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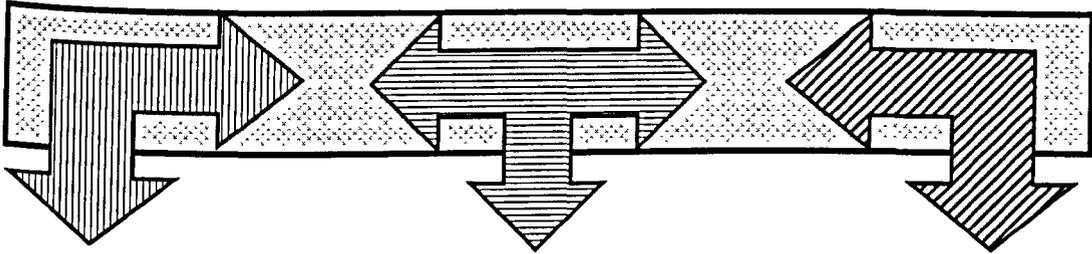
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***A SHIFT* In Approach**



Young Women's Experiences of Self-Harm:

An Interpretive Phenomenological Analysis

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Submitted in the fulfillment of the requirements for the degree
of Doctor of Psychology

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London

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Or an unsuitable treatment for Tracey?

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SECTION A: Overview

A.1 Introduction to the Portfolio

The impetus for the work presented in this portfolio, stemmed initially from my professional experience as a Counselling Psychologist working with a young homeless client group who have a particularly high incidence of self-harm. I became aware of the culture of negativity, indifference and misunderstanding surrounding self-harm and grew concerned at the frequency with which individuals who self-harm are stigmatised, pathologised and regarded as unsuitable for therapy (Turp, 2003). I also searched for guidance on effective therapeutic approaches and interventions for self-harm and found little that seemed appropriate for use with my clients.

My awareness and concern on discovering a high level of self-harm among my client group coincided with a more wide-spread national awareness of self-harm. In recent years there has been a growing anxiety about the increasing prevalence of self-harm which is reported to have 'reached epidemic proportions' (p.3., Camelot Foundation & Mental Health Foundation, 2006). There is also a heightened concern and confusion about how to respond to self-harm, at a national and local level as well as at an individual level.

However, despite a more wide-spread recognition of the problem of self-harm and a corresponding increase in research (Best, 2006, Walsh, 2006), there is currently a great deal of criticism and concern about the methodological difficulties (discussed in detail in the research project literature review in Chapter 2) that continue to 'plague' a great deal the self-harm research (Turp, 2003; Camelot Foundation & Mental Health Foundation, 2006).

The methodological inaccuracies and inconsistencies include those resulting from different definitions of self-harm as well as problems in the way data on the prevalence of self-harm is collected, reported and coded. As Fox et al., state, 'care needs to be taken in the interpretation of figures on prevalence' Fox & Hawton, 2004, p.24). Currently there is no reliable research available that accounts for the increase in the prevalence of self-harm and no national self-harm register for recording trends in self-harm (ibid,).

A.2 The need for rigorous qualitative research into self-harm

The need for rigorous research into the meaning and function of self-harm for the individual was cited in the final report of the two-year government-funded national inquiry into self-harm. The inquiry's final report described self-harm as 'an under-researched area' and 'a major public health issue in the UK'. (Camelot Foundation & Mental Health Foundation, 2006, p.3). The inquiry's recommendations included a request for more qualitative research into self-harm in order to:

'Develop our understanding of the feelings and meanings that motivate and arise from self-harm' and to 'inform the development of new guidelines for practice' (ibid, p.3).

The material presented in this portfolio constitutes a response to this request for qualitative research into self-harm and the need to develop theory and practice. The portfolio includes a research project, a literature review and a case study. A brief introduction to these three components follows below.

A.3 The Research Component

In the research project presented in Section B, IPA (Smith, 1997) is used to explore young women's experiences of self-harm. The participants' accounts of the diverse functions served by self-harm provided a base from which a new model was constructed: Self-Harm- Informed Functional Theory (*SHIFT*) and this is described. .

The *SHIFT* model has its base in the accounts of self-harm provided by the participants and consequently can accommodate the range of functions and diverse experiences they associated with self-harm. This is important because current self-harm theory and the corresponding approach to treatment tend to reflect what Turp (2003) describes as the 'one-size fits all' approach. One reason for this is that mainstream theories of self-harm have developed from specific theoretical paradigms which have shaped the direction and development of the research and the theoretical model and practice developed. As Arnold (1995), points out, there is a danger that when theories are developed from specific theoretical paradigms the resulting conceptual model may say more about the author's attempt to understand self-harm from his/her theoretical viewpoint than it does about the experience for the self-harmer. Further, the corresponding implications for treatment are not effective or appropriate for all clients who self-harm .

In contrast, *SHIFT* offers a comprehensive yet cohesive conceptual framework and a structure to inform the development of a range of therapeutic techniques that correspond with the functions of self-harm for the individual client. The practical application of *SHIFT* is conceptualised in terms of achieving a 'fit' between the clients' individual experience of self-harm and the therapeutic intervention. This involves the development and implementation of a 'FIT' ; a 'Function Informed Technique.' Examples of FIT's corresponding with the functions of self-harm reported by participants are outlined. The research project also includes a chapter that presents client material from a session with 'Carlos' which is used to illustrate *SHIFT* & FIT in practice. (Chapter 6).

