taking away their only way of coping, which would be irresponsible. Their role then became that of helping them to change their behaviour, by working on the underlying problems and trauma which caused them to need to do this:

"we should have taken out of our literature, y'know, the main thing is we're a self-harm unit, I do think somewhere we can finally re-word that, because it's just, self-harm is just pff (breathes out), one of the things these young people do to live"; "I think perhaps trauma in many ways would be more suitable I don't know.. you know it's really healing their trauma" (FG)

This was seen as a very different approach to other treatment providers, who implemented 'harm minimisation' ("allowing the girls to use safe tools to self-harm with" (FG)), or 'zero tolerance' to self-harm, to prevent harm and damage. This medical approach to treatment was viewed as harmful and negative, missing the real, underlying problem, which positioned the (psychological) approach as more helpful and responsible:

"if you're dealing with the presenting thing then I can't believe anyone is erm dealing with the life trauma, so actually it's just compounding the life trauma again"; "if I understand all behaviours as communication, then I've got to work out what they're trying to tell me.. erm and if I do believe that all behaviours are communication, then I don't believe hospitals listen" (FG)

Self-harm within the themes of choice, addiction and morality was continually presented as something that cannot be deliberately chosen: it may be a purposeful action but this was constructed as the only option for someone who is internally damaged and distressed, or too young to fully understand the severity of their behaviour. Otherwise the person is wilfully deviant, using self-harm for attention and gain, in which case it is no longer viewed as 'genuine'. The predominant construction sees self-harm as socially unacceptable and morally wrong, which leads to its understanding as a shameful and guilty secret that people must 'disclose' in order to recover from. This draws parallels

with the concept of 'confession' proposed by Foucault (1981), whereby people are required to 'express' their internal suffering in order for it to be relieved (as cited in Parker *et al*, 1995).

C4.3 Interview transcripts

Utilising and resisting discourse: positioning, action and subjectivity

Definitions and clarification

'Participant(s)' and 'interviewees' refer to the people who were interviewed for this research, all of whom considered themselves to self-harm or have self-harmed in the past. They referred to self-harm as specific types of behaviour, predominantly cutting but also burning their skin, pulling hair and banging themselves against hard objects. As before, quotations have been adjusted to increase readability; for instance, punctuation has been added and emphasised speech underlined, and speech omitted if deemed irrelevant (such as words started but not finished and minor words of encouragement from myself, the interviewer). My role as interviewer, however, cannot be ignored and should be seen as part of the process of discursive construction; because of this, I have commented more upon my role and my influence upon the interview than I have done in previous sections. Certain identifying details have been altered to ensure anonymity of participants. My speech is indicated with a 'C' (to avoid confusion with the interviewees) and that of the participants' by their transcript label (i.e. I3, I6). Overlapping speech is illustrated with square brackets.

The interviews were found to contain many of the same discourses and constructions mapped out in the previous section; however, rather than utilising these in a straightforward fashion, participants could be seen to struggle with them in a dynamic and complex way. Rather than simply re-listing the constructions, this section will instead focus upon the major struggles encountered within various discursive utilisation: describing instances of resistance and how taking up various discourses affected positioning and subjectivity, and corresponding opportunities for and limitations of action. Separating the analysis out into distinct 'topics' according to each struggle was a difficult process, and also slightly artificial, as participants often drew upon many different discourses in their speech. Because of this, the sections below often overlap and merge, but separating it out in this way was intended to make the data more manageable and analysis more readable.

Constraints upon time and words have regrettably made it impossible to comment on everything that came up within the process of analysis. Some important processes that cannot be explored in more detail include the positioning of participants as 'experts', being knowledgeable about something constructed as widely misunderstood by both the general public and health professionals. In this way, they were positioned as 'veterans' of experience, having been through it and 'survived'. Some participants also mobilised scientific discourse early in the interview to imbue their knowledge with authority, while simultaneously discrediting and questioning health professionals' status as expert. There was also an interesting struggle between portraying an understanding of self-harm as desirable, while at other times being undesirable, perhaps enabling them to keep their status as 'expert veteran'. Despite being unable to explore these and many other discursive dynamics, I have attempted to concentrate upon the major struggles, with the greatest implications for the practice of Counselling Psychology.

Moral recovery: confession and secrecy

There was a major struggle evident within many of the transcripts between utilising a discourse of confession, which involved talking about their self-harm behaviour to others (mainly health professionals and family members), and resisting confession by keeping it hidden and secretive. Within this discourse, others who tried to talk with them about self-harm were positioned as mostly 'good' and trying to be helpful, but the process was still resisted as undesirable:

> *"I went home that evening and.. it was really awful, I mean like, my mum was really good but it just felt so awkward and I was just, <u>oh god</u> (whispers), erm and she wanted to have this long heart to heart conversation and, I didn't really want to talk at all, I just wanted to go and sit in my room(…) and then she told my sister, and she decided that she wanted to see if she could help and I was like, you can't and let's never mention it again (laughs)" (I1).*

Despite being seen as an undesirable process, instigating talk about self-harm was constructed within a moral discourse as 'the right thing to do' and therefore understandable, particularly in terms of how family members and professionals were expected to behave within their social roles; while not wanting to talk was constructed as not wanting to provide help. This can be illustrated by I1, who speaks about an occasion when her parents were told about her self-harm without her consent:

"I mean it was like (sigh).. logically I think I knew that telling them was the right thing and.. it was what she needed to do as a teacher and you know, I knew all of that but.. I didn't really want it to happen anyway" (I1)

Some participants explained the lack of help from significant others (in terms of not talking about self-harm) as resulting from them keeping it so well hidden, which allowed others to be positioned as unaware rather than deliberately not wanting to help through shame or fear. However, one participant struggled with this when she discovered her mother was more aware than she realised, which led to a conflict over her mother then being positioned as purposefully unwilling to help:

I3: *the fact that she thought I'd stopped.. so long ago, kind of surprised me 'cos I thought I was quite good at hiding it.. and things like that, but obviously not quite*

C: *yeah, it sounds like she's actually more aware than you thought she was.. erm which, how did that leave you feeling? Did you feel, I mean you say surprised but..*

I3: *(intake breath) It actually made me think, well why do you think I've stopped because I haven't. I needed you there when I first started, I needed you there when you found out, I need you there now, so why do you think I've stopped? Not that she was ever there because I could never talk to her*

When a significant other was positioned in this way, as not helping in spite of knowing about the behaviour, the participant was correspondingly positioned as abandoned and in need of help. Others were expected to provide favourable conditions and behave in certain ways to help them in their confession; for instance, by reacting non-judgementally and compassionately, without disgust and/or shock. Whereas those people who did not want to talk about self-harm were constructed as doing so because they saw self-harm as wrong, bad and shameful. The latter were described as unhelpful and lacking understanding, ultimately being responsible for their non-disclosure of self-harm. By constructing and positioning the activities of others in this way, negative constructions of self-harm were opposed, including that of stigma and taboo, and more positive actions and constructions encouraged. Many participants also described taking part in the research as an attempt to decrease the stigma, and to 'raise awareness' by

encouraging people to talk more openly about it. Although a way of resisting negative constructions and destigmatising self-harm, this position also continues to encourage the confession of self-harm as an internal problem that needs to be resolved through individual recovery.

Despite others being positioned as responsible for providing help, within the moral discourse participants were however responsible for embarking upon recovery, which entailed trying to stop or reduce the behaviour. Confession was viewed within this discourse as necessary for recovery, and therefore something that they needed to participate in. However, utilising this moral discourse allowed for strong constructions of self-harm as wrong, shameful and abnormal, leading to descriptions of fear over others' negative and judgemental reactions; with people described as reacting with 'horror' when self-harm was made visible, as in the case of I2, who described a family member seeing her scars for the first time following an overdose:

> *"I actually remember.. vaguely, before I'd went out of it.. er, my aunt catching a glimpse of everything, basically my whole body(…) and I remember her recoiling(…) because it was such a reaction is why I remembered it because I don't remember anything else, I just remember her getting a glimpse of it all erm.. yeah and literally her physically jumping backwards" (I2)*

This discourse of horror was mobilised to account for why self-harm was kept hidden, to protect themselves from strong negative reactions, but also to protect others. Taking on responsibility for the protection of others from this 'horror' allowed for a role reversal, with them as 'providers of care', silently taking on the 'burden' of self-harm, while others were repositioned as vulnerable and unable to cope. Within this position, significant others were also positioned as responsible for contributing to the behaviour in the first place, with participants again protecting them from this 'truth':

> *"it was never something that I felt my mum could cope with, because she would ask why and would ask reasons and I never wanted her to feel like it was partly her fault.. because, in a way it was, but in a way it wasn't, it was our circumstance.. that put me in that place, but it wasn't her that made me do it and I knew she would feel like that(…) because you know what you're going through, and it's that bad that you don't want anyone else to go through it" (I3)*

Previous experiences of disclosing self-harm were portrayed as frequently negative, with control and choice being taken away in the process of seeking help, which were used to explain why they were reticent in coming forward; this position enabled them to maintain a responsibility for recovery while explaining why they were not seeking help:

C: *do you think you've been affected by the way other people treat you as well?*

I2: *yeah.. yeah I'd say so, 'cos I think all the younger years of all the people sort of saying, what did you do that for? You know, this is silly, it's pathetic and all that, you know? I definitely think that did affect me, which is why I never talked about it(...) I just did so much of it without anybody knowing"*

At times, the interviewees *internalised* the moral discourse as a form of self-surveillance, describing constructions of anger towards themselves for the behaviour and confusion over why they continued to self-harm when they knew it was 'not good' for them:

"it wasn't as simple as I'm ashamed of it and I don't want anyone to see 'cos they might judge me, I really don't like the fact that I do it, erm.. and that, but that's quite a strong feeling at times I get, I feel very.. angry that I do it, and in between when I'm not doing it (laughingly) I'm like, I'm vowing that I won't and it's an awful thing to do" (I4).

This moral discourse was internalised, separating out the participants from others as abnormal and deviant:

"I can still remember this woman sitting next to me in the ambulance and she was just like, looking at me so terribly (laughingly) and saying, you do realise how much of a waste of, you know, resources this is, how can you, and, but I did feel really bad 'cos I didn't know why and I thought, nobody does this.. nobody deliberately inflicts harm, you know?" (I4).

The resulting physical scars of self-harm were also referred to as 'ugly' and 'shameful': "*I know it doesn't look good when you've got scars everywhere.. erm, and there's*

always gonna be that stigma.. about it" (I2). However, at times participants struggled with this moral internalisation, instead constructing the scars as part of their history:

> *"I would never be able to wear a bikini, purely because I used to self-harm on my stomach and still do sometimes, erm.. I think I look at the scars and think, oh they're ugly, they're horrible, but they're part of my history" (I3)*

A conflict was subsequently produced between telling others about self-harm, which would position them as responsible and committed to their own recovery, and not telling others, which would protect them from negative judgements and being positioned as 'abnormal' and morally deviant. Some participants used this moral discourse creatively to resist the confession of self-harm, as others were constructed as 'not being able to help anyway', with responsibility for change coming from within themselves and/or their environment:

> *"people think they can help but it's, it's not actually other people that can help with self-harm, it's you learning another way to cope with this, another way to deal with this, or you actually getting through it, because a lot of it is, I'm stressed, I'm gonna stay stressed, but once that stress is over I can come out and I don't have to self-harm as much, or I don't have to self-harm for that reason" (I3).*

At times, self-harm was constructed as a positive and helpful phenomenon, which more directly challenged its construction as 'wrong' and 'bad': for instance, through descriptions of it providing control, regulation of emotions and survival. Within this construction, others' strongly negative reactions were explained as resulting from their lack of understanding, placing the fault within the other rather than with them. At times this could be seen to produce a more open defiance against the moral discourse and social oppression:

> *"Occasionally I'll go through what I call more belligerent phases, which probably aren't belligerent, they're just like.. well if you don't, y'know, if I meet someone and then I kind of get to a place where I kind of think, well if you judge me on that, it's your hard luck.. and I quite like that place, 'cos I feel.. I can be more myself" (I4)*

This suggests that 'being more myself' involves continuing to self-harm, while resisting negative judgments by other people. An acceptance of self-harm thereby resists the internalisation of self-harm as wrong, protecting the person against external judgements and repositioning the negative construction as within the other (rather than the self):

"maybe if I accepted it more in myself then I would have a less hard time being bothered about what everyone else thought (laughingly) and sometimes I think that, if I was 100% sure in myself that I wasn't ashamed or still feeling bad about it, then what everyone else thinks is up to them" (I4)

This could also be seen when 'guilt' as a direct result of self-harm was resisted and reconstructed as being caused by other people:

"it's not so much personal guilt, it's that other people will feel that I've not spoken to them, they've let me down, whatever else, and if it wasn't for other people.. I don't think I'd feel particularly guilty" (I5)

"she turned to my mum and said, 'I'm sorry'.. but why are you sorry because I'm not, don't feel guilty, uneasy or whatever because I'll talk to you about it, but then just don't make me feel like that" (I3)

These conflicting constructions of self-harm (as positive/wrong) produced quite a strong struggle with resisting a recovery that involved stopping the behaviour (instead accepting it as part of the self), while still positioning the self as morally responsible and a 'good citizen' who was committed to recovery:

"I wish there was a treatment and a cure that would just go (clicks fingers) you know, take a pill and that's it, nothing else erm.. but other times, it sounds really, really stupid, well I don't know if stupid is the right word but really strange.. but sometimes I think actually, no, I don't want to not do it.. it is part of me, and the endorphins it gets going is.. well, there's nothing like it.. erm.. and it just depends afterwards how you feel.. cos it can make you feel worse then y'know, yes the endorphins might have been great while you were doing it, but twenty minutes later you think, oh.. what have I done?" (I2)

"There are occasions when I look back on it with a great deal of fondness.. and it was the only thing that actually made me feel better in a really miserable time.. erm.. and I, I miss that(…) but it isn't, I don't think it's productive, in the long run to be honest(…) it's not bad, but it's (laughs) not perfect either, it's not the right solution" (I6)

Conflicts were also described when the participants' professional identities were constructed as being 'at odds' with self-harm behaviour:

"it's wrong because of the profession I want to go into, I will be the one stopping them from doing it, and I'm going home at the end of the day, and do exactly the same thing.. and so in that respect it's almost like, I'm not practising what I preach" (I5)

'Not practising what I preach' is an interesting use of words, and ties in closely with the discourses of confession and internalised morality. However, self-harm was also reconstructed from being incompatible with the professional and responsible practitioner, to contributing to the professional role in a positive way: for instance, by increasing empathy and understanding, and so increasing clinical skills and ability. These positive effects were constructed as only possible though if the self-harm was brought under control:

"well it can have a very negative impact on (my career) but it can also.. give me (sighs) the insight into why people do it, erm.. but it can have a negative impact if I don't get.. you know.. erm, a hold of it I suppose, get a grip of it, yeah it could" (I5)

This moral discourse created a tension between continuing the behaviour, which was constructed as undesirable, and going through a process of recovery, which was also constructed as undesirable but the only way to 'move forward'. A discourse of pathology enabled them to continue the behaviour, as they were positioned as having no alternatives, thereby relinquishing personal and moral responsibility (this discourse of pathology and internal dysfunction is discussed in further detail in the next section).

Discourses of addiction, which was one form the discourse of pathology could take, were also utilised to construct self-harm as an 'overwhelming urge' arising from an internal 'need', often compared to more socially acceptable activities such as smoking, drinking and drugs, which served to normalise it to some extent. Self-harm was portrayed here as unpredictable and out of control, regardless of any desire to change:

> *"suddenly it will be <u>there</u>, and all I can think about is hurting myself.. and there's no build up, it's just a sudden change(…) I don't have time to think.. or to sit down with my counsellor and say, well, just before that I was feeling like.. because I, it's not very often, it's once in a blue moon compared to the others but.. I don't know, it's just.. it just happens" (I4).*

Here, a lack of participation in confession was explained as resulting from self-harm's unpredictable nature, not due to some internal defiance or reluctance to change. However, a broader moral discourse constructed the person as permanently damaged by the addiction (i.e. 'once a drunk, always a drunk'), and therefore required great strength of character to overcome it. This positioned the person as at the mercy of the urge, something that they must *always* battle with, which people then struggled with:

> *"I don't want to accept that there's always going to be that tendency there but, maybe part of actually moving forward is that.. that it might be.. you know, whether I actually get to a point where I don't do it but then still feel I want to but can stop myself, that I really don't know" (I5)*

Self-harm was constructed as consistently being able to stop the internal urge and corresponding internal pain, leading to positive feelings of calm and well being, in contrast to replacement strategies that were portrayed as unreliable. Active attempts to stop the urge and strategies to replace the behaviour were described as useless once this urge became too strong, taking over 'rational' control; or self-harm was constructed as providing a dependable form of relief that therapy could not:

> *"it's something that's there for you 24 hours a day, and it doesn't matter how many counselling sessions you go to and how many doctor's appointments you have, how many psychotherapy appointments you have, they're not there at that particular time and you can guarantee that it won't be during your time with*

them that you want to do it and it's almost like, that's the one thing that's solid in your life, the one thing you can do instantly, for that sort of.. release" (I5)

"I have all sorts of strategies to stop it.. or to try and delay it and, and all of those things, but once a certain point has crossed, the rational brain does not have anything to do with it anymore" (I4).