A.4 The client study component

Section C presents a client study based on 'Tracey', a client who has a long history of chronic self-harm. The client material presented provides an overview of the nature, structure, content and process of the therapy over an 18 month period and includes an in-depth analysis of an extract of a transcript from a session. This material demonstrates the use of specific counselling interventions that were developed from a collaborative exploration of the meaning and functions of Tracey's self-harm.

The transcript is taken from a session during which Tracey is very distressed and talks about wanting to self-harm. She leaves the session for ten minutes and goes into the attached day centre to try out one of the alternative strategies generated. After ten minutes of experimentation, she returns to the counselling room and reports back on the experience. In contrast to traditional approaches to self-harm, the approach demonstrated in this client study, places emphasis on the acceptance and exploration of self-harm, rather than on reducing or stopping the behaviour. It is intended to illustrate how an exploration of the functions of self-harm can guide and inform the development of corresponding and effective therapeutic interventions.

A.5. The portfolio literature review

Section D is a literature review that focuses on the self-soothing/self-nurturing function of self-harm. The review includes a critical evaluation of accounts of the aetiology, processes and mechanisms underlying the self-soothing function of self-harm.

It is hoped that the different media offered in this portfolio provide some alternative ideas and ways of thinking about and responding to self-harm.

SECTION B: THE RESEARCH PROJECT

ABSTRACT 'A *SHIFT* In The Approach to Self-Harm'

Young women's experiences of self-harm: An Interpretative Phenomenological Analysis

In this research Interpretative Phenomenological Analysis (Smith, 1997) was used to explore young women's experiences of self-harm and a from this a new model of self-harm was constructed. This model is grounded in the participants' experiences, rather than in a particular theoretical paradigm or clinical perspective. The participants' experiences of treatment for self-harm were also investigated and many reported receiving treatment that was inappropriate to their needs.

It is hoped that this research offers an alternative because current theory and practice is not based on investigations of individual experience or researched from the 'self-harmer's perspective' and consequently does not accommodate or reflect the range of experiences associated with self-harm. In contrast, the model presented here: Self-Harm - Informed Functional Theory (*SHIFT*), can accommodate diverse experiences and provides a comprehensive yet cohesive framework for conceptualising self-harm.

SHIFT is based on the concept of a broad *SHIFT* continuum where self-harm can be located at one pole as a dysfunctional behaviour, across to the middle range, where self-harm may be conceived of as a functional response or a coping mechanism. At the other extreme of the continuum, self-harm that is experienced as a positive, exciting or euphoric phenomenon can be located.

SHIFT can also guide and inform the therapeutic approach and a range of specific interventions corresponding to the identified functions of self-harm are outlined. Stages in the development of 'Function Informed Techniques' (FIT's) are also described. It is hoped that the *SHIFT* & FIT model presented in this research provides an alternative to the current 'one-size fits all' treatment offered to clients and represents a shift forward in the approach to self-harm.

SECTION B Chapter: 1

Part 1: Introduction to the research project and literature review

1.1 Different perspectives on self-harm

The aim of this research is to use Interpretive Phenomenological Analysis (IPA, Smith, 1997) to explore young women's experiences of self-harm. This is important because until very recently attempts at understanding from the self-harmers' perspective have been given very little consideration in the main body of literature on self-harm.

As Arnold (1995, p. 1) states:

... Many approaches are based on the theories of academics and clinicians, rather than on what people who themselves self-injure say about their experiences and needs. Few seem to have asked individuals directly how they understand and interpret their own self-injury.

This present study offers an alternative approach because IPA is used to facilitate the exploration of self-harm from the self-harmer's perspective. The aim is to listen to the 'experts by experience' who have a great deal to offer the 'experts by profession' Pembroke (2007). As Camilleri (1997, p. 23), says:

We need to "hear" the voices of individuals as they articulate the reasons for self-harm, because as researchers we often do not consult the 'experts' with 'insider knowledge' and ask the people experiencing the problem for their insights and solutions.

1.2 The influence of the 'self-harmer's' perspective on the development of self-harm theory and practice

The clinical literature generally presents a negative view of self-harm (Pembroke, 2007). In contrast, the literature generated from the perspective of the self-harmer, largely from 'grassroots', or user-led organisations and internet sites, presents a less

negative view and offers alternative accounts of the meaning and function of self-harm. A problem is that the alternative accounts of self-harm that have emerged from the perspective of the self-harmer and 'grass-roots' organisations, have had little impact or influence on academic research or mainstream clinical practice. In fact, some of the mainstream responses to the contribution offered by user-led organisations and internet sites, have been very negative. For example, in a recent academic publication on self-harm, user-led internet sites were referred to by academic researchers as being potentially harmful. As Hawton et.,al (2006) state, 'these less professional sites' are 'a potential source of danger, especially where young people might access sites about self-harm that do not necessarily have prevention of suicidal behaviours as a primary objective' (Hawton & Rodham, 2006, p. 16). Further, the authors' warn:

'There has been a proliferation of Internet sites that focus on the topic of deliberate self-harm, but not always in a professional and objective manner ... there is a growing concern that these less professional sites may be harmful to an adolescent population and, at the extreme, may actually encourage adolescents to engage in self-harming behaviour, with potentially very serious consequences' (ibid, p. 167).

It can be argued that within academic research and clinical practice, there is evidence of a tendency to overlook the insights of the individual self-harmer and to disregard research from other perspectives. For example, the view that self-harm can be located on a continuum with suicide still directs a great deal of current research and clinical practice. The alternative view from the 'self-harmer perspective' of the 'survival' function of self-harm and its use as an important coping strategy, seems to have had little if any impact. This is evident in the continuing dominance of methods of clinical control of self-harm and the lack of recognition given to the view of self-harm as a phenomenon worthy of exploration (Turp, 2003).

As will be discussed later, in Chapter 4., a major problem with the continued association of suicide and self-harm is that it leads to treatment that is often inappropriate and may be contra-indicated for many individuals. A focus on self-harm prevention may also lead to unhelpful battles of control, rather than a therapeutic focus on understanding the meaning of the self-harm (Strong, 1998). Further, recent

research into treatment for self-harm by O'Donovan et., al (2006) found that the clinical focus on suicide risk management and prevention of self-harm not only had negative implications for the self-harmer, but also had a negative impact on the staff responsible for implementing the 'treatment'.

1.3 The influence of the 'academic-clinician-led' perspective on the development of self-harm theory and practice

The 'academic-clinician-led' approach to self-harm research and practice may also in part, account for the generally negative view of self-harm as a 'manipulative' behaviour or a symptom of an underlying personality disorder (Turp, 2003). In addition to the stigma associated with these views, another consequence is that self-harmers frequently receive inappropriate treatment and punitive responses from professionals. According to Harris (2000, p.46), 'the extent and nature of these punitive approaches experienced by self-harm patients appears to be more extreme than forms of hostility directed toward other patients'. Research by O' Donovan et. al., (2006) into psychiatric nurses perceptions of patients who self-harm also reported a negative and hostile response to 'self-harmers.' Further, O' Donovan (ibid.), suggested that another reason for the negative response to patients who self-harm, was a lack of understanding, training and guidelines to inform good practice,

The aim of this present study is to focus on the meaning and functions of self-harm from the individuals perspective and to investigate their experiences of treatment and views on what would be helpful . This exploration is important for the development of self-harm theory and practice because as a number of authors have argued, an exploration of the meanings and functions of self-harm is needed in order to develop a range of appropriate therapeutic approaches and interventions for clients who self-harm (Strong, 1995; Babiker & Arnold, 1997) .

1.4 The structure of this research report

This study begins with a literature review which starts with a discussion on the controversy relating to the definition of self-harm and the continuing connection of self-harm and suicide (Turp, 2003; O'Donovan, 2006). The methodological problems in much of the published work are also discussed (Camelot & Mental Health Foundation, 2006; Best, 2006) This is followed by a critical review of existing models of self-harm, which begins with a discussion on the paucity of explanatory models (Best, 2006), and the pervasive inconsistencies in current theories of self-harm (Turp, 2003).

The literature review then moves to a focus on accounts of the aetiology of self-harm. This includes work on early adversity, trauma, invalidation and psychopathology as antecedents. Literature on the role of neurobiology is also considered. The implications for practice that have developed from existing theories will be outlined and the different approaches to self-harm will be described and briefly evaluated. The section on research design presents an account of the research process. The rationale for the selection of a qualitative paradigm and for the use of IPA (Smith, 1997) is provided. A consideration of the role of the researcher in the process, with particular reference to power issues in the researcher-participant relationship, is included. A discussion of the ethical issues arising is presented and the criteria for quality that are incorporated to make this a rigorous qualitative study are described.

The first section of the analysis of results, presents the themes relating to the specific functions of self-harm reported by participants. The second section of the analysis focuses on the participants' accounts of treatment for self-harm. The themes are then discussed in Chapter 4. This discussion ends with an in-depth consideration of the implications for practice arising from this research. Areas of practice identified as in need development are then examined. This is followed in Chapter 5., with a response to the identified need for the development of theory and practice. A new *SHIFT* model and an alternative approach to practice (FIT) constitute part of this response. In Chapter 6., case material is used to demonstrate *SHIFT & FIT* in practice. The study concludes with an evaluation and recommendations for further practice .

Chapter 1. Part 2: Research project literature review

Definitions of self-harm

2.1 Controversy relating to attempts to achieve an adequate definition and classification system

In spite of a great increase during the past ten years in the literature and research on self-harm, researchers have still not achieved a consensus on what constitutes self-harm and research continues to be based on a diverse range of behaviours and a plethora of different terms (Best, 2006). The attempt to achieve a succinct definition continues to present a challenge (Best, 2006), and this is reflected in the self-harm literature. This contains a range of terms such as self-injury, auto-aggression, symbolic wounding, self-attack, self-inflicted violence, self-abuse, focal suicide, attempted suicide, suicidal gestures, Para suicide, antisuicide, wrist-cutting syndrome, wrist slashing, deliberate self-cutting syndrome, self-assault, carving, indirect self-destructive behaviour and deliberate self-harm (Yates, 2004; Hyman, 1999; McKay & Ross, 1979; Simeon & Favazza, 2001).

The most recent attempt at achieving a consensus, was the definition proposed by Camelot & Mental Health Foundation (2006), who defined self harming behaviour as :

- Cutting behaviours
- Other forms of self-harm, e.g., burning, scalding, banging, hair pulling
- Self-poisoning.

The Inquiry is not looking at: eating disorders, drug and alcohol misuse, and risk taking behaviours such as unsafe sex, dangerous driving (Camelot & Mental Health Foundation, 2004).