This split between rational understanding and control, and an irrational emotional urge, linked self-harm to the irrational part of themselves, which they were unable to control and which 'takes over'. More insidiously, this serves to construct the expression of, or inability to contain and regulate, strong emotions as irrational and therefore 'unreason', and the person as unstable and out of control. One participant resisted the label of addiction, by reconstructing it as a 'compulsion'. This resisted the implications of being addicted, and connotations of being out of control and *needing* to self-harm, instead constructing it as a choice (and therefore within the person's control); however, it still continued to utilise constructions of self-harm as an urge.

Self-harm was often constructed as too complex a phenomenon to describe in words, which was used to account for why they were unable to speak about it. Some participants internalised this as resulting from an inability to describe self-harm, due to some internal deficit:

"it's been really hard work to find words for things, that's not something I'm very.. I mean I sound eloquent at times and.. but it is, it is very hard for me actually to express my emotions, erm either sort of physically or.. to find descriptions for them" (I4).

However, when it was suggested that perhaps the words did not exist to adequately describe self-harm, many participants readily embraced this:

C: I mean do you think the words just don't exist, <u>to actually sum up</u> (laughingly) [how you're feeling?]

I4: [I do sometimes] yeah.. I think (coughs) erm.. I think actually that after a point then words get in the way and then.. it's.. it's kind of actually experiencing the feelings for what they really are

Opening this alternative construction enabled this participant to resist confession as obscuring the experience of feelings, which led to a questioning of therapy as effective or necessary. However, this created a dilemma over therapy being ineffective, or it not 'working' because of the participant's own internal pathology or deficit:

> *"I tried to take control through verbalising everything really well and, or I thought I was really well, and, and yet I didn't feel any better, and in fact I was self-harming even more then because I thought I was communicating but, to some extent I wasn't cos I was still keeping all these feelings(…) there was no kind of.. I was terrified of any outward expression of it" (I4).*

> *"I often wonder if like, to some extent the more you talk about things, the worse it gets, because it keeps it fresh in your mind, it keeps you thinking about, at that point(…) I was having weekly counselling sessions in effect erm.. and it just, yeah I mean it got.. got quite bad" (I1)*

In one interview, the participant questioned the effectiveness of one therapeutic establishment who forbade her to self-harm, actively resisting their authority and knowledge:

> *"I did (self-harm) a number of times that I was there.. but I made sure nobody knew about it and they didn't like search you or.. erm, I didn't immediately because I really thought there was a point to not doing it, cos I thought, well they must know what they're doing.. and.. after a couple of months and, I think I was still on quite a lot of medication at that point, and then you start coming off it and.. when that came off and I realised.. you know, that actually no-one was talking about this thing and I couldn't talk about it, and I still didn't feel any better" (I4).*

Keeping self-harm hidden was quite often portrayed as hugely important, in terms of being seen as 'genuine' (as opposed to 'attention-seeking'), and also as something intimately personal and private:

"She wanted me to show her, which I didn't at that point, because that was kind of personal and, that's like opening up your diary and going here look have a read" (I3)

"the only thing I was ever concerned about was hiding it, and that wasn't even really because I was ashamed of it, it was because it was private, it was mine" (I6)

However, hiding self-harm was also described within a moral discourse as undesirable, with one participant expressing feelings of 'huge relief' at being able to disclose the behaviour to others who responded non-judgementally. This created somewhat of a paradox, as making self-harm visible was constructed as non-genuine, attention-seeking and unacceptable, so therefore not an attractive position, but self-harm within a moral discourse of shame positioned people as needing to make the self-harm visible (through a process of confession), and subsequently having to identify themselves within a discourse of pathology. Constructing self-harm as hidden out of choice, rather than shame and fear, therefore avoids this pathology and positions people with increased control, but also sits uncomfortably within a moral discourse of recovery, as people are no longer entering into confession. They are therefore stuck between a position of deviance or pathology. This struggle with pathology can now be explored further.

Internalising pathology and labels

Participants often utilised a psychological discourse to account for self-harm as the end product of early childhood trauma. Such traumatic events were explained as resulting in strong internal feelings of distress, which were often constructed as overwhelming. A discourse of pathology constructed childhood trauma as resulting in internal dysfunction and deficit, which then accounted for self-harm behaviour (i.e. they did not know how else to express feelings, or cope with distress): *"as a child I was taught not to cry, you don't cry.. and so if I really need to cry, I'll self-harm instead"* (I2). Within this discourse, self-harm was portrayed as a 'symptom' of internal distress and pathology, which positioned people who self-harm as vulnerable, unable to cope and in need of external help. This also enabled a more compassionate understanding of self-harm, where people were positioned as not responsible for the behaviour.

One participant resisted this psychological discourse, rejecting self-harm as always resulting from childhood trauma, instead constructing it as 'just a general thing that happens to some people'. The below quote was taken from a discussion on the information available on self-harm:

> *"it's all related to childhood sexual abuse and this massive dramatic event and it's.. for a lot of people it very much isn't(…) (for me) there was no kind of traumatic experience that set it off erm, and I think to some extent that makes it harder because you think, well everyone else has got this kind of valid reason for it and, and you then haven't(…) it's still very much promoted as like, you know, it's a response to this traumatic event, something that you'll kind of, you work through your issues and then you get over it and then it's gone, finished" (I1)*

This participant both externalised self-harm from the self, as something that happens *to* people, and also constructed it as a response to the external environment, rather than as indicative of an internal and fixed pathology that must be resolved through therapy. However, having a *reason* for self-harm behaviour was also portrayed as important, as people without a traumatic childhood were constructed as then having no 'valid' reason to be upset, and therefore positioned as 'childish' and 'silly'. Those without a 'valid reason' struggled within this discourse of pathology, at times resisting it (as seen above), but at other times utilising it: for instance, in constructing self-harm as a symptom of underlying internal distress (e.g. caused by family conflict), which allowed them to be positioned as in need of help and therefore 'genuinely' deserving, despite not 'qualifying' within a psychological discourse of childhood trauma.

Self-harm was constructed within the pathology discourse as serving an important function, such as providing control over and release of overwhelming feelings, a way of self-soothing, coping and surviving, often described in positive language. Within an addiction discourse self-harm, as an 'external other' which 'takes over,' shifts responsibility outside of the individual but also repositions the person as out of control, with self-harm as mainly negative and destructive: *"it does kind of eat you up" (I3).* This discourse of addiction constructed any positives as temporary and unhelpful in the long run; similarly, a psychological discourse reconstructed self-harm as a dysfunctional way of coping, so therefore also undesirable (repositioning people as unable to cope). All constructions were placed within a wider moral discourse, so that everyone was

positioned with responsibility for change (through learning new behaviours, overcoming the urge and/or resolving past trauma through confession).

The discourse of addiction related the urge to self-harm with instability and irrationality, and was closely linked to constructions of internal pathology:

> *"every so often it will happen instantaneously there's no.. build up and I can feel.. what I think is fine, but obviously I'm not"* (I4)

These discourses of pathology and addiction constructed self-harm as being 'triggered' by external events, positioning other people as responsible for the behaviour, having triggered it by their actions:

> *"for all the times that we argued it'd be like, I would go back and self-harm and then I'd see him the next time and I'd just wanna scream at him, see what you did, see what you made me do, stop making me feel so upset, stop doing that to me.. but he would never understand" (I3)*

The position that resulted from this discourse of pathology created a dilemma between its utilisation and it's resistance. Utilising it provided participants with a valid reason for their behaviour and allowed responsibility to be shifted onto other people or external events, but it also positioned them as unable to cope, internally damaged in some way and vulnerable. Participants struggled with accepting this position as 'truth' (through descriptions of the self as unable to cope, vulnerable and in need of help), and also resisting it as 'untruth'. This struggle was particularly evident when pathology was internalised as a fixed entity, such as through descriptions of 'madness':

> *"I think most people's opinion (of self-harm) is that you're a bit messed up in the head, erm.. in all honesty, obviously I know I am messed up in the head but.. (laughs)"* (I2)

> *"it would just make me feel that they were.. thinking that someone who (self-harms) is not mentally stable.. all the time, and I would say that I can be mentally unstable at times, but most of the time I'm not"* (I4)

One participant resisted this internal 'instability' by positioning other people as the ones who were unstable:

> *"one (flatmate) has got a complete morbid fascination by it, erm, wants to know how you do it and whatever else, and I just think (laughs) and you think I'm the one that's unbalanced!"* (I5)

This internalisation of pathology was particularly resisted when it became attached to the person as a label:

> *"I haven't got mental health problems because I self-harm"* (I3)

> *"I've never properly had a proper diagnosis in my eyes for a start, someone that's met me twice can't say that I've got a personality disorder"* (I2)

Or, for instance, when this label had certain implications for action, such as preventing them from following a particular career path, or resulting in hospitalisation and certain invasive medical treatments:

> *"the psychiatrist I had, he was like I want her sectioned, I want to take her up to the big hospital and give her ECT, and my (family) was going, no, and then a doctor came along who was just doing his rotation there, and he'd kind of come across this before I think and he, he said, no, we need to get her help"* (I4)

> *"I was told that I couldn't study medicine at a couple of universities because of my history of self-harm(…) so I wrote to (the university) under like a pseudonym and said how would it affect if I applied to medical school and they went, well you can't.. and that was it, that was all I got back on email, and I was like, well you know, I'd quite like a little bit more discussion (laughs) than just, you can't.. and they sent an email back that said er, self-harm is usually.. er, a marker of personality disorder with wider behavioural ramifications"* (I1)

The above participant struggled with internalising this pathology and resisting it as the 'truth', particularly with regards to its implications for action:

"I didn't realistically think I'd be able to cope with studying medicine at that point erm(…) I can to some extent see it from their point of view in that, you know, it's a very stressful course, it's a stressful job and, and obviously stress and self-harm do not go together particularly well.. but at the same time you think.. it just shouldn't affect everything(…) I mean I had a friend at the time who applied and went to (university) and she was self-harming but she didn't disclose it so, you know, it's obviously not.. it doesn't affect, you know, she's doing really well and almost graduated now as a doctor" (I1)

Another participant resisted the position of being 'unable to cope' that disclosing self-harm resulted in:

"for someone to actually know you self-harm is admitting.. cos to the outside world, a self-harmer can be someone that's perfectly respectable, an A star student, she can cope, she can do this, she can do that, to actually say 'I self-harm' is to someone to then go, ooh she actually can't cope, ooh, she does need this and she does need that, rather than going, oh well she's fine, we've had no trouble with her, you know?" (I3)

Which resulted in participants withholding information and hiding their self-harm, to prevent the behaviour from being attributed to an internal characteristic, and from negatively affecting their future:

"nobody wants to put themselves in the situation where they're going to be made to feel.. that it's abnormal, that they're mentally ill, that anything else they don't, nobody leaves themselves open to criticism or anything like that, erm, willingly" (I5)

"I don't wanna go and say I self-harm, because then that's gonna get put down on my record and what happens years down the line? I don't want to do that like for my (career), I've got to go through a health check, now if that was on my medical record, would I have got in?" (I3)

However, this 'wilful' withholding of self-harm behaviour created a tension within the wider moral discourse. When I commented that people would be 'better off lying' about

their behaviour to prevent negative consequences, one participant agreed but reinforced this position with expert evidence and advice encouraging people to lie about mental health problems to employers, to prevent their positioning as 'deviant':

> *"I'm not entirely sure what his title was erm, but it was an official title erm, you know, he'd won awards for talking to people and things(…) and then he encouraged her to lie to the board of staff that were due to reassess her, to get herself back in (to employment), and then they talked to erm a clinical psychologist about it and he said, well yeah, we'd always encourage people to lie on like occupational health forms and things"* (I1)

Such negative implications can be seen to bear similarity with criminal discourse, where criminal behaviour becomes imprinted on a person's official records (and similarly attributed internally, defining who they are as a person), resulting in stigma and prejudice, affecting actions such as gaining employment. When self-harm is attributed internally within this discourse, behaviour that happened in the past is constructed as indicative of internal character and functional ability. So even if a person no longer self-harms, it has become part of their history and part of 'who they are'. Institutions, such as universities and employers, can then regulate who is able to access courses/jobs, dependent on these internal abilities, with people who are positioned as unstable and/or vulnerable having to prove that they are able to cope:

> *"(I was told) if I wanted to apply to study medicine there I'd have to prove that I'd been living independently for two years without any problems (laughs) and I was like.. but I've just finished 6th form (laughs)"* (I1)

> *"occupational health took so, so long and kicked up such a fuss and wanted more proof and more proof and more proof that I was fit to do the job"* (I1)

This dilemma was particularly evident for one participant who's self-harm resulted in hospitalisation and hospital staff threatening to take her children away from her. This participant utilised an internal construction of pathology (with self-harm as indicative of her inability to cope), but stated that she had asked for help many times before this point, which positioned her within a moral discourse as responsible (for asking for help

and trying to recover) and the health professionals as irresponsible for not providing this and then blaming her for her inability to cope:

I2: I just didn't get the help that I asked for, which didn't help, so obviously then that whole spiral went down.. erm, and then after that I was kept in hospital for a few days and told if I did it again, my kids would be taken off me(…) she said she'd make sure of it

C: wow, how did that make you feel?

I2: (2 sec pause) I wanted to punch her at the time, cos I'd asked for help weeks before and she might not have been aware of that but I had, and it, you know, so it wasn't like I hadn't been trying

By utilising this discourse of pathology, responsibility is shifted onto the health professionals, but the participant is also then positioned as unstable and unable to cope, potentially being unable to care adequately for her children. One participant struggled with accepting a psychological construction of self-harm as 'truth', with its utilisation allowing others to react with more compassion:

"I got upset and (my friend) said to me, she said, what's really sad is I just see in my head, y'know, she said I don't see like you.. like this adult doing these awful things to you, I see a young child who's sort of standing there with a razor blade kind of going, y'know, look, and that's the only way they can.. explain and, and that kind of caught the essence I suppose" (I4)

But this participant also resisted it's positioning as disempowering, particularly when this discourse constructed her 'inner vulnerability' as now visible to others:

"(my therapist said) something really simple like.. erm, now I can see how much you hurt inside and it just, like all the defences I'd had in place just kind of.. crumbled because someone had actually, not just seen it, but kind of seen for me what's behind it(…) I think that I'm scared that they'll actually see behind (the surface scars) and see how vulnerable I am, actually how difficult my inner life actually is(…) people seeing it for what it <u>really</u> is I suppose.. makes me feel more vulnerable" (I4)

This participant went on to describe how this discourse had positioned her as *more* vulnerable, which had resulted in constructions of others as needing to provide safety before she could disclose her self-harm, and subsequently make her inner pain visible:

I4: I wouldn't want to delve down too deeply cos I don't trust myself, or (others) probably, I don't know why.. to kind of.. keep me safe

C: hmm-mm.. it sounds likes that is very important for you, this feeling of safety

I4: yeah

C: do you think you're consciously aware of this, or is it something that you've become more aware of, through talking about it?

I4: erm.. it probably always has been there, but I wouldn't have.. I'd have just got, you know, if someone had said to me, what are those marks on your arm? I'd say, oh fuck off, mind your own business (laughs), I'd have been angry, I wouldn't have kind of felt.. vulnerable

Within a moral discourse it also became important for participants to emphasise that they did not *purposefully* self-harm to communicate this inner pain to other people, as within this discourse this would be constructed as 'attention-seeking' and 'non-genuine':

> *"I don't kind of go, I'm gonna do this on purpose so that people can see how much I hurt, it's not calculated like that"* (I4)

And so participants kept the behaviour hidden, to prevent others seeing their inner pain, and to maintain it as a genuine behaviour. While enabling its construction as genuine, however, this also prevented a construction of self-harm as a 'choice'. Many participants described having no choice over self-harm (within both pathology and addiction discourses), but at times participants struggled with this, constructing self-harm as both deliberately chosen and symbolic. This was described in more detail in the previous chapter, but suffice to say, 'choice' within these discourses is at odds with constructions of self-harm as 'genuine'.

The majority of participants strongly rejected being categorised as a 'self-harmer', and resisted any shared identity with others who self-harmed. Many described this resistance within a moral discourse: for instance, through constructions of 'disgust' in

response to other people's scars of self-harm, with these people positioned as 'attention-seeking' and so 'not genuine'. In these instances, no sense of shared identity was possible, as doing so would include them within this 'non-genuine' category and also allow the internalisation of self-harm as wrong/bad:

I2: If I saw a lady in town, which I have done, I saw her about a year ago with loads of scars, I instantly knew and I thought.. oh that looks dreadful.. ooh, I'm one of those as well, but.. (intake breath)

C: and how did you feel towards her, did you feel anything kind of..