One problem with the definition of self-harm used in the National Inquiry, is that it does not make a number of distinctions that other researchers regard as important. For example, Simeon & Favazza, (2001), argue that a classification system needs to make a number of distinctions and have proposed a system that is regarded currently, as the most comprehensive and widely accepted approach to classifying self-harm (Yates, 2004).

The system developed by Simeon & Favazza (2001), has four categories of self-harm: (1) stereotypic, (2) major, (3) compulsive, and (4) impulsive (Simeon & Favazza, 2001, In Yates 2004). Stereotypic self-harm includes that associated with pervasive developmental disorders and disabilities (e.g., autism, Rhetts's syndrome, Lesch-Nyhan syndrome, Cornelia de Lange syndrome). It tends to be performed independently of the social context and according to Simeon, et., al., it does not have a meaning, but has a repetitive, rhythmic, driven quality. (Simeon & Favazza, 2001. In Yates 2004).

Major self-harm includes examples of mutilation (e.g., auto castration, self-nucleation) that tends not to be repetitive and is often linked to a psychotic episode (Simeon & Favazza, 2001). Compulsive self-harm is repetitive or ritualistic behaviour that occur many times daily (e.g., hair pulling, nail biting, scratching). This type of self-harm can be categorized as an impulse control disorder (e.g., trichotillomania) and is repetitive (Ibid.,) Episodic self-harm includes cutting, burning, self-hitting that tends to be related to tension release and emotional regulation. Episodic self-harm, according to this classification may become repetitive and become more compulsive over time. Here it may take the form of an addictive quality and would then be re-classified as compulsive. (Ibid.,)

However researchers such as Suyemoto & Kountz (1998) and Yates (2004), also argue that a classification system needs to also make a distinction between the diverse range of 'self-harming' behaviours and between direct self-harm such as 'self-cutting' and indirect self-harm such as alcohol and drug abuse. Further, Suyemoto & Kountz (1998) propose that behaviour that might be classified as socially sanctioned self-harm, such as body piercing, needs to be separated from self-harm such as cutting, which is not regarded as socially acceptable. (Suyemoto & Kountz, 1998. In Yates, 2004.)

There are many issues that make it difficult to achieve an adequate and comprehensive system of classification for self-harm and the attempts to do so are continuing (Best, 2006). One very controversial issue relating to attempts to classify and conceptualise is that many conceptualisations of self-harm do not make a distinction between self-harm, attempted suicide and suicide.

2.2 Classifications of self-harm and suicide

Many conceptualisations of self-harm associate it with suicide. For example, some propose a continuum in which minor self-harm is located at one end and suicide at the other. Another recent attempt to classify self-harm, is provided by Fox and Hawton (2004) who have classified self-harm on a continuum with suicide. Here self-harm is conceptualised as 'suicidal behaviour with no intent to die' (p.4). However, it is possible to question the logic of the use of the term 'suicidal behaviour' to describe self-harming behaviour that does not have a suicidal intention, and this highlights the need for a separate classification of self-harm based on its underlying intentions, meaning and functions.

Further, in spite of a wealth of literature on self-harm that identifies its motivation as being the opposite of suicide, the association with suicide continues. Many authors have emphasised the 'life affirming' nature of self-harm. As Nathan (2004, p. 4) comments:

... one profoundly important clinical fact that I have come to learn from patients is that self-harming behaviour, at the level of lived experience, is not consciously destructive, but the opposite. Self-harm can be said to be life affirming as there is a desire to live and not to die.

Furthermore as Babiker & Arnold (1997, p. 21) point out: 'self harm is often an attempt to communicate and relieve pain and maintain discourse. Suicide attempts are directed at discontinuing the discourse and ending consciousness.'

In an attempt to shift the current focus on suicide in the development of classification systems for self-harm, Turp (2003), has developed the 'self-care continuum' of self-harm, which ranges from 'good enough self-care to compromised self-care to moderate self-harm and finally to severe self-harm' (p.29). The self-care continuum presents an alternative classification, which as Turp (2003, p.30), states, 'is not based on current stereotypes.' The problem with a 'self-care continuum', is that it does not incorporate other identified functions of self-harm. However, Turp's continuum, does offer an alternative conceptualisation of self-harm and an alternative approach to treatment. (This is discussed in the evaluation of treatment in Chapter 4.)

The attempt to achieve an adequate and comprehensive system of classification for self-harm is a continuing focus of research (Turp, 2003). However, the alternative view is that it may not be necessary to achieve a consensus on definition and classification. It can be argued, as Levitt, Sansone & Cohen (2004, p. 75) point out, that what is really needed is 'a theoretical perspective that can illuminate the possibilities beyond simple diagnostic classifications'. I would argue that what is needed is a classification system of self-harm that is comprehensive and developed from a 'cohesive theoretical perspective that can 'illuminate the possibilities'.

2.3 Further issues relating to the definition and classification of self-harm

Another issue relating to definition and classification is how the perspective from which self-harm is viewed shapes the definition and classification system which is constructed. Further what constitutes self-harm may differ across the range of clinical and non-clinical populations in which it is researched. This can be clearly seen in the DSM-IV-R and ICD-10 (APA, 1995) classification systems, where self-harm appears as a criterion for diagnosis of borderline personality disorder (BPD). Yet neither the DSM-IV-R nor the ICD-10 provide criteria for diagnosis of deliberate self-harm as a syndrome in itself (Turp, 2003). The continuing confusion over the definition and classification of self-harming behaviour is one of a number of factors that make it difficult to obtain accurate demographic data (Best, 2006).