I2: I didn't feel close to her at all, I didn't feel, no, there was nothing, yeah, so it was just more about, oh wow that looks really bad

C: and er, did that kind of reflect on how you feel about, about yourself?

I2: (2 sec pause) it did at the time yeah.. it doesn't now because I know, erm.. I guess in my eyes, if you're going to do it you need to do it in a proper way, you don't do it in front of other people and things like that, that was the difference(…) she used to do it in front of people when.. to me it's something private

One participant utilised a pathology discourse to describe such non-genuine behaviour (constructed as a teenage 'fad') as detracting from the underlying distress felt by people who self-harmed for 'genuine' reasons:

"my youngest nephew told me a few months ago about this 'Emo' culture where you've got to cut yourself to be part of it.. and I was just, you know he's ten.. and I just thought.. well, that's going to put a whole new slant on the whole thing and almost.. glamorise it(…) where at the moment for people in the professions that know what to look for, it's erm.. a sign that there's probably something else wrong, with everybody in the Emo culture doing it.. all of a sudden it takes away (from) those vulnerable few that's it's a cry for help, rather than a fashion statement" (I5)

The internalisation of self-harm (through a pathology discourse) was resisted, however, when it then defined who they were 'as a person', particularly within a larger system of mental health where such categorisation was constructed as depersonalising (putting

them ‘in a box’). For this participant, self-harm was reconstructed as a ‘derogatory’ term that was rarely used:

> *“I don’t ring up my counsellor and go, I’ve self-harmed.. cos I don’t <u>like</u> that term, I suppose I’ve never thought about it but I don’t like, I probably don’t like it actually, I will say I’ve hurt myself(…) it took me years to work out that I wasn’t.. a depressive, y’know, because of having had that label since I was a teenager, and then when that label kind of went on my medical (record), borderline personality disorder, and when I finally found out what that meant, I was like eugh! (shudders)(…) and it took me years to kind of come out from under that and actually think, no, I’m me, I’m me, and I have depression which actually gets better sometimes and gets worse, but I have an underlying <u>mood</u> that is classed as depression, but I am not.. a depressive, y’know, and my label is not.. just a self-harmer.. I’m just someone who happens to hurt themselves sometimes” (I4)*

The mental health system was constructed as contributing to this labelling, making it harder for people to define themselves in any other way:

> *“unfortunately, the mental health system that I was in for so long didn’t help me get out of that and it was only.. through finding someone I could work with and eventually come out of that and, y’know, it was like I found my way out.. I didn’t know I was lost in there until I kind of came out(…) I just have that fear of going back in a box and like people sort of like, here’s the medication for that and y’know.. and I’m like, no, that’s not me, it’s just part of me” (I4)*

Participants struggled with utilising this discourse of pathology, which positioned them as internally ‘shaped’ by the self-harm, but then resisting being defined by this:

C: do you think it’s shaped how you actually see yourself as a person?

I2: yeah.. yeah, I would say so

C: again, it’s something you’ve been doing for a long time as well, so it sounds like it’s quite difficult for you to separate this behaviour from who you are?

I2: yeah and it's, it's also I think quite difficult for family members to separate it, although they don't know a lot of it, they know it goes on, erm, but yeah I think.. it's well, it's been I'd say part of my life for literally half my life

"it's like, oh you self-harm, you can't get over anything and, it should be easy to leave your past behind and stop doing all these things and.. but in reality, I really.. hate that I, it's like, it's a duality of wanting to be seen as just me with all these facets that are different parts of me, but these actually, they're quite big facets that have quite a huge impact on how I live my life(…) I have to accept it's a big part of my life, but it's not me, it doesn't define.. y'know, who I am" (I4)

However, another participant (interestingly, the only male within this study) readily embraced a construction of both self-harm as part of their identity and with sharing this identity with others who self-harmed. This participant explained this within a psychological discourse, constructing self-harm as inherently linked to childhood abuse and therefore as an inherent part of their 'self', which positioned others within this shared identity as also sharing previous abusive experiences. This discourse allowed for a greater compassion towards other people who self-harmed and, in contrast with the above moral discourse, taking up this identity was no longer constructed as shameful and wrong, or attention-seeking and non-genuine:

C: do you feel like (the self-harm) is part of who you are?
I6: yes
C: do you feel like it's part of your identity?
I6: very much
C: yeah very much so, erm.. I guess in that way, do you identify with other people who also self-harm or have self-harmed?
I6: yes.. yeah, erm completely, erm.. I suppose mainly because for me it's, it's bound up in the abuse which is.. unquestionably the single most important formative factor in my life, it's affected everything about the way I am and, and because it's attached to that, it's very much part of who I am and yes, I feel erm, very connected to other people who have had to do the same thing, or chosen to do the same thing

The words used at the end of this quote are particularly interesting, firstly positioning people as *having* to self-harm (as a result of child abuse), which utilises a discourse of pathology to position people as having no alternatives (due to internal dysfunction); however, a discourse of choice is then mobilised which opens up the possibility that people may have chosen, rather than been forced, to self-harm.

One participant constructed a social need for more services and help for self-harm, positioning people who self-harm as in need of external help. However, they also separate this out from mental health services and from general medical services, resisting it as a mental health or medical problem. Within this construction it becomes a 'specialist' topic or issue, perhaps in a similar way to constructions of addiction or child abuse and trauma, which results in a need for health professionals to undertake further training so they can 'deal with the issue' appropriately:

> *"you know, you get 'Ask Frank' for drugs and you get other helplines for this that and the other and.. and there's nothing primarily for (self-harm), I mean I know Childline operators are addressed in dealing with children primarily that have been abused, neglected, but there's a limit to the amount of people that have had training for dealing with that" (I5)*

Constructing a *need* for external help was closely linked to constructions of self-harm as 'risk' and 'danger', positioning people as unsafe and in need of containment. This will now be explored in more detail in the following section.

Risk and danger:

Every participant strongly resisted constructions of self-harm as 'risk' and 'danger' that occurred within a wider discourse of suicide. They all emphasised a distinction between self-harm and suicide, constructing them as qualitatively very different, with the former an act of survival and way of preventing suicide. Self-harm was constructed within a psychological discourse as a way of stopping negative, internal feelings from escalating to a point where they may eventually cause a person to commit suicide. One participant constructed self-harm as allowing her to 'make sense' of the world again, which prevented her from feeling a need to escape (through suicide):

"when everything gets too much and.. you know, everything inside and outside is just like, horrendously awful.. that kind of, something about that.. brings everything back to a place where the world makes sense again, and I don't feel like I need to.. get off it" (I4)

Self-harm as a 'failed suicide attempt' was strongly resisted, along with the resulting position as 'attention-seeking', and the individual was constructed as having no intention to die:

"it was something that was thrown at me a lot in those days, oh you're attention-seeking, you're just you know pretending that you're going to kill yourself and, and I was like, I used to get very upset and say no, if I wanted to kill myself I'd take an overdose" (I4)

"I suppose for me it would be a really, really dumb way to commit suicide(…) I mean it's not that hard to kill yourself (laughs)(…) it's possible that you could, pretty much commit suicide by accident, erm.. also based on my own experience.. people who self-harm are likely to be very reticent about coming forward and asking for help, so it's possible they may inflict injuries upon themselves which won't heal properly, and then they don't come forward and ask for help, so I suspect that's also a possibility but, those are accidental deaths, I don't, they're not really suicide" (I6)

Self-harm was instead constructed as a source of refuge and safety:

C: I don't know, just calling it a behaviour doesn't seem to sum it up to me, it seems to be much more than just something you do

I4: yeah.. no, no, that's.. I often look back now and think were those people, you know, when I was in the hospital and I would run, I would escape to actually be able to go and cut myself

Within this discourse of survival, taking away self-harm was reconstructed as *removing* instead of providing safety:

C: Where does it lead when other people try and talk to you about it?

I3: How can you do that? Why do you have to do that? Let me help you. Can I see? (pause) Give me all the things that you use erm, let me wrap you up in cotton wool, let me make you feel safe, but you don't, because to take away that.. is to take away.. that is like a safety barrier, the things that you use, razors, glass, whatever it is, that's your safety barrier, so for someone to take that away makes you feel.. very uneasy, very on edge.. and quite isolated because they now know, so they're conscious of watching you and how you behave, and that's not what you wanted

Preventing self-harm was then reconstructed as the 'risk'. Within this reconstruction, self-harm was portrayed as the *only* thing able to 'satisfy' or stop the urge to harm, which was constructed as 'other', having 'taken over' the person, almost like a type of 'possession'. If left unsatisfied, this urge was constructed as potentially growing to the point whereupon the person was no longer in control, and subsequently in danger of more severely harming themselves and/or committing suicide:

"it's a horrible feeling and it builds up inside, and I feel like I'm losing control but it also feels like I'm being pushed somewhere where things are so awful that if I don't do something I might actually end up opting out completely(…) then all I can think about is hurting myself to get rid of this awful feeling, and I know when I do I'll feel better.. but also I try to do it before it goes too far, because once I go past a certain point, the longer I leave it, the more likely I am to do more damage(…) if they shut me in a room and said, there's nothing in here to hurt yourself with erm.. I don't know what I would do (I4)

Participants struggled with these constructions, both utilising and resisting self-harm as 'risk':

"it's even knowing basics about it, knowing that we're not at risk, hugely, and things like that, because people always think it's very graphic, it's very.. whatever, but it's not, it's not as graphic as people imagine it to be(…) people assume that it's really harsh and you're doing it really badly, and like admittedly some people are, but it's not like that for everyone, and people assume that you're gonna kill yourself and things like that through it, which doesn't happen

sometimes, ok admittedly sometimes it does, but that's a very small percentage of people" (I3)

Alongside a risk for suicide ('risk to self'), self-harm was also resisted as indicating 'risk to others', for instance when it was constructed as being a symptom of internal instability and 'dangerousness'. This construction had important implications in terms of other people's behaviours:

"it just gets completely out of hand because, they don't almost they don't hear what you're saying, and before you know it, you're going to commit suicide, we want to put you in a safe house, but we can't put you in a safe house unless there's somebody with you 24 hours a day because we think you're going to commit suicide" (I5)

"I said look, I've come from (name of hospital).. erm, and she knew straight away that I was (on) a psychiatric wing and she said, can you come in, and from then on it went downhill because I mean I was no threat to anyone, but suddenly she left me in this room and all these policemen piled in, and they were like, have you still got this thing on you? And I did still have the broken glass in my pocket and I said, oh I'll take it out, and they wouldn't let me, and it was like, kind of.. grabbed me and then.. and it was a, that was a completely terrifying experience, and they were like, oh it's another nutter" (I4)

Here, this participant resists a construction of danger and repositions herself as the one who is terrified and at risk from *their* behaviour, which she constructs as resulting from prejudice within a discourse of mental illness. Many participants resisted being positioned as in need of safety and protection at all, or being unable to make rational decisions:

"she.. tried to protect me a little bit more, but I was always very independent, I always stood on my own two feet, I never asked them for anything.. I don't' ask for money, I've always had a job since I was 16.. I do my washing, I cook, I go out if I want to, I don't ask for permission.. so in that way I'm, I am very independent" (I3)

"I don't think that just because someone is self-harming it means that they've necessarily taken leave of their senses, or that they've, erm, lost the ability to make rational decisions about how somebody's erm capable of preserving themselves, so.. I think.. some kind of acceptance that self-harm is something that people do and it can actually be done.. fundamentally safely" (I6)

Other people's reactions to self-harm as 'risk' were also resisted:

"(people's) first reaction to see it is shock, horror, why is she doing that? You've got to stop her doing that not, oh well that's helping her cope at the moment and things could be a lot worse if she didn't do that then.. they go, oh my god, she's got to stop right now" (I3)

Such reactions to self-harm within a discourse of risk were often constructed as unhelpful, and ridiculed for being 'over the top', positioning them as lacking understanding (undermining the construction of risk as 'truth'). This also reconstructed other people's behaviour as the 'horror', rather than self-harm:

"she didn't trust me to be on my own, she stopped buying razor blades and things like that as well which I noticed, which I thought was quite silly 'cos I could go out and buy them anyway" (I3)

"I mean there are some really awful stories of health care professionals and various other people and things they say and do, and there's stuff about like stitching people up without anaesthetic(…) I just thought, I didn't think these things really happened (laughs) I thought these were like urban legends, I didn't realise that people actually were stupid enough to say something like that" (I1)

However, within discourses of addiction, and in resisting a moral discourse of recovery, self-harm was often constructed as out of control, thereby positioning the person as unstable:

"you can't stop it or change it, it gets out of control and then it gets to a point where, or for some people it gets to the point where, you don't care then where you do it, how you do it and everything else and the whole, what started off as..

something small, a way of coping or.. trying to let people know that something wasn't right, gets completely out of hand" (I5)

Just as behaviour that was constructed as 'overreacting' to risk was resisted, so too was behaviour that did not take self-harm 'seriously'. Despite a construction of risk being resisted, it was also utilised when self-harm was constructed as attention-seeking, and other people then positioned as reacting flippantly to this risk:

"he spent ten minutes talking about his thermos mug, and I was just sitting there thinking.. I'm stocking up tablets at home, and you're talking about a thermos mug(…) and he finished the session by saying, so you're not going to jump in front of a bus then.. and I walked out and I went to my doctor's appointment that afternoon and I ranted solidly for like 20 minutes, and I was just like, I'm so mad!" (I1)

"(my family) they're like, oh what do you do that for, or.. and that's it, or.. don't be so stupid, that kind of thing(…) then a couple of years ago, everything came to a head and they found out.. the severity, kind of what it was about.. and they've been more intrigued into finding out about it, and not just being so, dismissive" (I2)

For this last participant, constructions of self-harm as 'serious risk' enabled other people to take her behaviour more seriously, which resulted in them talking to her more about her self-harm, making attempts to understand and reacting more compassionately, and also to access therapeutic help, which had not been open to her before this point. Within these discussions, participants positioned themselves as in need of safety and containment, needing to be cared for and checked on by others, and self-harm constructed as a 'cause for concern'. Positioning oneself as 'unsafe' within a discourse of risk could also be seen to make accessing help and support easier, particularly within a wider moral discourse, when 'admitting' to an urge to self-harm would be constructed as wrong and bad:

"(my friend) would often say to me, oh ring if you need me, day or night whatever, and it's not something you can ring someone about, it's really hard, how do you ring someone up and say.. I want to cut myself(…) I only ever did

ring her once and that was about 2 o'clock in the morning, and, I just said.. I don't feel safe, and she was here within minutes" (I2)

One participant also utilised a discourse of risk to demand specialist services and help for self-harm, which she constructed as being currently unavailable. This enabled responsibility to be shifted onto others to provide help and support for self-harm, positioning people who self-harm as in need of this external help in order to stop the behaviour:

"for as much as it's on the increase and it's on the rise, what are people doing to combat it? They put up banners and try and help people that have HIV, put up banners to try and stop people getting sexually transmitted diseases, well, what's helping us? What are they setting up to help us? Nothing(…) they say out of a class of 30, three people self-harm, that is <u>huge</u> amounts!" (I3)

'Helpful' behaviour from professionals was constructed as helping them to manage the risks of self-harm, within a non-judgemental and accepting environment, rather than 'overreacting' with alarm and fear. Such a construction allowed participants to retain a position of control within a discourse of risk, and to continue the self-harm behaviour, while still being taken seriously and the behaviour as 'genuine':

"I think it's always going to alarm people who are sort of parents of children who do it, but.. but it's.. it doesn't have to be something that makes people scream and shout about it, it could be something where they say, right, then you need to actually make sure you've got a bottle of antiseptic by your bed because, if you're going to cut yourself, then you have to be able to tend to the wound properly erm, and you know, you have to be prepared to check it carefully, on a regular basis(…) so that if something starts to go wrong, that you've got to seek help, and if they did that in a sort of non-judgemental way, I think it might help" (I6)

"it's someone going, it's acceptable for you to do what you're doing right now.. <u>but</u>, maybe if we work together, maybe if I give you more information.. you can look or we can look at a different way, but it's going, it's ok, for someone to go, it's ok what you're doing" (I3)

So by utilising discourses of risk, self-harm could be constructed as something that needs to be taken seriously and as a cause for concern, which enabled help and treatment to be provided and accessed. However, such discourses were resisted when they resulted in control being taken away, and physical restraint and force being used by others. So although utilised as a 'serious cause for concern', constructions of self-harm as linked to suicide and as an indicator of mental instability and danger were strongly resisted. Behaviour that resulted from these constructions, such as preventing self-harm, physical restraint, invasions of privacy and hospitalisation, were reconstructed as 'over the top' and 'ridiculous', and participants repositioned as being put at risk and made to feel unsafe by other people (rather than by self-harm). Discourses of 'horror' were utilised to talk about other people as opposed to self-harm, which was now reconstructed as survival, safety and a source of refuge, which needed to be accepted with compassion rather than condemned. Despite still utilising discourses of risk and danger, participants resisted the most damaging aspects of this and repositioned themselves within it to allow greater control and less judgement.

C5. Discussion and evaluation of analysis

The aim of this research was to analyse ways in which self-harm was constructed in the discourses of health professionals and people who self-harm. This was achieved by adopting a social constructionist approach to discourse analysis, drawing upon the work of Foucault and influenced by a critical, feminist ideology. Through a careful and systematic analysis of expert texts and interview transcripts with both health professionals and people who self-harm, constructions of the object 'self-harm' were identified. Such constructions resulted in the production of largely disempowering positions, with important consequences for action and subjectivity. This chapter will firstly present a brief summary of the analysis, focussing upon the main constructions identified and subsequent positions made available. The implications in terms of actions and subjectivities made possible, for both health professionals and people who self-harm, will then be further elaborated.

I do not believe this analytic approach lends itself to a simplistic and unproblematic application to practice (such as in the form of a series of concrete recommendations); nevertheless, language is very powerful, and the way an object is constructed allows for positions to be taken up which are more or less preferable to others, in terms of what can then be experienced and achieved. I will argue that resistance is far from simple and, as Parker *et* al (1995) drew attention to, by utilising the same discourses that we are challenging, opportunities for substantial and radical change are restricted. However, as noted by Willig (1998), refusal to take action is still a form of action, and so by doing nothing we are perpetuating current systems of discourse and practice. In response to this, I shall consider ways in which practice could potentially open up more empowering positions for people who self-harm. I remain mindful that such changes are limited within wider social constructions of mental health and normality, but my attempt is to consider ways of improving what is currently possible for both people who self-harm and the health professionals they come into contact with. Finally, I shall reflect on the research and analytic process, evaluating both its quality and limitations with a focus on future research possibilities.

C5.1 Summary of analysis

Self-harm was often constructed within the expert texts as 'pathology': both as a symptom of internal pathology and as external 'other'. Within the former, psychological discourse constructed self-harm as resulting from (and as a symptom of) internal dysfunction, deficit and/or damage, which was often seen as a consequence of childhood trauma. Within the latter, self-harm was portrayed as 'horror', something that 'takes over' and that people are at risk from. Discourses of addiction reinforced these constructions of 'other', with people positioned at the mercy of an overwhelming urge that they could not control. Certain populations were constructed as more at risk than others, such as women and young people, and in need of protection. These various constructions of pathology positioned people as out of control and vulnerable: either as patients needing treatment, or as victims needing help. They were subsequently not responsible for their self-harm behaviour, being positioned as having no alternatives (due to internal dysfunction). The diagnostic label resulting from this construction was attributed internally, so that a person who harms him or herself becomes a 'self-harmer'.

Self-harm was also constructed as 'risk' (for suicide) and 'danger', and therefore to be taken seriously by health professionals who were positioned as responsible for providing safety and containment. Within this construction, self-harm could be triggered by the behaviour of others, requiring professionals to understand the behaviour (within a psychological discourse) and respond appropriately (to prevent this happening). People who self-harm were positioned within this construction of risk as unstable, out of control and in need of external containment, and as unable to make reasonable and rational decisions in their own best interests. Addiction was constructed within discourses of both pathology and morality: as a permanent internal urge and need, which required 'strength of character' and 'willpower' to overcome. A moral discourse positioned people as responsible for their own recovery from self-harm, which was constructed as a long and difficult process of resolving past traumas, overcoming addiction and learning new behaviours.

The dominant constructions available separated self-harm out as socially unacceptable, abnormal and morally wrong. Any positive constructions were immediately reconstructed within discourses of pathology, addiction and morality as harmful, temporary and/or shameful. It was therefore virtually impossible to construct self-harm

as deliberately chosen by someone who is viewed by society as reasonable and rational. If constructions of pathology and/or addiction were rejected, then the behaviour was framed within moral discourses as deviant and therefore no longer 'genuine', and the person positioned as childish, attention seeking and manipulative. As a consequence, the person must either be seen as 'mad' or 'bad'.

C5.2 Implications for practice and experience

Constructions of self-harm can be seen to vary across history and culture, as illustrated by Favazza (1996; 2009). These constructions have implications for what is then made possible, in terms of behaviour and experience. As outlined above, self-harm is constructed within contemporary, western cultures as 'pathology', 'risk' and 'deviance'. Such constructions have far-reaching, largely negative implications for people who are positioned by their behaviour as 'self-harming'. This section will explore the ramifications of available constructions and their corresponding positions: namely by asking, what are we able to do and feel from these positions, both as people who self-harm and as health professionals?

Analysis of interviews with people who self-harm demonstrated an incredibly complex discursive process, whereby constructions were both utilised and resisted. The dilemmas inherent in utilising conflicting constructions created a tension, resulting in a constant shifting between constructions and subsequent positioning. One of the major struggles evident was between confession and secrecy. Constructions of confession as necessary for recovery produced a dilemma between being positioned as a morally responsible member of society on the one hand, and then being positioned as 'bad' and 'wrong' by the internal attribution of this very same moral discourse. By keeping the behaviour secret, participants were able to maintain some control and prevent being positioned as 'bad', a position within which they were likely to feel guilt and shame. From this position, they were also able to reconstruct others as the ones in need of protection and unable to cope (with the 'horror' of self-harm); however, this created tension with the moral discourse, which required commitment to recovery through confession and disclosure of self-harm, as they were now constructed as purposefully resisting 'positive change'.

Through adopting a discourse of pathology, people were able to continue to harm themselves while relinquishing personal and moral responsibility (as pathology

positioned them as having no alternatives and/or being at the mercy of overwhelming urge). This position also provided them with a 'valid reason' for their behaviour, being seen as genuine and resulting in more compassionate behaviour from other people. However, this led to another dilemma as they were subsequently positioned as internally damaged/dysfunctional, and therefore vulnerable, unable to cope and in need of help. This was particularly dilemmatic when the pathology was attached to them as a label, as indicative of mental illness and instability, which resulted in very negative social effects by impacting upon what was then available to them in terms of career possibilities and treatments, and in questioning their ability to 'cope', such as within the role of 'capable parent'. For instance, a construction of internal pathology resulted in being positioned as unstable and therefore potentially unable to care for children and hold a position of professional responsibility, and in need of forceful treatment options and external containment: this position was particularly disempowering, as people were then required to prove their stability and ability to cope (to those positioned as rational and reasonable) in order to be afforded the same opportunities as others. Once again, by hiding the behaviour (keeping secret) this position was avoided and future negative consequences prevented, but was then immediately in conflict with a moral discourse of responsibility and recovery.

At times this strong moral discourse, particularly its attribution to internal characteristics, was directly opposed with a more open defiance. Here participants constructed self-harm as part of them and their personal histories, as a form of survival within constructions of positive regard and fondness. Negative constructions were resisted as resulting from other people's lack of understanding, relocating the problem with other people rather than within themselves. However, in doing so, participants often utilised discourses of pathology (to account for the behaviour), which then repositioned them as internally damaged and needing to change/recover. Only one participant (interestingly, the only male) was able to negotiate his way through this dilemma in a relatively unproblematic way, by accepting a pathological discourse of abuse and positioning himself as needing to recover from this (not the self-harm): the self-harm was separated out as survival not the 'problem'. However, this did not totally free him from the dilemma and he also at times constructed self-harm within a moral discourse, and therefore as not a desirable solution to the problem (of abuse).

Additionally, participants could not be too openly defiant (in a visible sense), as this would not only position them as irresponsible (morally), but also attention seeking and therefore no longer genuine. This also prevented a shared sense of identity with other people who self-harmed, being reluctant to be seen as openly displaying the behaviour (which again would no longer be 'genuine'). So, it seems, the only way to be constructed as 'genuine' was to position the self within a discourse of pathology and distress, and to keep the behaviour hidden (except within a practice of confession) with a commitment to recovery. Stepping outside of this led to conflict with a moral discourse. A construction of self-harm as genuine could also be seen to allow for more compassionate behaviour in others, as opposed to disgust and anger.

A construction of pathology can also separate the behaviour out from the person, as 'horrific other', a process which Parker *et al* (1995) have also commented on. They note that this separation has a number of effects: firstly it creates a frightening social reality, as something that exists externally that can destroy and take over us (and threaten us through contagion); secondly, this 'demonising' makes it very difficult to talk in terms other than a 'reason' and 'unreason' split, with unreason separated out as 'other' and therefore not normal; finally, the separated object takes on a life of its own, as if it exists 'out there' in reality: "outside language, outside all of the persuasive and coercive practices that brought it into being and which maintain it against the protests of so many patients" (Parker *et al*, 1995, p.116). Although these authors are discussing constructions of psychosis this could equally apply to the discourses surrounding self-harm, and any other constructions separated out as 'abnormality' and 'madness'. As well as making it difficult to operate outside of these constructions, this process of separation also creates a fear within people who are in contact with those who have been positioned as 'abnormal'. This position of fear then becomes important within constructions of 'risk' and 'danger' in accounting for decision-making and actions taken, as discussed below.

A construction of self-harm as 'risk' and 'not risk' could be seen to represent the final dilemma. Participants strongly resisted a link between self-harm and suicide, particularly when this construction positioned them as mentally unstable and dangerous/out of control. By constructing self-harm as risk and danger, they were positioned as needing containment, increased surveillance and protection. Participants strongly resisted this disempowering position and reconstructed the *prevention* of self-

harm as the risk (not the self-harm itself). However, by utilising this discourse of pathology, a potentially dangerous and overwhelming urge was constructed with a need to be satisfied; once again positioning them as unstable and out of control. Although resulting in a disempowering position, a dilemma occurred when constructions of risk enabled the behaviour to be taken seriously (as opposed to being seen as attention-seeking and childish), and therapeutic help and support now made available. A psychological construction of self-harm (as resulting from internal distress/pathology) also allowed more compassionate reactions from others. Within this construction, responsibility was shifted onto others to provide help and support, promoting a dilemma between being positioned as needing and not needing help. Evidently, it is hard to access help in any other way, as a moral discourse prevents being more open about the behaviour, so it must therefore be seen within discourses of risk and pathology.

The constant discursive 'shifting' that results from the struggles described above may inadvertently have negative effects on the way people who self-harm are then positioned by us, the health professionals. For instance, this 'shifting' may be constructed as providing further evidence of a lack of internal stability which may then result in a diagnosis of disorder, such as borderline personality disorder. This construction of instability may also affect how they are positioned within the role of 'client'; for instance, as difficult and frustrating (by not consistently aligning themselves within one dominant construction, such as self-harm as morally wrong and/or as indicative of pathology). By continuing to self-harm and resist a pathologising discourse people are subsequently positioned within a moral discourse as wilfully deviant, and our efforts as therapists (to stop the behaviour) frustrated, positioning professionals as ineffectual. Positioning such clients as morally deviant and childish allows us to avoid being positioned in such an uncomfortable way, but results in very negative effects for the person who self-harms. Warner (1996) noted a construction of female inpatients as 'girls' commonly utilised within high security mental institutions, which could also be seen in the expert discourse analysis described here, whereby residents on the self-harm unit were commonly referred to as 'our girls' and 'our kids'. Warner (1996) explains this as resulting in the positioning of such women as passive victims within wider discourses of childhood abuse; again similarities can be drawn, with young people on the unit positioned as children and therefore passive victims within wider discourses of self-harm.

This 'mad/bad' dilemma, illustrated by Thomas Szasz in the 1960's (as cited in Ogden, 2000), positions the person as either 'mad', therefore *not responsible* for their behaviour, or 'bad' and therefore *responsible*. Szasz argued that at least from the position of 'bad' they are given choice, control and responsibility, which he sees as preferable to that of 'mad', where responsibility and control is taken away. However, I would argue that, as seen above, being positioned as bad results in a more punitive response whereby recovery is not seen as possible (or appropriate) and so treatment within a model of care is not provided. At least within discourses of pathology recovery becomes an option, and so compassion and treatment are then also made possible. Unfortunately, implicit social assumptions around gender mean that women seen as 'bad' are more likely to be treated as either mad or extremely bad, and subsequently either given harsher criminal sentences or pathologised in a move that legitimises hospitalisation, where they may then be "compulsorily detained under the Mental Health Act (1983), often without a time limit" (Warner, 1996, p.98). Interestingly, Warner and Wilkins (2003) have noted a large rise in the number of women sentenced to prison over the past decade, and a reduction in numbers sent to 'special hospitals', which may reflect 'a more punitive attitude' (p.176): this is certainly reflected in the strong moral discourse described within my analysis.

So here we can see that health professionals are also enmeshed in these dilemmas. A medical discourse "constructs pathology in ways that mean that the doctor is genuinely frightened for the safety of the patient, and for his or her own safety" (Parker *et* al, 1995, p.117). However, by resisting constructions of self-harm as risk, we risk being positioned as unethical and unprofessional. The strong moral discourse results in certain ethical and moral obligations within a 'duty of care', which requires that we react to risk and provide our clients with safety. This potentially adds to a construction of fear when faced with self-harm, resulting in responses that are more compatible with professional responsibility, such as hospitalisation and enforced containment. By not being seen as responding to risk, we may also be positioned as uncaring and as encouraging a damaging and harmful behaviour to continue. People who self-harm may themselves construct the lack of prevention as uncaring and unethical, as they are equally bound up in such discourses of damage and recovery.

What is clear is that these available discourses shift the focus from problems at a societal level to an individualised account of pathology and abnormality. Attempts to

gain power (and shed the victim/patient label) by eschewing offers of help and incorporating self-harm as a positive part of identity and personal history are constructed as defiant, childish and irresponsible. Psychological and moral discourses increase the emphasis on an individual responsibility to accept and heal through change: increasing the internalised and individualised nature of abnormality. So how can we go about change and implementation of improvements in the provision of care, and is this possible?

C5.3 Thoughts for the future: where do we go from here?

A social constructionist discourse analysis does not lend itself easily to the provision of concrete recommendations for practice. A practical 'deconstruction' can itself inform us about the nature and effects of dominant discourses, and expose power relations that often operate at a hidden level. For instance, by discussing self-harm as a construction we are already destabilising its 'truth' as 'internal reality', and in doing so, opening up alternative constructive possibilities. However, at the same time, if we cannot draw any implications for practice then we surely have to question the usefulness of such research. A typical argument against making such recommendations within this type of research enquiry are that in doing so, one runs the risk of making claims to 'truth' that are in opposition to a social constructionist ideology. By thinking about possible ways forward, I am not claiming to assume a greater truth but instead claiming that some accounts may still be 'better' than others (Kitzinger & Wilkinson, 1997).

> *"we as human agents find ourselves within a context in which things are always already going on or being done. Within this context it is impossible to abstain from involvement since inaction is always a form of action. Thus, we can only ever argue for or against, support or subvert particular practices or causes but we can never disengage ourselves from them" (Willig, 1998, p.96)*

Recommendations involve more than attempting a simplistic form of humanistic empowerment, but still, as I have alluded to above, interventions have consequences that result in better or worse outcomes for users of mental health services. However, applying such research is far from straightforward as taking up one position which appears more empowering can have unintended, undesirable consequences. This was argued by Foucault, who controversially suggested that in providing kindness instead of punishment to the 'mad', people were further enmeshed in the invisible binds of self-

surveillance and individualism (as cited in Parker *et al*, 1995). But if we take no action, we are still perpetuating 'the way things are', therefore accepting dominant discourses and constructions, which is a form of action in itself (Willig, 1998); and as Harper (1995) states: "all options have possibilities and danger" (p.7). As practitioners, we are already involved in the provision of services to people positioned as having mental (and/or physical) health problems; we are therefore already involved in political action and so, as addressed by Harper (1999), the more pertinent question becomes, in what way are we then to intervene? And where does this leave us as practitioners? Perhaps rather than doing nothing, we need instead to take action based on a careful consideration of the positions and consequences arising from our language.

> *"I still hurt myself in lots of ways, really. Worrying, blaming myself for things, doing too much, not letting me sleep – they're just as bad for me" ('Woman A' in Arnold, 1995, p.8)*

By constructing certain behaviours as constituting 'self-harm', we continue to delineate what is normal and acceptable behaviour in society, and what is abnormal pathology. Why, for instance, are other harmful and deliberate behaviours, such as smoking and drinking alcohol, not constructed within discourses of pathology? Smoking is often constructed within a discourse of addiction, and the person correspondingly positioned as 'out of control' of their behaviour, but this would not lead to constructions of risk and danger, even though they could conceivably be constructed as putting other people's lives at risk through secondary smoke. The distinction between what is socially acceptable and what isn't seems relatively arbitrary, but has powerful effects upon those who are labelled in this way. So, if we are providing treatment and care for people who are constructed as self-harming, how then can we create more empowering positions from within available discursive practices?