2.4 Problems with reported figures on the prevalence of self-harm

There are a number of problems with reported figures on the prevalence of self-harm. One cause of inaccuracy in the data is that it tends to reflect only those who seek medical treatment and therefore provides an under-estimate of the level of self-harm (Camelot Foundation & Mental Health Foundation, 2006). Further, a great deal of self-harm is hidden and many self-harmers never reveal their self-harm (Camelot Foundation & Mental Health Foundation, 2006).

However, the data that is available suggest that rates of self-harm have increased over the past decade, and the level in England is reported to be the highest in Europe (Camelot Foundation & Mental Health Foundation, 2006). Demographic data from a number of studies suggest that the majority of people who self-harm are female, that they use multiple methods, that they do so spontaneously and that they begin this behaviour in early adolescence (Conterio, Lader & Kingston Bloom, 1998; Levitt, Sansone & Cohn, 2004).

2.5 Research within specific populations

Following an extensive review of research into self-harm, only a small number of studies could be identified that focused on prevalence in specific populations. The majority of studies have been conducted in clinical populations and prison populations where there tends to be a high level of self-harm. For example, a review by the Scottish Development Centre for Mental Health (2005) suggested an annual incidence among men and women in the English prison population of 129 per 1000 population.

2.6 Research that has focused on self-harm in different cultural groups

It has also been suggested that self-harm cuts across geographic, cultural and class boundaries (Levitt, Sansone & Cohn, 2004). Research that has focused on self-harm in particular racial or cultural groups has produced some interesting findings. For example, research by Bhugra (2004) identified young Asian women as being at highest risk from self-harm. Bhugra proposes that higher rates of self-harm in the young female

Asian population are the consequence of a 'cultural clash'. He describes self-harm as 'an expression of disconnection and reaction to the sense of cultural alienation experienced by this particular group' (ibid, p. 39). However there is a paucity of research into the experiences of self-harm in different cultural groups and it can be argued that until more research into minority ethnic groups and self-harm has been conducted, it is difficult to draw any real conclusions about the aetiology and meanings of self-harm in particular racial or cultural groups (Yates, 2004; Camelot & Mental Health Foundation, 2006).

2.7 Research that looks at the influence of the wider socio-economic environment on the aetiology of self-harm.

There has also been very little research that looks at the influence of the wider socio-economic environment on the aetiology of self-harm. A study by Ayton, Rasool & Cottrell (2003) examined the importance of socio-economic deprivation in the aetiology of self-harm in young people. Following an empirical analysis of data from 730 young people who presented with self-harm at casualty departments, the authors concluded that there was 'an important relationship between self-harm defined as self-injury, overdosing, and poisoning by illicit substances and socio-economic deprivation' (ibid, p.17). However other literature contradicts this finding. For example, a study by Dohm et al., (2002) found that elevated rates of symptoms were connected to abuse or childhood trauma regardless of socio-economic status, ethnicity or diagnostic status.

2.8 Demographic data and gender

There are a number of problems with demographics relating to gender (Yates, 2004). One problem is that figures which suggest that the majority of self-harmers are women may be inaccurate because much of the research is based on psychiatric samples in which women are over-represented. Recent research based on other samples reveals a less pronounced gender difference (Pattison & Kahan, 1983). Further, there is very little research that looks at men and self-harm, and most of the research on males is based on prison populations (Yates, 2004; Zweig-Frank, Paris & Guzder, 1994).

2.9 The relationship between self-harm and early adversity

A wide range of research associates self-harm with experiences of childhood adversity, trauma and abuse (Van der Kolk, Perry & Herman, 1991; Everett and Gallop 2001; Sansone, Sansone and Fine, 1995; Zweig-Frank, Paris & Guzder, 1994; Dohm et al., 2002; Levitt, Sansone & Cohn, 2004). Research based on retrospective data has indicated that a high percentage (up to 79%) of self-harmers retrospectively report a history of child abuse or neglect (Favazza & Conterio, 1989; Van der Kolk, Perry & Herman, 1991). Research using longitudinal data also replicates significant associations between early childhood maltreatment and adolescent self-harm (Yates, 2004).

A quantitative study by Van der Kolk, Perry & Herman (1991) concluded that exposure to abuse in childhood was a reliable predictor of the amount and severity of cutting. Similarly, research has consistently demonstrated that the loss of a parent or significant other in childhood is a significant predictor of later self-harm (Yates, 2004; Walsh & Rosen, 1988).

Abuse and neglect in childhood have been found to relate to later self-injury in both clinical and community samples (Arnold, 1995; Camelot Foundation & Mental Health Foundation, 2006.) As part of the national inquiry into self-harm by the Camelot Foundation and the Mental Health Foundation, an analysis of 147 personal testimonies from individuals about their direct experiences of self-harm was conducted. It concluded that 'there does appear to be some overlap around certain life experiences' (ibid, p. 3). Identified life experiences included physical, sexual and emotional abuse in earlier childhood, eating disorders, depression, low self-esteem and strong feelings of being rejected. Difficulties associated with being bullied and self-expression was also talked about.

In Arnold's (1995) survey of 76 women, she found that the majority of participants reported that childhood experiences had led them to self-harm. As Arnold stated: 'there were several common sorts of childhood experience which women felt had been important in leading to their self-injury. Many women reported having suffered multiple forms of abuse and deprivation' (Arnold, 1995, p. 10).

However, while some studies propose that early adversity can precipitate self-harming behaviour, the converse does not hold. For example, a study by Zweig-Frank, Paris & Guzder, (1994) showed no relationship between abuse and self-harm. Brodsky (1995) conducted a follow-up study which also concluded that abuse as a child was not a predictor of self-harm in adulthood.

Further there are a number of methodological problems in the research on self-harm and the relationship to adversity. Generally, it is argued that it does not take into account the wide range of potential variables that will both shape the research process and influence the findings drawn and theory developed. For example, the interrelationship between research, the research context and findings relating to early adversity and self-harm is highlighted in current research. This can be seen in the new classification of a sub-group of 'high functioning young people.... who come from capable, caring families in which trauma has not been a problem' (Walsh, 2006). However, the reported absence of trauma in this new sub-group, can be accounted for in terms of the change in research populations, rather than in terms of the relationship between self-harm and early adversity. Conversely, it is possible to account for the strong association between early adversity and self-harm in terms of the previous research focus on clinical populations, where levels of early adversity are higher than in the general population (Gallop, et., al. 2001).

Despite the methodological problems in the research on self-harm and early adversity, there is a wealth of research that indicates an important relationship between early adversity and self-harm.

2.10 Accounts of the relationship between early abuse and self-harm

The more recent models of self-harm and the relationship with early abuse have been developed from different theoretical paradigms and diverse methodology (Gerhardt, 2004), but most share a central hypothesis that early adversity disrupts individual development and results in the later use of self-harm as a response to a developmental deficit or as a compensatory adaptive response (Yates, 2004). One current hypothesis that has found support in research from different disciplines is the idea that early

trauma, abuse or neglect has an adverse impact on the early development of different regulatory systems and predisposes the child to turn toward alternative regulatory strategies such as self-harm in later life (Yates, 2004). The various models of self-harm are reviewed below.

Chapter 1. Part 3. Models of self-harm developed from various theoretical paradigms.

3.1 Psychodynamic theories (Gardener , 2001 ; Holmes, 2004; Freud , 1917; Fairburn, 1952)

Psychodynamic models propose that self-harm can be accounted for in terms of internal processes and dynamics. Freud (1917) first formulated the idea that self-harm could be understood in terms of an internalised representation of a 'powerful object' towards which anger is felt. The concept of the individual internalising the object has been developed in psychoanalytic and object relations theory. For example, it can be seen in Fairburn's (1952) concept of the 'internal saboteur' where rather than experience the "badness" in the other, the individual internalises it and incorporates it as part of the self.

More recent models emphasise internal processes and dynamics. These include the 'object relations' model of Gardener, (2001), in which self-harm is regarded as an expression of conflict originating in early object relations. Holmes (2004), also accounts for self-harm in terms of disruption in internal processes originating from early interpersonal and intrapersonal interaction between infant and carer. Recently, these underlying processes have been explained in terms of the concept of 'reflective function' (Holmes, 2004). He suggests that this capacity for reflexive function first develops in the attachment process in which an 'attuned' carer processes the infants experience and regulates emotions. Holmes suggests that in 'good enough' interaction this capacity is gradually internalised. If early interaction is not adequate the corresponding deficits in the reflective function and the ability to internally process experience using thought , may result in the later use of concrete expression in behaviour such as self-harm.

3.2 Constructivist theories (Dieter , Nicholls & Pearlman, 2000)

Constructivist theories also suggest that the individual's early experience of relationships is a central factor in the later development of self-harm. Dieter et al., (2000) propose that individuals who self-harm have not developed three important self-capacities: the ability to tolerate strong affect; the ability to maintain a sense of connection to others; and the ability to maintain a sense of self-worth. They account for the failure of the individual to develop these abilities in terms of an early adverse or 'invalidating' environment.

3.3 Trauma theory and self-harm (Miller, 1994; Farber, 2006; Yates, 2004).

The trauma re-enactment theory of self-harm proposed by Miller (1994) and Farber, (2006) suggests that self-harm provides a method of re-enacting traumatic experiences that have been dissociated. These are expressed through the body, rather than processed using thought and language.

Another account of the link between trauma and self-harm is proposed by Babiker & Arnold (1997). They suggest that the impact of intense emotion that is beyond the ability of the individual to manage, is a central factor implicated in the association between self-harm and trauma.

Gallop & Everett (2001, p.20) suggest a similar account, they say that:

For many self-harmers a history of childhood trauma leaves them vulnerable to intense, overwhelming and painful affect. The internal capacity to comfort or self-soothe themselves when confronted by these feelings is often lacking.

Other models of trauma, propose that adversity, trauma and abuse result in disruption in neurobiological and psychological systems that result in deficits in self-regulatory systems (Yates, 2004; Farber 2006). For example, Farber (2006, p.79) suggests that early adversity results in disruption in emotional regulation and in 'relatedness to others'. She proposes that 'the individual turns to self-harm in order to circumvent the need for human relatedness, and to release tension by terminating dysphoric moods, affect states, and states of consciousness.'

Recently a new trauma model has been proposed by Yates (2004). This incorporates developmental psychopathology within a trauma paradigm. Self-harm is viewed as adaptation made by the individual in response to trauma. This model has particular relevance to the *SHIFT* model and is discussed in detail in Chapter 5.