Psychology as a discipline has come under much attack in discourse analysis, for separating individuals from wider social practices and reducing complex relationships to an individualisation and internalisation of external problems, and in doing so it: "pathologiz(es) those who fail to fit its norms" (Burman, 1996, p.5). Such individualisation organises experience according to a 'psychological complex' (Rose, 1998), which has become 'common sense' in contemporary western society. But a discourse of psychology also arguably allows for a more compassionate construction

than punitive alternatives, which construct self-harm as morally wrong and shameful. For instance, Chandler (2008) describes the consequences of mental health staff on an inpatient unit reconstructing their understanding of self-destructive behaviours within psychological discourses of trauma, and how the adoption of 'a trauma informed approach' resulted in 'a deep cultural change that subsequently won state recognition for the reduction of seclusion and restraints' (p.363)

Perhaps what is necessary then is for practitioners to adopt a depathologising approach to therapy and treatment, which I believe is possible, even from within an individualising discipline such as psychology. For instance, as already illustrated, psychological constructions of trauma and internal distress can provide valid reasons in accounting for self-harm, and can reconstruct it from 'deviant and childish' to 'genuine and serious', all of which can promote more compassionate responses and experiences. According to Gavey (2003), such 'psychologising' of trauma, 'might in some cases be extremely liberating' (p.205). However, great care is needed within this discourse to not attribute the behaviour as indicative of a fixed and permanent internal characteristic or 'damage'. As Reavey (2003) proposes, by focusing on individual internal 'problems' we fail to recognise the social dynamics involved in these constructions. There is no reason why psychology as a discipline should inevitably result in a fixed internalisation of 'problems': by remaining alert to this pathologisation, and widening our focus to recognise the social productions of trauma, abuse and self-harm, we can "militate against an overarching focus on individualised choices and personal responsibility" (Reavey, 2003, p.163).

There have been various attempts towards developing therapeutic approaches that destigmatise and depathologise clients. I shall briefly discuss those considered of most relevance to this study: the development of alternative mental health movements, Dialectical Behaviour Therapy (DBT), feminist and social constructionist approaches to therapy, and art therapy. Parker *et al* (1995) detail a number of alternative movements to the traditional discursive practices of mental health, most notably the Hearing Voices Network, which was set up to directly challenge the psychiatric definitions of pathology and abnormality. Also of importance is the UK self-harm survivors' movement, which took shape in the early 1990's by people, largely women, who had survived both the psychiatric system and abuse: this movement led to the development of a number of organisations, conferences and publications, and the National Self-Harm Network, which

further established self-harm support and self-help groups (Spandler and Warner, 2007). Such movements bear much in common with the current trend towards increased involvement of service users within the NHS, especially within assessment, policy and treatment. Although challenging dominant systems of power and doubtlessly well intentioned it is possible that such approaches, having been seized upon by the Government, may end up merely serving to further conceal systems of oppression and increase compliance with self-surveillance through encouraging active participation and 'choice' in this process. However, such approaches demonstrate that resistance *can* be turned into influential forms of action.

DBT was developed by Linehan (1993) to treat people with a diagnosis of BPD and a history of self-harm. The structure of DBT was explored in more detail in the introduction section of this thesis, so will not be elaborated upon here, but by focusing upon emotion regulation and validation it encourages increased compassion and patience among practitioners, and a less pathological positioning for those people often considered 'difficult'. This focus upon validation and compassion perhaps reflects an increasing therapeutic turn towards *acceptance* of negative (and potentially fearful) inner 'states', rather than forceful attempts towards stopping and/or fleeing from them. This can also be seen within the acceptance and commitment therapeutic arm of CBT, developed by Hayes *et al* (2003) (ACT). Interestingly, ACT has generated controversy and criticism among psychology for not being able to scientifically validate its effectiveness; which is perhaps not surprising when the outcome measures are focused upon reducing (rather than accepting) those constructs considered pathological. Gratz and Chapman (2009) have adapted DBT techniques into a self-help book for people who self-harm, and in doing so: "The authors start in a place that most others skip. They do not assume that everyone wants to stop" (p.viii). However, DBT is not without its criticisms with some questioning its focus upon internal emotional 'deficits' and challenging its avoidance of contributory and social factors, such as abuse and trauma, in favour of present day symptoms, in addition to its focus on cessation of self-harm as the primary outcome measure (e.g. Spandler and Warner, 2007; Warner, 2004).

Feminist therapy, explored in more detail in the introduction section, can take many different forms, but of particular interest to this research is therapy combining both feminism and social constructionism. One such approach, proposed by Warner (2003), is Visible Therapy. Within such an approach, the notion of confession as necessary for

recovery is challenged, as is "the implicit therapeutic assumption that talking (about childhood sexual abuse) is always beneficial" and should always be the "the assumed object of therapeutic concern" (Warner, 2003, p.226). This could equally be applied to people presenting to therapy with self-harm behaviours. As demonstrated through the analysis, many participants questioned the necessity of focusing upon self-harm as 'the problem,' as immediate risk and as needing to be remedied.

Other therapies informed by social constructionism include Narrative Therapy, developed by White & Epston (1990). This attempts to adopt a non-pathologising approach to therapy, where clients are engaged in discourses that externalise the internal, to reconstruct 'truths' by exploring how they and others have been involved in the pathologisation of their experiences. Such an approach prevents the use of individualising constructions of pathology and also allows acknowledgement of the wider social context. Finally, art therapy as applied to self-harm (described by Motz, 2009a) also provides a reconceptualisation of treatment: constructing self-harm as a symbolisation of inner pain thereby valuing therapeutic effectiveness as allowing another (less damaging) form of emotional expression (i.e. through art, music or drama), providing an environment in which this 'transformation' is encouraged, rather than pathologised.

By focusing on change at an individual level, I am aware that we remain within wider social constraints, however, this is not to say that individual action is ineffective; as Warner (1996) illustrates, action at a 'local' level may be "a starting point, not the end", but nevertheless by analysing the inherent tensions within available discourses we expose its instability: "and therein lies the possibility of change" (p.113). This provides us with grounds for optimism, even for those discourses that seem impenetrable to change, embedded within society as truth and common knowledge:

> *"Some discourses are so entrenched that it is very difficult to see how we may challenge them. They have become 'common sense'. At the same time, it is in the nature of language that alternative constructions are always possible and that counter-discourses can, and do, eventually emerge" (Willig, 2001, p.107).*

By focusing on individual approaches to practice, and through being more mindful of the impact of language upon possibilities for action and experience, and the complex inter-

relations of power within social and institutional practices, we can begin to instigate small but important changes. By working towards a greater destabilising of what is held to be 'true' we are helping to free people from pathologising positions, whereby the past is permanently inscribed into a damaged sense of self, prescribing a bleak future of constant individual struggle and recovery through confession and self-surveillance. Constantly analysing the impact of our discourses, and looking for ways to destabilise and change current practices is a challenge for:

> *"not only students and practitioners of psychology, but all of us who as professionals or as individuals subscribe to psychological notions about ourselves and our relationships as part of contemporary cultural life" (Burman, 1996, p.3).*

C5.4 Evaluating the research

As mentioned in the methodology section of this research, traditional positivist concepts of reliability and validity have no place within a piece of qualitative work informed by social constructionism. However, it is still necessary to demonstrate quality to assure readers that a thorough analysis was undertaken and that such analysis is therefore trustworthy. There have been many discussions surrounding the criteria by which such work should be evaluated and different terms have been suggested. However, guidelines produced by Henwood and Pidgeon (1992) and Yardley (2008) were considered relevant within this research:

- **Ensuring analytic categories fit the data**: by clearly explaining the process by which categories were generated, and illustrating categories with appropriate examples. This also includes attempts to ensure a coherent fit between the epistemological approach adopted, the methodology, analysis and presentation of the data. Willig (2001) emphasises that the type of research epistemology adopted will shape the way research is evaluated: for FDA, exploring 'the quality of the accounts they produce' is important; for instance, in terms of how clear, coherent and convincing they are (p.148), which relates to the concept of good 'internal coherence (they tell a good clear story)' (Harper, 2006, p.6). This also relates to both data collection and analysis being thorough and undertaken with competence, demonstrating a satisfactory level of engagement with the topic in question. Using excerpts to illustrate my analysis was intended to allow the

readers to judge the analysis for themselves, and allow for the possibility of alternative readings.

- **Triangulation:** 'as a method of enriching understanding.. by viewing it from different perspectives' (Yardley, 2008, p.240). I have viewed this term, more commonly associated with quantitative research, to mean gathering data from different sources (people who self-harm, health professionals and professional texts), using a variety of different methods (interviews, focus groups and text analysis); rather than deeming it necessary to seek to corroborate my analysis with and from different viewpoints (to gain greater access to 'reality'): given the nature of social constructionism, such an outcome would not be seen as possible or relevant.

- **Reflexivity:** Willig (2001) highlights the need within qualitative research to acknowledge in what way 'the researcher's perspective and position have shaped the research' (p.148). My part in this process of construction cannot be ignored and it reflects an important part of discourse analysis. All forms of knowledge, including research papers and documents, are seen as the result of discursive construction; hence I am seen as an author of this research study, which makes my reflexive awareness a key component of the analysis (Willig, 2001). I have commented throughout upon my reflections of the research process at each key stage; however, there are many reflections that I have been unable to include in the final write up, due to word limitations and the need to be concise and relevant. There is a point at which reflection can become a rather self-indulgent exercise, even perhaps an 'agonising confessional' (Parker, 1999, p.31), which I attempted to avoid by keeping reflections pertinent to the research: in other words, by focussing on reflections that may inform the reader's understanding of my position in relation to the analysis: "I see reflexivity not as an end in itself but rather as a means by which I can be made accountable for my analysis through an explication of my interests and context" (Harper, 2003, p.78). See the section below (C5.6 Relevance to Counselling Psychology) for a further exploration of the impact this research has had upon my personal and professional development as a Counselling Psychologist.

- **Documentation or 'paper trail'**: recording in detail a transparent account of what was done and how at each stage of the research process, essentially so it remains open to replication and evaluation by others.

- **Negative and disconfirming case analysis**: identifying and exploring cases that do not fit with the categories generated, to help balance the inevitable biases influencing the researcher (Yardley, 2008) and to guard against any temptation to fit the data into preconceived categories.

- **Sensitivity to negotiated realities**: this study decided not to include participant validation of themes/categories generated, mainly because of the complexity of the approach adopted making it difficult for people to readily understand and relate to (Yardley, 2008), and also because 'people may disagree with the researcher's interpretation for all kinds of personal and social reasons' (Willig, 2001, p.143) making any feedback difficult to use constructively; but it remains important to be aware of the variety of responses and experiences expressed. Essentially, I made concerted efforts to be 'equally respectful and non-blaming of all participants' and avoid any 'creeping intentionalism' (Harper, 2003, p.84), thereby trying to stay as true to the data as possible; while recognising Stainton-Rogers comments on the inevitability of committing violence to the words of others 'as they were originally expressed' (1991, p.10), I tried to keep this to a minimum.

Limitations, improvements and further questions:

DA allows us to take a critical look at commonly held and taken-for-granted assumptions and social practices, and in doing so open up subversive power relations and examine the consequences that discourse has upon possibilities for action and experience. Explanations for constructions cannot be found *within* individuals, but instead in the interactions between people and social structures. Such a discursive approach widens the focus and "enables a critical perspective on psychology as fundamentally and intrinsically individualizing" (Burman, 1996, p.5). By examining such processes in this way, we can begin to shake up 'the way things are,' and allow for reconstructions to emerge.

I have attempted to address some of the more common criticisms applied to studies employing methods of discourse analysis: for example, claims to the generalisation of findings and issues of quality, such as preventing implications of intentionality and individual blame in the analysis, and arguing against claims to a 'greater truth'. This research has explored the resources available within expert documents and discourses, and also within a small sample of people who self-harm within the community. The issue of attempting a representative sample has already been addressed earlier; however, it should be noted that the majority of participants were female and recruited from a website for people abused in childhood. This may have had implications for the analysis, particularly with regards to the similarities drawn from other research conducted on childhood trauma. It may subsequently be interesting to conduct a similar type of research upon a sample recruited via other means (i.e. from organisations not specifically related to childhood trauma), and also one targeting males only, to see if similar discursive resources were being drawn upon.

It would have been interesting to see if including a focus group for participants who self-harmed affected discourse dynamics, as I am aware of the power relations inherent in talking with myself, a psychologist, often seen within the university grounds. Similarly, it would be interesting to see if recruiting specifically therapists and psychologists would have resulted in any changes to the 'expert' discourse. Widening the analysis to include a greater range of texts and targeting different sources, such as media (newspapers, television, film, magazines), self-help literature, and autobiographical accounts, may also expose different discursive dynamics and resources. Extending the study to analyse discourses within Internet chatrooms may also be illuminating, especially given the proliferation in number of sites and people using them. It would be particularly interesting to see if removing the physical presence of the interviewer would generate different discourses, given the potential change in power. I would also be interested in exploring different cultural constructions of self-harm, and analysing these differences in terms of historical developments and the discursive resources available. Finally, given the very physical act of self-harm, I would have liked to have focussed more upon issues of embodiment, perhaps exploring experiences and meaning through a phenomenological approach to analysis, as embodiment and subjectivity within a discursive framework still "needs to be theorized and researched more fully" (Willig, 2000, p.559).

C5.5 Relating to existing knowledge

Comparing this research to other studies in the same area is a difficult task, as no studies were found at the time of writing that have applied discourse analysis to explore constructions of self-harm. Only one other study was found to employ FDA: to analyse how participants constructed *websites* dedicated to self-harm and suicidal behaviours (as opposed to self-harm itself). Interestingly, their analysis certainly relates to the discourses identified within my research, stating that people who self-harmed constructed the websites/internet forums "as sources of empathy and understanding, as communities, and as a way of coping with social and psychological distress", whilst also commenting that these discourses made the acceptance of social identities and understanding of the behaviour possible (Baker and Fortune, 2008, p.118). The focus here upon identity and acceptance is very pertinent given my commentary upon the lack of possibilities for acceptance of identity within strong moral discourses of self-harm.

Adler and Adler (2007) concluded that self-harm is in the process of becoming 'demedicalized' and reconceptualised as a 'voluntary chosen deviant behavior' (p.537), which compares with my commentary on the construction of self-harm within discourses of pathology or morality, also noting an increase in moral constructions. It appears that Internet forums may provide an escape from discourses of morality, and opportunities for greater freedom of expression that can be both anonymous and controlled. This is certainly worthy of further exploration. This lack of self-harm research from a DA perspective, however, does indicate that my research study provides a unique contribution to the field, and an important first step into opening up different ways of understanding self-harm.

Although DA has not been widely applied to self-harm, its use has been far more widespread within related research topics of sexuality, madness and childhood sexual abuse. Research conducted within these areas can be seen to draw similarities with my research, particularly those exploring constructions of childhood abuse. For instance, research by Warner (1996), and Warner and Wilkins (2003), explored the diagnoses of BPD in women, relating this to their histories of childhood sexual abuse and focussing particularly upon their incarceration within high security mental institutions. Specifically, how implicit gendered assumptions surrounding 'normal' femininity served to separate these women out as *so* abnormal and unstable that high-security containment was warranted. This research comments that although past trauma is acknowledged, it is

used to explain dysfunctional response/behaviour based on abnormal development (as a consequence of abuse), rather than allowing their behaviour to be seen as a way of coping and positive survival. The consequences of abuse are then *internalised* as inevitable dysfunction (as residing within the individual who has become permanently damaged), which deflects attention from the environment onto individual pathology. By drawing attention to the hidden assumptions of gender and femininity that are bound up in discourses of abuse, the authors propose that women who do not fit into social norms (i.e. who are violent and angry) are subsequently labelled as 'mad'.

The collection of research within Reavey and Warner's (2003) book, exploring discourses surrounding childhood sexual abuse, is all highly relevant to this research, particularly those chapters by Gavey (2003), O'Dell (2003) and Reavey (2003). These authors illustrate the power of psychology and its tendency towards pathological reductionism and individualism: reducing people's experiences to symptoms within a wider developmental discourse, which serves to obscure gendered assumptions of normality and position survivors of abuse as victims. The focus is then upon distress as internal rather than as a response to the environment. Importantly, such accounts of the past also delineate possibilities for the present and future, as they set behaviour and imply permanent damage.

Although not especially contemporary, Kitzinger's work (1989) is nevertheless relevant and worthy of comment here. Her focus upon 'deviant' sexuality draws similarities with the strong moral discourse identified within my own research. Kitzinger's research demonstrated how the marginalisation of homosexuality through the construction of normal and desirable 'heterosexual family life' was resisted through the use of liberal humanist discourse involving romantic love (to emphasise love and personhood and unimportance of sexuality). Despite being a resistance, she argued that this was inadvertently counter-productive, as it perpetuated the accepted moral order of things (and so corresponding oppression). Similarities can be drawn with my own commentary upon the resistance of morality through hiding the behaviour, which served to prevent undesirable positioning but also perpetuated social acceptance of a construction of self-harm as morally wrong.