3.4 The bio-social emotional regulation model (Linehan, 1993)

According to Linehan (1993) self-harm is a method of emotional regulation. She views self-harm as the result of a combination of environmental factors and innate individual vulnerabilities and the interaction of these in response to an 'invalidating early environment.' Linehan proposes that 'invalidating' experiences such as abuse or neglect or being punished for expressing strong feelings do not facilitate the development of healthy strategies for tolerating and expressing emotions. Consequently, the individual is predisposed to developing alternative strategies such as self-harm as a method of emotional regulation. According to Linehan, self-harm provides a way of regulating levels of arousal and provides a method of bringing the body back to equilibrium in the face of distressing feelings (Linehan, 1993).

3.5 Psycho-social theories (Babiker & Arnold, 1997)

From a psycho-social perspective a comprehensive account of self-harm needs to consider the socio-economic and political forces that have an impact on the individual. For example, Babiker & Arnold (1997) view self-harm as socio cultural and political issue as well as an individual personal issue. They argue that it is 'inextricably related to the social conditions in which it occurs' (p.56) and a 'reflection of complex psychosocial difficulties in distressed individuals' (p.IX).

As will be argued later the psychosocial view of self-harm has important implications for both theory and practice. It indicates a need to move away from individualized accounts of pathology and dysfunction towards a view that considers the interaction of the social context in understanding self-harm.

3.6 Behavioural theories (Walsh & Rosen, 1988; Chapman et al., 2006)

Behavioural accounts generally explain self-harm in terms of two main theories.

These are social learning theory Bandura (1973) and the theory of operant conditioning Skinner, (1953). Bandura's (1973) social learning perspective emphasizes the role of modeling and imitation in learning. The initial act of self-harm is explained in terms of modeling and imitation of others in the immediate social context or broader cultural settings via the media for example. The behavior is then reinforced by both external and internal contingencies. The 'social contagion' view of self-harm can also be explained in terms of social learning theory.

Skinner's (1953) model of operant conditioning emphasizes patterns of reinforcement in shaping and maintaining self-harming behavior. It is suggested that self-harm leads to attention which then serves as a positive reinforcement (Walsh & Rosen, 1988). Another implication of this is that the sensory stimulation associated with self-harm acts as a positive reinforcement.

Most recently, Chapman et al. (2006) have used the concept of reinforcement in their Experience Avoidance Model (EAM) of self-harm. It is proposed that self-harm is primarily maintained by negative reinforcement in the form of escape from, or avoidance of unwanted emotional experiences.

3.7 Neurobiological theories (Coccaro, Klar & Siever, 1989; Harrison, 1995).

Neurobiological theories of the aetiology of self-harm include models of deficits and dysregulation in neurochemicals. It has been hypothesised by Coccaro et. al., that a deficit in the serotonin system is implicated in self-harming behaviour (Coccaro, Klar & Siever, 1989). Research by Coccaro et al. suggests there is a relationship between low serotonin and increased impulsive aggression against others as well self-harm. However, what the findings fail to explain is why some individuals direct aggressive behaviour towards others and some direct aggressive behaviour towards themselves.

Other research reviewed in Gardener (2001) suggests that self-harming releases natural opiates and other brain chemicals which create an addiction and withdrawal cycle. Yet, a problem is that the theory fails to explain what triggers the initial self-harm behaviour.

Other accounts include the theory of an addictive endorphin rush when self-harming that maintains the behavior (Harrison , 1995). Other research by Harrison (1995) focuses on the potential sexual nature of self-harm and compares it to orgasm. According to this hypothesis, self-harm can be effective in releasing tension and producing pleasurable endorphins. Again, while this may explain the maintenance of self-harm, it does not account for how, why or what triggers the initial act of self-harm.

Chapter 1. Part 4: Treatment Approaches For Self-Harm

These different theories, which seek to explain the reasons why some individuals may develop self-harming behaviour, are reflected in the different approaches to the treatment of self-harm.

4.1 The neurobiological approach

The main focus of the neurobiological approach to treatment is on medication (Tantam & Whittaker; 1992). Research, such as that by Bourin (1999), has focussed on the role of neurotransmitters and indicates that drugs such as Venlafaxine, have been found to significantly reduce self-harming behaviour

4.2 The behavioural approach (Walsh & Rosen, 1988)

Behavioural approaches to the treatment of self-harm are common. According to Tantam and Whittaker (1992, p. 4) 'behaviour modification often seems to underlie treatment in hospital settings'. They report that punishment may be an overt or covert element in behavioural treatment and the withholding of attention is a common therapeutic strategy. For example, Walsh and Rosen (1988) suggest that the level of care and attention should be limited as much as possible immediately after an individual has self-harmed to minimise the opportunity for secondary gain.

4.3 Trauma Approach (Farber, 2002; Miller, 1994).

The focus of the trauma approach is initially on achieving safety and stability and ensuring the physical and emotional safety of the client and therapist (Farber, 2006). Treatment is usually based on a stage approach, roughly divided into three phases. Stage 1 focuses on safety, stabilization and trust. Stage 2 addresses trauma work and the third stage explores issues of mourning, resolution, reconsolidation, and reconnection (Farber; 2002).

A great deal of literature advises caution in the exploration of trauma and stresses the essential need to promote client self-care and safety before moving to the next stage in

which involves systematic ‘de-conditioning’ of traumatic memories and responses and the integration of the traumatic experience. Premature exploration of trauma may also result in an increase in self-harm and other symptoms (Farber, 2002).