Parker et al's (1995) research on the 'demonisation' of madness as 'other', have already been commented upon. The ideas of 'contagion' highlighted remain highly relevant for

my own research, and appear rooted in historical constructions of madness: such constructions of contagion resulting in an embedded social fear that madness will be somehow caught like a type of infection. This can be illustrated within fears that certain populations are at greater risk of self-harm, that it can be taught and imitated/copied, and has resulted in constructions of an 'epidemic' affecting our young people. So self-harm is contained in efforts to understand and treat it, and to prevent it before it threatens society.

C5.6 Relevance to Counselling Psychology

Feminist writings in this area have endeavoured to normalise women's mental distress in light of context and environment, primarily focussing on the conflicts inherent in the social gender roles expected. By doing so, feminist writers have attempted to move the focus away from the medicalised concept of distress as an internal illness/pathology. This study hopes to have added to this body of work, drawing attention to the negative impact of current pathological constructions of self-harm. Rather than adding to this internalised, individualistic notion of mental illness, I believe that psychology has much to offer in the advancement of alternative understanding. Rather than separating out such behaviours as 'abnormal' and 'mad', we can act in ways that increase understanding and compassion, grounding them in their appropriate social context. As proposed by Johnstone (2010), the strength of psychology lies in its use of formulation: in contrast to psychiatric diagnosis which reduces meaning and context to a list of visible symptoms, formulation enables restoration of meaning to a person's distress, placing their problems within an understandable context. This study emphasises that by viewing distress and behaviour in their appropriate social context, and through challenging constructions of pathology and abnormality, it becomes possible for psychology to be positive and liberating. By doing so in a way that avoids labels of permanent dysfunction and deficit, we can increase the provision of compassionate and empowering services to those who need it.

The particular type of analysis utilised in this study is complex and difficult to learn, especially for those new to qualitative research such as myself. This analytic process was certainly not a simple one, being at times daunting, overwhelming and incredibly time consuming, requiring substantial in-depth reading and learning a very new form of analysis which remains relatively undocumented and unstructured. However, it was

also fascinating and mind-expanding, and essentially the only approach that could explore the type of research questions posed.

Reflexive sections have appeared throughout this research to help the reader understand how the research was informed and shaped by my personal and political positions. However, this research has also simultaneously impacted upon my own personal and professional development. The research process, and the adoption of a social constructionist analytic framework, has strongly influenced my way of thinking about my practice as a Counselling Psychologist. I have become more mindful of using non-diagnostic language and of the impact that language can have on the positioning of people and upon opportunities for action. Thinking outside dominant discourses is difficult, particularly within the large institutions such as the NHS where diagnosis and pathology are an inherent part of the culture and medical framework. As argued above, I believe psychology as a discipline has much to offer people, enabling a discourse of trauma and survival that is arguably preferable to that of blame and moral deviance; but it also brings with it responsibilities and challenges. We must be vigilant against positioning people as victims based on their past histories and present behaviour; constructing self-harm as a way of coping can be positive, as long as it does not become indicative of a fixed and permanent internal dysfunction.

At an individual level, by being aware of risk without reacting to disclosure of self-harm as in itself indicative of immediate 'danger' (as also suggested by Allen, 2007), and providing safety through emotional containment and a non-judgemental acceptance, we can satisfy both our ethical obligations and also try and ensure we are not disempowering others by taking away their control. Such an approach can be seen as based on a 'feminist understanding of self-injury' (Craigen and Foster, 2009), and may include increased attempts towards the dissolution of power imbalance through involving the client in a collaborative therapeutic relationship, and resisting both pathological labelling and moral and punitive discourses of self-harm, while still helping them work towards therapeutic goals that they value.

In my early training days I felt a strong discomfort with pathologising my clients, seeing many problems resulting from social circumstances rather than individual dysfunction, and leant towards a belief in aiding empowerment and personal growth instead. This research process has enabled this spark of belief to grow into a burning light that has

pulled my training together into a coherent whole with a solid sense of purpose. If we continue to pathologise and demonise the people who come to us for help, then we become part of a system that perpetuates the very powerlessness that we should be aiming to change:

"the mental health system that I was in for so long didn't help me get out of that and it was only through finding someone I could work with and eventually.. y'know, it was like I found my way out.. I didn't know I was lost in there until I kind of came out(…)

my label is not just a self-harmer.. I'm just someone who happens to hurt themselves sometimes"
(I4)

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Appendix 1: advert for recruitment of participants

Do you ever intentionally harm yourself?

I am interested in hearing about the experiences of self-harm, and I would like to give a voice to people who self-harm (or have self-harmed in the past). I am seeking participants (male or female) who are willing to talk about their experiences with me, in a safe and non-judgemental environment.

The study aims to explore how people talk about and understand self-harming behaviours, which may include a variety of behaviours (such as cutting, burning, poisoning, repeatedly picking at the skin) directed towards the self. I would be very grateful if you could spare me an hour of your time to talk about your experiences. This study is strictly confidential and anonymous. Your contribution and involvement in this project would be greatly appreciated and valued. Please note that you need to be over the age of 18, and to have self-harmed on more than one occasion, to take part.

If you are interested in taking part, and would like further information, please contact me on abbw298@city.ac.uk, or at the Department of Psychology, City University, Northampton Square, London, EC1V 0HB.

Dr Carla Willig at City University is supervising this research, and she can be contacted at: C.Willig@city.ac.uk. This research is being conducted as part of my doctoral study at City University.

*I am hoping to conduct interviews in London, but I am willing to travel to interview participants, so please contact me if you live in another part of England.

Appendix 2: Information Sheet

Date:

Researcher's Name: Caroline Silcock

Supervisor: Carla Willig

Institution: **Department of Psychology, City University, Northampton Square, London EC1V 0HB**

Email: abbw298@city.ac.uk

Supervisor's email: C.Willig@city.ac.uk

Study Title:

"Understanding Self-Injury: Analysing the Discourse of Health Professionals and People who Self-Harm".

You are being invited to take part in a research study that is being carried out as part of a doctoral requirement at City University. Before you decide to participate, it is important for you to understand why the research is being carried out and what it will involve. Please take your time to read the following information carefully, and discuss it with others if you wish. Please feel free to ask if there is anything that is not clear or if you would like more information. Take your time to decide whether or not you wish to take part.

Purpose of research:

The aim of the study is to explore how people talk about self-harm, and how they make sense of their self-harm behaviour. It is also looking at health professionals involved in the care of those who self-harm, and how they understand self-harm. The purpose is to increase our knowledge of how people make sense of self-harm through looking at the way they speak about it. The views of people who self-harm, especially in the community, have been neglected in the research literature. This research will add to our understanding, and has implications for improving treatment services and the education of health professionals involved in providing these services.

What will happen to me if I take part?

You will be required to participate in an interview that should last approximately 45-60 minutes. The interview will be tape-recorded and will take place at a location that is

acceptable to you (this could be your home, in a room at the university, or somewhere else agreeable to both of us). The interview will then be written up and discussed in a final report, which may be published. All interview material will be anonymous and no identifiable details will be included in any notes, interview transcripts or final written reports. All written interview material (including notes and transcripts) will be stored in a lockable unit, for which only I have a key. Interview transcripts will stored on my personal computer, which is password protected. All interview material will be securely destroyed by September 2010, one year after this study is due to finish.

This interview will be conducted by myself, a Counselling Psychologist in Training, and will provide an opportunity for you to discuss your experiences in a safe and non-judgemental environment. However, please note that this is a research interview, and so cannot be seen as an opportunity to receive therapy. Details of how to contact counselling organisations and emergency support numbers will be provided at the end of the interview, and can be provided at any time upon request.

You may keep this information sheet and, if you decide to take part, you will be asked to sign a consent form prior to being interviewed. Participation in this research is entirely voluntary. You do not have to take part if you do not want to. If you decide to take part, you may withdraw **at any time** without giving reason and without prejudice. Any material collected will be destroyed immediately.

An Ethics Committee reviews all proposals for research using human participants before they can proceed. Two people from City University's Department of Psychology have reviewed and approved this proposal.

Thanks you for expressing an interest in my research and for taking the time to read this form.

Appendix 3: Informed Consent Form

Consent to Participate in Research

Date:

Researcher's Name: Caroline Silcock

Supervisor: Carla Willig

Institution: Department of Psychology, City University, Northampton Square, London EC1V 0HB

Email: abbw298@city.ac.uk

Supervisor's email: C.Willig@city.ac.uk

"Understanding Self-Injury: Analysing the Discourse of Health Professionals and People who Self-Harm".

This is a written informed consent form to check that you are happy with the information that you have been given about the study, you are aware of your rights as a participant, and to confirm that you wish to take part in this research.

Please read the following and sign below if you understand and agree with the statements:

- I understand that I must be at least 18 years old to participate in this project.
- I understand that my participation in this study will involve attending an interview, which will last 45-60 minutes.
- I understand that participation in this study is entirely voluntary and that I can withdraw at any time, without giving any reason and without prejudice, and that all material collected about me will be destroyed immediately.
- I understand that I am free to send any questions, or discuss any concerns, with the researcher or the researcher's supervisor at the above address.
- I understand that the information provided by me will be held totally anonymously, so that it is impossible to trace this information back to me individually.
- I understand that any interview material will be kept securely (in a locked unit and a password protected computer) and will be destroyed by September 2010, one year after this study ends.
- I understand that the interview is for research purposes only and does not constitute therapy.

- I understand the details of the research as explained to me by the researcher, and that it is being conducted as part of a doctoral study at City University.
- I understand that I am free to refuse to answer any questions asked in the interview.
- I have received enough information about the research to decide whether I want to take part.
- I agree to take part in this study.
- I confirm that quotations from the interview can be used in the final research study and other publications, and I understand that these will be used anonymously.

Signature of participant: **Date:**

I, the researcher, agree to comply with the above statement and I am signing on behalf of anyone else who may be involved in the research process (e.g. supervisor, examiner).

Signature of researcher: **Date:**

Appendix 4: Interview Schedule Guide

1) Tell me a bit about your history of self-harm.
2) What does self-harm mean to you?
3) How do you make sense of your self-harm?
4) Can you tell me about your first experience of self-harm?
5) Have you ever approached anyone for help?
6) Do you think self-harm has changed the way you see yourself?
7) Do you think it affects how other people see you?
8) Is there anything else that you feel I should have asked, or that you would like to add?

Appendix 5: Focus Group Schedule

Health professionals' understandings of self-harm

Introduction (recap on aims of research, schedule and ground rules)

Questions:

1. Can you tell me about your experiences of treating people with self-harm?
2. How do you approach the treatment of self-harm?
3. How did you feel about the people you treat?
4. How do you make sense of their behaviour?
5. What functions do you think self-harm serves?
6. What do you think causes self-harm?
7. Do you think treatment for self-harm is effective?
8. What do you think the general view of self-harm is among health professionals?
9. How do you feel about the current provision of services?
10. Has being involved in this line of work affected your life in any way?
    a. including your general outlook on life?
    b. on you personally?
    c. on others around you?
11. Are there any particular experiences (of either self-harm or working with other professionals) that have stuck in your mind, or affected you in some way?
12. Is there anything else you would like to say about your experiences of working with people who self-harm?

Conclusion (summary, thanks and de-briefing)

*This schedule is modified from that provided by Wilkinson (2008: 192-3).

Appendix 6: Transcription Key

Extended square brackets mark overlap between utterances, e.g.:

P: Right so [I'm not sure if]

I: [yeah because I] didn't know that

Numbers in brackets indicate pauses timed to the nearest second:
(0.1) indicating a pause of 1 second; (0.2) indicating a pause of 2 seconds etc..
A full stop in brackets indicates a pause that is noticeable but too short to measure, e.g.:

P: I decided (.) like when I decided to do that (0.2) it wasn't

A dash at the end of a word indicates the speech was interrupted, e.g.:

P: I didn't think I'd-

I: right so you thought that by doing that

Certain events not captured by the speech, such as sneezing, nodding, intakes of breath, and any emphases, are included in round brackets and italicised, e.g.:

P: yeah cos I didn't want to let him see that

I: *(nods head)* yeah I see

Words are included as said, for instance errors or words started but not finished, e.g.:

P: because I don't think it ever goes away it nev (.) the feeling never goes away

Words are included in round brackets if there are doubts about accuracy, or if they are inaudible e.g.:

P: I'm not (sure if that's true) but I

Or P: I don't know (inaudible) although

Appendix 7: Transcription time

Time spent transcribing:

5 minutes of text took 1 hour to transcribe

Interview 1: 1hr12mins = 14.5 hours

Interview 2: 1hour = 12 hours

Interview 3: 57mins = 12 hours

Interview 4: 1hr5mins = 13 hours

Interview 5: 53mins = 10.5 hours

Interview 6: 57mins = 11.5 hours

Focus Group: 1hr40mins = 20 hours

Total transcription time: 93.5hours

Appendix 8: Full Coding Table

G1: Mental Health Foundation (2006). Truth Hurts: Report of the National Inquiry into Self-harm among Young People – Executive Summary. Retrieved January, 2008, from http://www.mentalhealth.org.uk/campaigns/ self-harm-inquiry/

G2: NICE (2004). Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. Retrieved January, 2008, from: http://www.nice.org.uk/ nicemedia/pdf/CG016NICE guideline.pdf.

P1: The Royal College of Psychiatrists (2007). *Working with people who self-harm: Information for staff in emergency services.* Retrieved January, 2008, from:http://www.rcpsych.ac.uk/clinicalservicestandards/centreforqualityimprovement/self-harmproject/changeinterventions.aspx

P2: The Royal College of Psychiatrists (2007). *Self-Harm*. Retrieved January, 2008, from: http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/depression/self-harm.aspx

T1: Petit, J.R. (2004). *Handbook of emergency psychiatry* (pp.189-203). Philadelphia: Lippincott Williams & Wilkins.

T2: Sidley, G.L. (2006). Self-harm. In N.Tarrier (Ed.), *Case formulation in cognitive behaviour therapy: The treatment of challenging and complex cases* (pp.312-29). East Sussex: Routledge.

I1: Interview transcript

I2: Interview transcript

I3: Interview transcript

I4: Interview transcript

I5: Interview transcript

I6: Interview transcript

FG: Focus group transcript

D. Professional Practice

Acceptance and Fear: Embracing Self-Management in Chronic Pain

D.1. Introduction

I chose this case study for inclusion in my professional portfolio, as it demonstrates my developing interest as a psychologist in the area of chronic pain. This work was carried out within a 6-month placement at a department specialising in pain management and as such I had to learn a lot in a short space of time. I found that my MSc in Health Psychology came in useful and I also realised that the area of chronic pain related to my wider interests in trauma: trauma can manifest itself in many different presentations, and pain that occurs following a physical trauma (such as whiplash, road traffic injuries, falls or, as in this case, a dental procedure) is just one of these. Such pain vividly demonstrates the unhelpfulness of attempting a mind/body split in a therapeutic approach. The mind and body are intricately enmeshed, with past trauma affecting both cognitive and physical aspects of functioning. In this sense, chronic pain is not proposed as being a simple result of trauma, or as being 'all in the mind', but nevertheless, trauma can have various cognitive, emotional and physical effects that result in pain becoming chronic and persistent.

On a more practical level, I believe this client study is a good example of the application of Cognitive Behaviour Therapy (CBT) to a long-term physical condition whilst also highlighting my evolving practice and understanding of CBT. My previous view of CBT as a 'dry' and formulaic practice evolved through my growing interest in constructivism. I first believed these two approaches to be incompatible, but increasingly came to see how these two strands could be woven together in practice, allowing me to practice within CBT while still being true to my constructivist beliefs. Such an approach places emphasis on individual meaning of experience and the wider social context, while also paying attention to language, replacing terms such as 'irrational' and 'maladaptive' beliefs and 'thinking errors', with less pathologising terms such as 'unhelpful thoughts' and 'thinking traps'. This work highlights the importance of empowerment and allowing the client to take an active role in their own progress. I felt that initial resistance and scepticism was worked through successfully and that, in doing so, a collaborative and individualised case formulation resulted in positive outcomes. This work demonstrates my broadening knowledge of trauma and the various manifestations it can take, as well

as highlighting how my professional career and personal interests have subsequently been shaped.

The following case study is divided into 4 parts: D.2. introduces the context for this work and the theoretical framework adopted; D.3. explores the initial assessment and formulation; D.4. discusses the development of therapy and key content and process issues; and D.5. evaluates the work in terms of therapeutic outcome, and in terms of my own professional development.

D.2. Context and Therapeutic Framework

Referral and work setting

Katie[1] was referred to the Pain Clinic by her GP for chronic facial pain. The first point of contact was with a medical consultant who assessed all people referred to the clinic. The team consisted of psychologists, physiotherapists, occupational therapists and nurses, who all specialised in pain. A consultant at the Clinic had conducted a series of medical assessments, and referred Katie for individual psychology sessions as part of the Pain Management Service. Following these assessments, and through consulting her previous medical records, the consultant was satisfied that there was no ongoing, organic cause for the pain, which had now become chronic and persistent. As such, he did not believe any physical treatment would be effective in curing the pain, or in offering anything other than short-term relief, and so further medical intervention was not warranted. Referral to psychology was intended to help Katie understand the nature of chronic pain, and manage the impact that this was having on her life, and so encourage her towards adopting a long-term approach to the management of her pain. These psychology sessions took place weekly in the hospital, in a clinical room normally used for medical assessments. This room was not particularly conducive to therapy, being fairly sterile in appearance, and may have contributed to an expectation within the client of therapy being similar to previous medical encounters, of which there had been many. This may have also contributed to the client being positioned within the role of 'passive patient'.

[1] names and certain biographical and personal identifying details have been changed to preserve client confidentiality

Rationale for choice of framework

CBT has been shown to be the most effective therapy for chronic pain conditions in a range of studies (Turk *et al* 2008; Turner *et* al 2007; Hatten *et al* 2006; Vlaeyen and Morley 2005; White 2001; Eccleston 2001; Turner and Jensen 1993), including two meta-analyses (Morley *et al* 1999b; Flor *et al* 1992), and has been described as 'the leading non-medical treatment of chronic pain' (White, 2001: p7).

Therapeutic framework

Cognitive therapy has grown rapidly over the years since it was originally developed by Aaron Beck in the early 1960's to treat depression, and has now been adapted to treat a wide range of presenting problems, including physical health conditions. At the heart of CBT is the belief that our emotions and behaviours are strongly influenced by our thoughts. Core beliefs and assumptions are developed through experience, and violation of these gives rise to negative automatic thoughts. These negative thoughts trigger negative emotions and a vicious cycle results, with 'feedback loops that serve to maintain the problem' (Westbrook *et al* 2007, p. 11). The meaning a person attaches to something (such as pain) has received increasing emphasis within CBT (White 2001), as this is linked to emotional, behavioural and physical responses (Sage *et* al 2008); additionally, meaning is seen as central in the adjustment to physical illness, through the acceptance of experience within schemas (Fife 1995). Treatment within CBT is collaborative, problem-focused and structured, with a strong emphasis on empirical foundations (Beck 1995).

The application of CBT to chronic pain has developed considerably over the past 30 years, alongside our understanding of pain. Original understandings linked the sensation of pain directly to the severity of the injury: so that increased pain was thought to indicate a more severe injury. However, the development of Melzack and Wall's (1982) 'Gate Control Theory of Pain' replaced the previous notion of a direct causality between physical damage and pain. We now understand pain to be much more complex, involving a variety of factors in its moderation and mediation (Vlaeyen and Morley 2005). This theory proposes that signals being sent from the nerves in the body first enter the spinal cord, whereupon they go through a series of gates in order to enter the brain. The brain then processes these signals and understands them as 'pain', which results in decisions regarding further action (such as taking hand away from hot object/increased attention to the pain). All of which happens within seconds. The key

information here is that the gates processing these signals can both open and close, subsequently affecting the amount of signals getting through to the brain (and being registered as pain). It is also now understood that other factors can influence the degree to which these gates are kept open, such as stress, negative emotions, increased attention to pain, lack of exercise and movement, and that other factors can help to close the gates, such as massage, medication, relaxation, distraction, exercise and belief in the ability to cope (Nicholas *et al*, 2005).

CBT for chronic pain incorporates a biopsychosocial framework, which places importance on a range of factors in a person's life, including: thoughts, beliefs and fears about pain (often leading to avoidance); belief in ability to self-manage; worries about the future; stress and responses to stress; and low emotional mood (Turk and Okifuji 2002). Biological and social factors such as family, medication and occupation, are also considered (White 2001). From this perspective, thoughts and feelings are seen to have 'a profound impact on functional adaptation to the (pain)' (Thorn 2004; p26). There is currently no permanent cure for chronic pain, medical or otherwise, and so the focus of treatment is on management rather than cure (Nicholas *et al* 2005).

D.3. Initial assessment and formulation

Client profile

Gender:	Female
Age:	48
Ethnicity:	White, British
Relationship status:	Married with three children
Living situation:	Living with husband, in jointly owned home
Occupation:	Working full time in office based job
Family:	Both parents alive and retired, good relationship No siblings (only child)
Experiences of pain as a child:	Remembers normal childhood illnesses such as measles, and being looked after by her mother
Medication:	Amitriptyline (20mg, twice daily)
History of pain:	Onset of pain following dental treatment 4 years ago, which did not reduce over time

Description of pain:	'Cramp' sensations down neck and across face, there all the time, in varying intensity from discomfort to agony
Things that made pain worse:	Stress, tiredness, excessive talking
Coping:	Watching TV, going to bed, reading
Impact of pain:	Difficulty concentrating, tiredness and fatigue, decreased socialising, difficulties sleeping, reduced activity (particularly enjoyable ones, such as previous hobbies) and movement of her jaw, depression and hopelessness, anxiety and frustration, fears for the future, constant search for a cure

Therapist's initial impressions

Appearing anxious, Katie's voice shook slightly when speaking. She did, however, hold my gaze and engaged well in the session, answering questions openly. She did not have any real expectations for our meetings, and voiced her uncertainty as to how psychology could help. Katie sat quite rigidly in her chair, and held her head very steady as if fearful of any sudden movements. I noticed that she was particularly restricted in the movement of her jaw.

Client presentation of problem

Katie told me that she had been experiencing pain for the past four years, which started after dental treatment, and described it as a 'constant state of cramp', which radiated down her neck and across her face. Describing the pain as there 'all the time', varying in intensity from discomfort to agony, she was able to identify things that made her pain worse, such as feeling tired or talking a lot. Katie's GP had prescribed Amitriptyline two years ago: an antidepressant, which at low doses helps with sleep and pain. Katie believed this helped to "take the edge off" her pain. When the pain was bad she would watch television or read, or go to bed early feeling "unable to cope anymore".

Katie worked full-time in a busy office job involving a lot of deskwork. She often felt exhausted, unable to concentrate and go out socialising, despite having a supportive network of friends. Katie had tried many different solutions, including physiotherapy, osteopathy, acupuncture and massage, but "nothing had worked". She had felt "very

depressed" when her Doctor said there was nothing more that could be done for her, and remained certain that there "must be something out there".

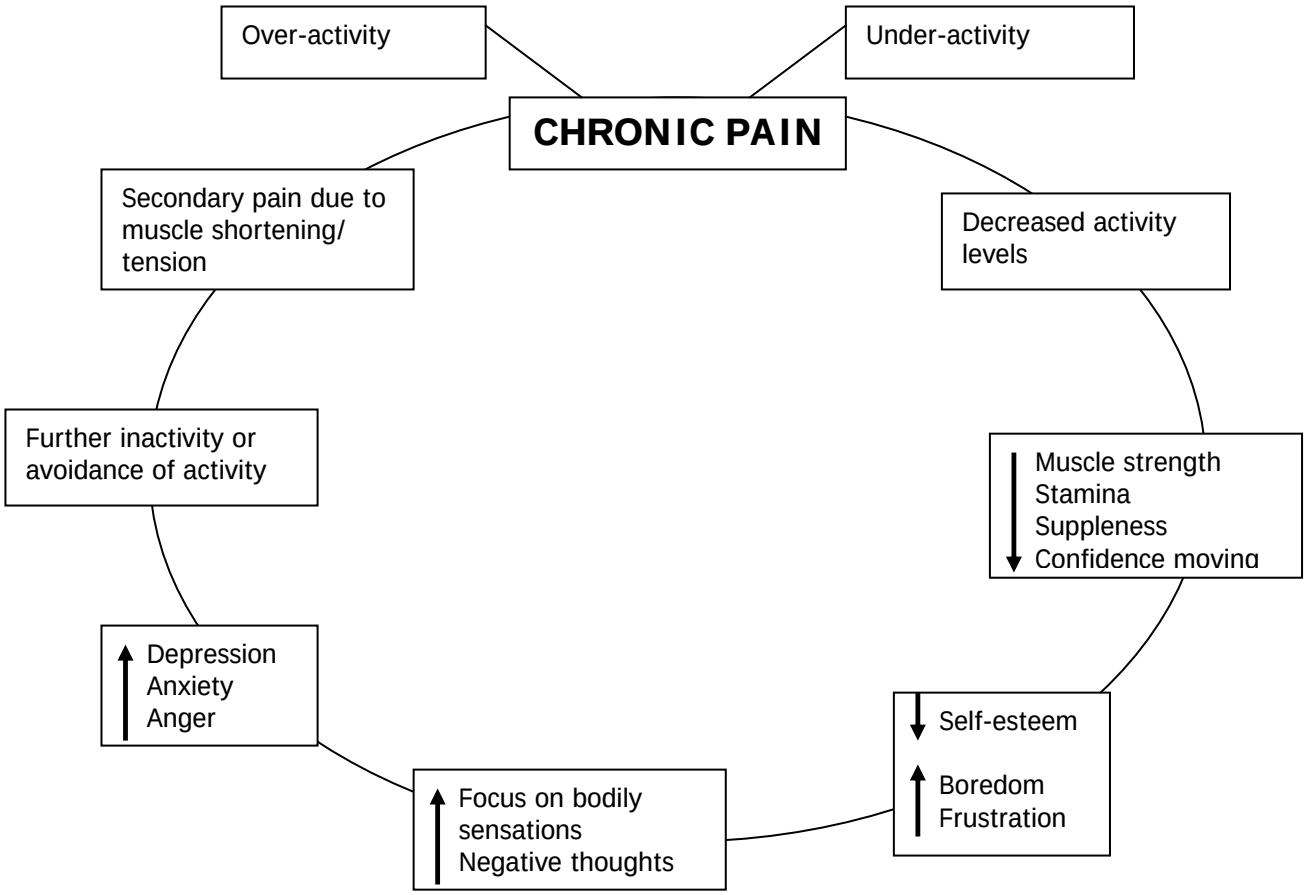

Figure D1: Vicious cycle of pain: Drawing upon the fear avoidance model (Vlaeyen and Linton, 2000)

Therapist's assessment and formulation

Towards a formulation

Following dental treatment, Katie experienced continuous acute pain, eventually receiving a diagnosis of chronic pain a year later. Pain is considered chronic if it lasts beyond 6-months duration, or has persisted past the point where an injury would have expected to heal (Nicholas *et al* 2005). Once pain is established as chronic, coping strategies that are helpful for acute conditions often make the situation worse (e.g. resting and avoiding movement) (Turk and Okifuji 2002). Often, the interaction between pain appraisals and coping lead to a downward spiral (Thorn 2004), and 'fear avoidance' is believed to play a large part in the development of a vicious cycle of pain (Vlaeyen and Linton, 2000): Figure D1. Katie's experience of pain increased her attention on her pain symptoms, which in turn led to specific interpretations of the pain

and the activation of pain-related beliefs, such as: "pain = something seriously wrong with me; the pain will continue to get worse". These reflected a *catastrophic thinking style,* which has been found to be a greater predictor of disability than pain itself (Main *et al* 2008).

Katie's pain beliefs created a loop, increasing attention to pain symptoms and subsequently increasing catastrophic thinking. This in turn influenced other aspects of functioning: behavioural (fear avoidance behaviour leading to reduced movement and activity); emotional (depression, anxiety and frustration); cognitive (attentional bias towards pain, worry and self-critical thoughts); and social (reduced socialising, increased concern from husband). All these effects reinforced illness beliefs, as well as having direct physiological effects (physical deconditioning of muscles, tension and stiffness, sleep disturbance, lowered pain threshold), which resulted in secondary pain and increased illness beliefs and attention to symptoms (e.g. 'the pain will continue to get worse' = reduced activity = depression/worry = deconditioning of muscles = increased pain upon even slight activity = confirmation of belief that pain will get worse). These processes set up a vicious downward spiral of increased pain and negative thoughts, lowered mood and reduced activities (Figure D2: formulation).

Given Katie's low mood, negative beliefs about herself and hopelessness about the future, I considered it appropriate to conduct a risk assessment. She assured me that despite sometimes thinking about dying, she would never kill herself. We explored these thoughts in more detail, such as: triggers, what dying would achieve for her (i.e. escape or a form of communication), social supports and protective factors (Froggatt and Palmer 2008). For Katie, thoughts of death were often fantasies of escaping her pain, which would be triggered when her pain was very bad. Katie named many positive social supports, including her husband and three children who she believed loved and needed her. I did not believe Katie to be a high risk for suicide, and hypothesised that starting our sessions would help increase her self-efficacy and lessen her sense of hopelessness.

Negotiating a contract and therapeutic aims

Katie identified goals of learning to relax and coping with her stress more effectively, although she was reluctant to name concrete goals as she feared her hopes would be lifted and then dashed again 'like so many times before'. This highlighted potentially

low expectations of treatment that had developed over repeated experiences of unsuccessful treatments, a very common experience for people with chronic pain (Vlaeyen and Morley 2005). I realised the importance of preparing Katie for treatment: laying out the aims of our sessions (what we could and could not do), and to make the process as clear and transparent as possible.

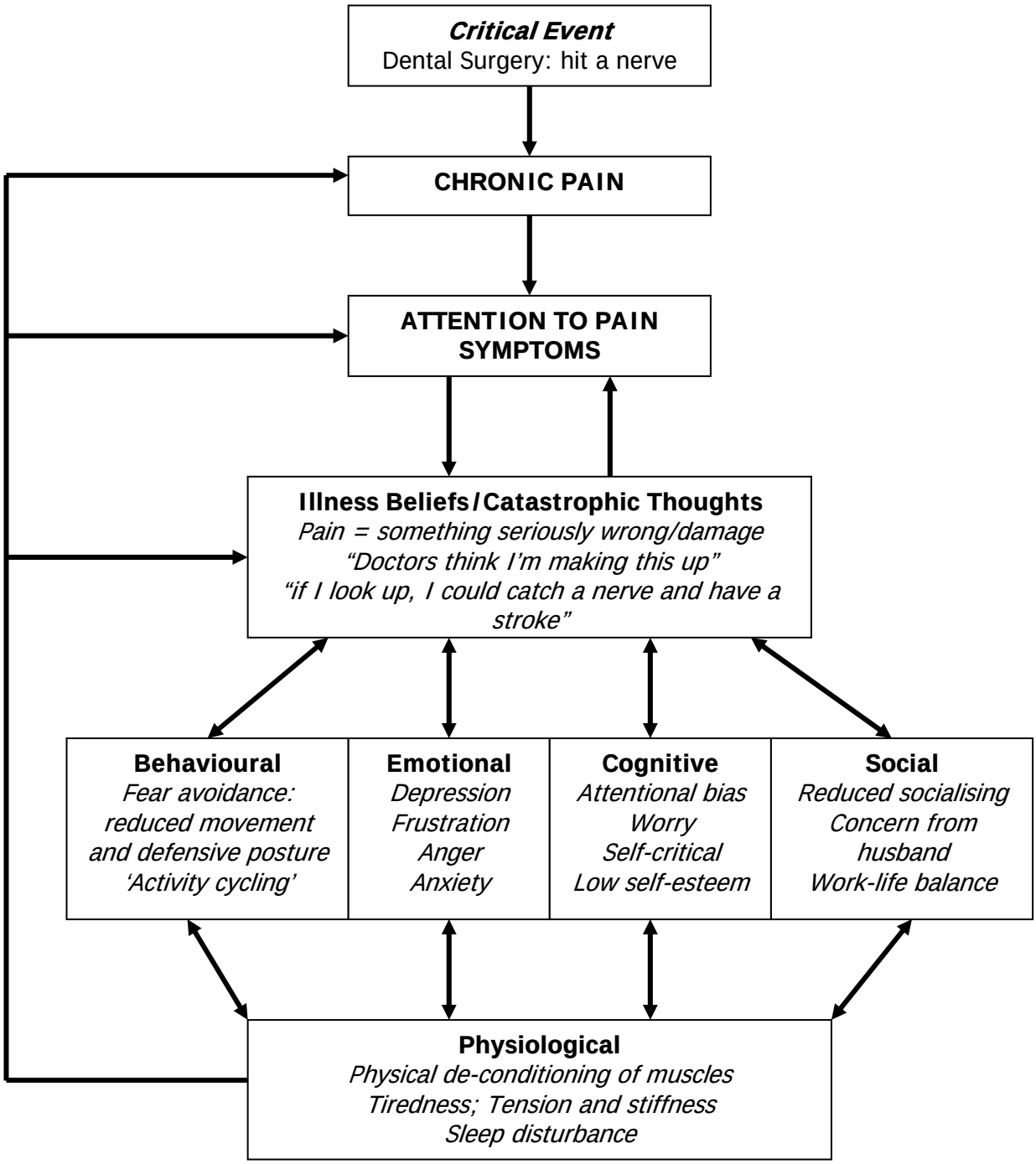

Fig D2: Personalised formulation of chronic pain (adapted from Brown (2006)).

We drew up a problem list (see Table D1) and organised these in order of Katie's priorities. I explained the rationale of CBT, emphasising the collaborative framework and role of homework, and described how our approach was focused on the management of pain rather than cure or reduction. Katie reassured me that she understood we could not cure her pain and would remain open-minded. I discussed my role as a Counselling Psychologist in Training and issues of confidentiality and we agreed to an initial number of 8 sessions, to be reviewed as therapy progressed. The overall aim of treatment was 'maintenance of pleasurable and independent living' (Holman and Lorig 2000), by reversing her vicious cycle of pain, and helping her manage her pain more effectively.

PROBLEM LIST	
1	Constant state of tension/cramp in neck
2	Lack of concentration, particularly at work
3	Difficulty distracting self when pain is bad: will cope by resting and stopping activity
4	Work/Life balance: has demanding job, will feel exhausted in the evening and so not do much outside work; no energy
5	Not as much enjoyment in activities anymore: wants to increase pleasurable activities, such as walking.

Table D1: Problem list

D.4. Development of Therapy

Therapeutic plan and main techniques used

I believed that an individualised cognitive formulation approach to treatment, as recommended by Tarrier (2006) and White (2001), was most appropriate, as it would target the maintenance factors involved in Katie's personal cycle of pain and would be more likely to engage her in the treatment. By consulting Katie's problem list, we planned how to go about reversing the maintenance factors involved and drew up a plan for therapy (see Table D2). The main techniques used were: psychoeducation, learning and practising relaxation and attention management, cognitive restructuring (through Socratic questioning and verbal challenging) and behavioural experiments.

Therapeutic Plan	
1	Education in chronic pain and cognitive behavioural therapy (CBT)
2	Relaxation techniques/stress management
3	Attention management
4	Increasing activities (goal setting and pacing)
5	Working on unhelpful thoughts

Table D2: Personalised plan to guide therapy

Content and process issues

Worry and distress will continue until a person can make sense of their pain, and education is seen as crucial for effective coping, so I began socialisation in the CBT approach early on (Eccleston 2001). To illustrate the interaction of thoughts, feelings, physical sensations, behaviour and environment, I drew a 'hot cross bun' diagram (Sage *et* al 2008: see Fig D3). Handouts were given explaining chronic pain and what we covered each session, especially as Katie had voiced her concern over difficulties with concentration.

I introduced a thought record in session 2, and explained the nature of automatic thoughts, separating these out from her emotions and physical sensations. Katie struggled initially with accepting the role of thoughts in her experience of pain. I needed to demonstrate the mediating role of thoughts, without minimising her experience (White 2001). By recounting that pain was worse when she was tired or stressed, I illustrated that pain was not always experienced in the same way. I introduced the 'gate theory of pain' to explain the role of various factors (emotional, cognitive, physiological) in the mediation and moderation of pain intensity, plus thinking traps, such as 'black and white thinking' and 'catastrophising', commonly seen in chronic pain (Main *et al* 2008). At this early stage, Katie reported in detail her pain symptoms and fears around these, which was expected given her focus of attention (Eccleston 2001). For homework, Katie agreed to try and 'catch' some of the thoughts she had.

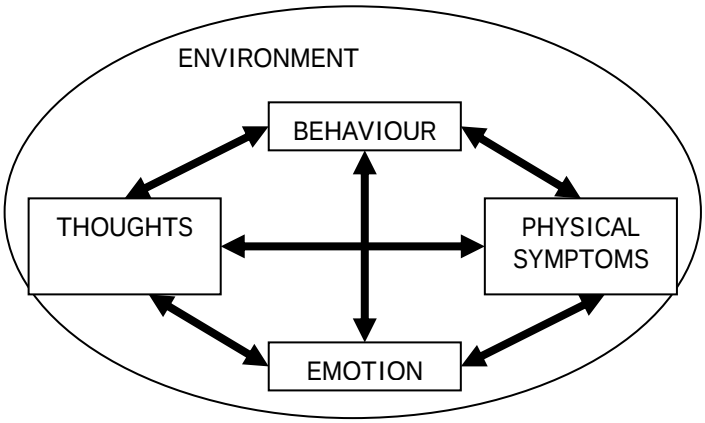

Fig D3: 'hot cross bun' interaction (Sage et al, 2008)

Session 4 and 5

Katie reporting being unable to 'catch' any of her thoughts, so had not written any down. To help with this process, I asked about any shifts she had noticed in emotion over the last week (Greenberger and Padesky, 1995), and Katie was able to identify feeling tearful immediately following our last session. Upon further prompting, Katie identified a key thought: "this won't work, just like everything else"; and we were able to explore that problems recording thoughts often stemmed from their overwhelming and distressing nature. This highlighted her understandable tendency towards avoidance, and also catastrophic thinking in relation to her pain. I drew her attention to the negative role that avoidance can play by revisiting the vicious cycle of pain. We also explored what she meant by 'work', which she admitted meant to take away her pain. I took this as a cue to revisit the aims and goals of our sessions together, in not providing a cure for her pain, but in helping to manage its impact upon her life. This acceptance of both her pain and the aims of our sessions was an ongoing process for Katie.

Alongside an ongoing focus upon identifying thoughts, these sessions also involved the introduction and practice of formal relaxation techniques, such as diaphragm breathing and progressive muscle relaxation. I gave her a CD to continue practicing outside the sessions. We used problem solving to identify and overcome potential barriers to regular practice. Katie subsequently reported increased perception of tension, taking more breaks from her computer and an increase in activity levels. I emphasised the importance of pacing and a gradual build up of activity rather than 'activity cycling' in response to pain symptoms (Turk and Winter 2006). We agreed to extend the sessions

by two (to 10 overall), in order to allow for a follow-up of her progress, which was usual practice within this department.

Session 6 to 8

These sessions were mainly concerned with attention management: specifically, this involved learning ways of focusing attention, such as identifying and switching focal points, mindful breathing, imagery and pain transformation (Morley *et al* 1999a). Katie completed a coping strategies questionnaire (Morley *et al* 1999a), which showed that her current coping involved a narrow range of, predominantly passive and avoidant, strategies, such as watching television and going to bed. Katie took quickly to these sessions, understanding that when she was fully involved in activities (such as cooking or gardening), the pain was still there, but her perception of it had decreased, emphasising the importance of adopting more active coping. It was important for Katie to understand that distraction was not intended to 'push the pain away' or as an attempt to ignore it. To illustrate this point, I used a metaphor, with thoughts being similar to a 'jack-in-the-box', to illustrate the effect of pushing thoughts away. We also looked at the impact that focusing so much attention on her pain had on her life, and at this point she became tearful, saying it had "taken over". Again with imagery, I tried to convey my understanding of this, plus reinforce the aims of our sessions together (see Fig.4).

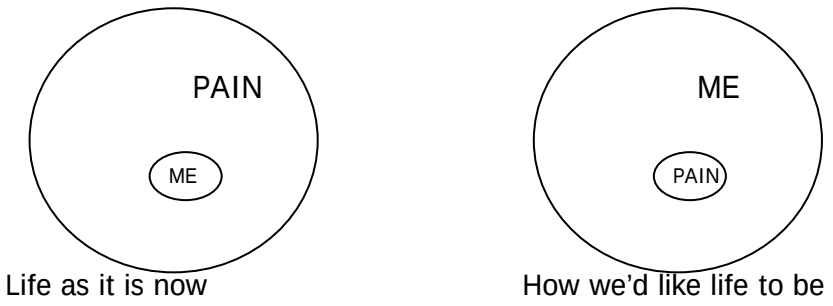

Fig. D4: Impact of pain and aims of psychological therapy (adapted from Dahl and Lundgren 2006).

Katie had also become much more proficient at both identifying and challenging her thoughts, and we continued to work on this throughout our sessions. Katie was able to identify when her thoughts were becoming 'catastrophic', and this helped her detach from the level of negative emotions usually associated with these thoughts (Thorn,

2004). Generating alternative thoughts was at first very difficult for Katie, as she had a strong belief in these (e.g. "my pain will continue to get worse, and I'll end up in severe pain all the time"). Asking her to think what she would say to her closest friend, if she were in the same situation, helped her to generate alternative thoughts that managed to impact upon the extent she believed in these (Greenberger and Padesky, 1995).

Towards the end of these sessions, we discussed the difference between 'acceptance' (of pain) and 'giving in', and how it was important to maintain hope without keeping her life constricted by a 'bubble of hope'. I explained this concept as being surrounded by a bubble, growing each time she hoped for a total cure, which Katie related to (Dahl and Lundgren 2006). This understanding was important as continuously searching for a diagnosis and cure keeps people's attention focused on their pain. Katie described beginning to see this as a long-term approach, a 'change in lifestyle' rather than a 'quick-fix'. I remember feeling real encouragement when she said this, as it represented a major shift in her thinking and an acceptance of her role in reversing the vicious cycle maintaining her pain, rather than looking for external cures. This is seen as a critical process in therapy for chronic pain (Eccleston 2001).

Session 9 and 10

These final sessions focused on reviewing the progress that we both felt had been made, the aspects that Katie believed still remained to work on, and preparing for the ending. Upon reviewing the original problem list, Katie expressed shock at how depressed she had sounded. She reflected that even though the pain was still there, she felt much less distressed and more able to cope. I gave Katie resource materials to summarise the work we had done together, on relapse prevention, and self-help materials to continue with the work we had started. We identified potential ways in which relapse may occur, particularly in the occurrence of a 'flare-up' of pain. We identified things she could do if such a relapse was to occur, such as catching and challenging her thoughts (e.g. remembering that pain flare-up is only temporary, and that she is able to cope), reducing her activities before gradually building up again, and utilising her relaxation and mindful breathing skills.

In these sessions, Katie expressed a fear of allowing her teeth to touch together, which allowed us to further cement our work on acceptance of pain. We devised a behavioural experiment to allow her teeth to touch for a few minutes at a time: to

encourage her to 'play with her pain', to reduce her fear, challenge her catastrophic beliefs and increase her self-efficacy (Morley *et al* 1999a). I saw this sudden surfacing of a previously unmentioned fear as partly reflecting her anxiety at ending. Interestingly, this also caused anxiety within myself, and a desire to extend the sessions believing she was not ready to end. I hoped that by giving her a structured exposure experiment, and calmly re-emphasising the skills she had already learnt, would reassure her. The next session, Katie said she had not found this experiment as unpleasant as she originally feared and agreed to continue. She appeared much calmer at this point and said she felt ready to end.

Difficulties in the work and use of supervision

In the early stages of our work, I felt a great pressure to provide all the answers to Katie and to give her a way of controlling or curing her pain. White (2001) reflects that medical advances have resulted in people expecting that all medical problems can be cured. Katie believed that the medical profession thought she was 'mad' or 'making it up', which understandably increased her frustration, depression and self-criticism, and she found it incredibly difficult to accept there was no medical cure. Discussions with my supervisor helped me to see this was a very common occurrence, and compounded my belief that I needed to allow time to explore pain symptoms and the damaging impact these had upon her life. Stressing a collaborative approach and engaging Katie in the process from the start, in an empathic and non-judgemental environment, was of paramount importance in moving her away from her position as 'passive patient', and re-empowering her to take control of her life.

Preoccupation with physical symptoms of pain is often a major component (and challenge) of treatment in chronic illness as, not only is this a key maintenance factor in the vicious cycle, but in order to reach their goals people will often need to focus on doing so *despite* their symptoms (Sage *et al* 2008). This calls for a re-working of priorities and beliefs at a very deep level, which can understandably be a difficult process (Sage *et al* 2008). A delicate balance is needed between encouraging action and personal responsibility, but at the same time not minimising or suggesting that they are causing their own pain. I noticed that Katie's initial preoccupation decreased quite rapidly, and that by our final sessions she no longer talked about her pain symptoms much at all.

Much of the challenge for Katie was learning to accept the ongoing nature of her pain, rather than focussing all her efforts on a cure. I discussed issues of acceptance as an ongoing theme in supervision, and began to recognise that acceptance often comes indirectly, such as through encouraging lifestyle changes. This indeed was the case with Katie, and she began to accept her pain through changing the way she approached its management and her relationship to it. Therapy then became the place where she could struggle with her acceptance and what this meant to her. Supervision was an incredibly useful resource to help me unravel feelings, to understand processes that were occurring between us, and help me find an appropriate way forward.

D.5. Evaluation

Evaluating the work and my own learning

Involving Katie in the work early on, and establishing a collaborative relationship, encouraged her to take more responsibility for her own progress, and to embrace the self-management approach inherent in the psychological treatment of chronic pain. White (2001) stressed the importance of this collaborative relationship, particularly since a self-coping model is often difficult to accept. Towards our later sessions, Katie stopped referring to her pain symptoms, which demonstrated a refocusing of attention outside of her pain. I also noticed that physically she appeared more relaxed, less rigid and controlled in her movements, suggesting a gradual reversal in her avoidance behaviours and pain beliefs. This paralleled with her increasing acceptance of pain, which emphasised a willingness to experience pain, rather than attempting to control it (Wicksell *et al* 2008). Such acceptance is desirable as it is related to lower avoidance behaviours, depression, pain intensity and disability (Wicksell *et al* 2008).

I learnt so much about both chronic pain and CBT throughout our experience together, demonstrating an evolution in terms of my own personal practice. Conducting therapy within a wider framework, which incorporates both cognitive and constructivist principles, focuses upon individual meaning and formulation of problems within a social context. Adopting this flexible approach to CBT allows for increased empowerment and acceptance while decreasing distress. Such an approach reflects the changes that are currently taking place within CBT, as noted by authors such as Kellogg and Young (2008), Neimeyer and Raskin (2001), and Ronen (2003). Constructionist and discursive approaches have begun to shape cognitive therapeutic practice in important ways,

resulting in what has been termed the 'third wave' of CBT (such as acceptance and commitment therapy, narrative approaches and mindfulness based cognitive therapy), or the 'cognitive revolution' (Mahoney and Gabriel, 2002). Even before this point, authors had commented on the compatibility between constructivism and cognitive psychology (e.g. Pujol and Montenegro, 1999), with Harré seeing the cognitive revolution as 'nothing more than the advent of discursive psychology' (Harré, 1995, p.144). Social constructivism here can be seen as increasing the 'depth' of therapeutic practice, with a focus upon meaning and social context as opposed to 'distorted' or 'erroneous' cognitive processes:

> *"Viewed from this perspective, cognitively oriented therapies have "deepened" across time by refining their approaches to less easily accessed core features of personal knowledge, and by reaching towards models more adequate to the complexity of human meaning systems and their social embeddedness" (Neimeyer, 1995, as cited by Neimeyer and Raskin, 2001, p.394)*

Neimeyer and Raskin (2001) propose that this has freed cognitive therapy from its realist epistemological roots: challenging the authority of the therapist over the client's inner world, while not denying that the client must still live in a 'real' world. Such an approach challenges the dominant use of diagnostic categorical labels and moves away from pathologising, turning instead towards an individual's meaning of experience (Neimeyer and Raskin, 2001).

This case study demonstrates that presenting a clear rationale of treatment early on within an individualised formulation, ensuring we had a clear set of goals and meaningful list of problems, helped Katie feel more involved and a partner in the process rather than a passive patient. This evolution in my approach has influenced my work with all clients, not just those with chronic pain, as I believe this process of partnership through structured and meaningful practice is an important and integral part of CBT, and I strongly believe that constructivism and cognitive principles can be complementary to a unified and coherent practice.

Conclusion

In the introduction section I proposed that chronic pain could be seen as just one manifestation of trauma. Physical and emotional trauma can result in the development

of chronic physical pain conditions, which involve a complex interaction of physical, emotional, behavioural and cognitive factors. In this way, CBT can be seen as an effective way to help empower people within their lives, when pain threatens to dominate. It also helps to extrapolate people from their position as passive patient, waiting for a medical cure and solution to their problem. In doing so, people are given a greater control of their lives.

In working with chronic pain, I noticed the similarities with my interest in trauma and complex trauma presentations, and I realised that trauma could indeed be seen as presenting itself in a physical form. This work has shaped my practice, in terms of paying more attention to personal empowerment through involving the client in a collaborative process, identifying valuable and meaningful goals instead of imposing my own agenda or conditions for change, and in helping me to see that initial presentations and diagnosis are far from simple. On another level, this work has also helped to shape my career and research interests, and has demonstrated how trauma and chronic pain interact in a synthesis of theory and practice. This case study reflects my growing confidence and evolution of practice, combining my philosophical beliefs with my clinical practice, which has significantly influenced my development as a Counselling Psychologist.

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