4.4. Biosocial theories (Linehan, 1993)

Linehan (1993) has developed Dialectical Behaviour Therapy (DBT) as a treatment approach for self-harm based on her biosocial account. Although DBT was devised as a treatment method for self-harm in Border Line Personality Disorder, its apparent success in self-harm treatment has resulted in it being applied more widely in self-harm treatment across clinical populations (Scottish Development Centre, University of Edinburgh, 2005). DBT combines a range of different approaches. The dialectical philosophy underpinning the approach relates to the therapist’s acceptance and validation of the client’s behaviour as well as the focus on changing it. A stage approach to treatment is similar to the trauma treatment framework and the first stage has the goal of eliminating self-harm.

The main focus in the first stage of DBT is on changing thinking patterns and teaching alternative methods for discharging emotions as well as ‘mindfulness skills to facilitate emotional tolerance.’ Compliance to treatment is regarded as essential. The continuing use of self-harm during treatment is regarded as non-compliance and may result in a ‘vacation’ from therapy or termination of treatment (Linehan, 1993). As will be discussed later in Chapter 4., a problem with the DBT approach is the insistence on the client stopping self-harm which may not be appropriate for all clients. Further, it is argued that this assumption that self-harm is unacceptable contradicts the philosophy of acceptance and validation (Babiker, et. al, 1997).

4.5 Evaluation of models and approaches

A general problem with the different theoretical models and corresponding approaches to treatment is that they tend to individualize self-harm and pathologize the individual. As Babiker et al. , (1997, p.14) write ‘ the major work in the area of writing about self-injury takes what might be called a clinical approach; that is, one that pathologizes self-mutilation, seeing it as an aberration, a maladjustment, a disorganization of normal functioning or illness. Self-injury has been seen variously as manifestations of

personality or character disorder'. Yet as a number of authors have pointed out, when self-harm is attributed to individual pathology attempts to understand the reasons for the behaviour tend to stop.

Another problem with many of the theories of self-harm and the corresponding treatment approach is that they do not offer a comprehensive account of the aetiology and maintenance of self-harm. For example those that propose a biological account explain the maintenance of self-harm, but do not account for the motivations or reason for the initial act of self-harm. Those that identify early adversity as a factor often do not take into account the range of potential mediating variables or provide an account of why some individuals with similar backgrounds do not self-harm. Further, the processes or mechanisms by which early adversity, abuse or trauma contribute to self-harm are not accounted for.

Another common feature of the different theories and corresponding approaches to treatment is the focus on eliminating the behaviour. The use of no-harm contracts continues to be central aspect of treatment for self-harm. However there are many problems associated with the use of contracts and approaches that focus more on the elimination of self-harm than they do on exploring the functions of the behaviour for the individual (Strong, 1998; Harris, 2000; O'Donovan, et., al. 2006; Pembroke, 2007). As discussed in Chapter 4 of this present study the use of no-harm contracts is not an effective strategy for all clients. Furthermore, no-harm contracts may be counterproductive for some individuals. (Strong, 1998; Harris, 2000; O'Donovan, et., al. 2006; Pembroke,2007).

While more recent treatment approaches such as Pembroke (2007) have attempted to address the current over focus on no harm contracts, with a harm-reduction approach, this raises important legal and ethical issues for professionals who have a duty of care. However as suggested later in this present study (Chapter 4), a no-harm contract may offer some reassurance to the clinician, but in practise may not be as effective as a comprehensive risk assessment process implemented and revised throughout treatment.

More recent research has indicated the importance of exploring the meaning and function of self-harm for the individual . Further as some writers have argued, self-harm

also needs to be understood with reference to the social and political context in which it occurs (Babbiker et.al 1997, Pembroke, 1994; Harrison 1985) .

It can be argued that it is important to move towards a focus on the functions of self-harm and away from the 'one-size fits all approach' that characterizes current self-harm theory and practice. It is suggested that an alternative approach to theory and practice is to move away from the clinical structuralist approach towards a more functionalist phenomenological approach (Babiker, et.al, 1997). This approach would shift the focus to an exploration of the meaning and function of the behaviour and the subjective experience of the client, rather than subscribing to a specific theoretical model. A shift forward in the approach to self-harm towards a more functionalist phenomenological approach also raises important issues about the ethics of treatment and professional duty of care which need to be addressed. It can be argued that a more functionalist phenomenological approach would generate further research into self-harm and legal and ethical issues in self-harm theory and practice. This is an area needs to be developed and currently there is only one piece of research on ethical issues in self-harm treatment (Mental Health Foundation & Camelot Foundation, 2006).

In this present study it is argued that a great deal of treatment for self-harm is ineffective and one reason for this is the tendency to view self-harm as a heterogeneous behaviour that does not reflect the diverse meanings and functions of self-harm for the individual.

A range of different accounts of the function of self-harm have been generated and can be drawn on to inform the treatment approach (Strong, 1998; Spandler , 2007). These accounts are briefly reviewed below.

Chapter 1. Part 5: Accounts of the functions of self-harm

5.1 The four main categories of function: control, communication, and emotional regulation and dissociation

The self-harm literature also includes many accounts of self-harm which focus on particular functions. These are broadly grouped in the literature in terms of 4 main categories control, communication, emotional regulation and dissociation.

5.2 Self-harm and control

A number of authors account for self-harm in terms of controlling others or manipulation. The use of self-harm for secondary gain and to force others to give love and attention is cited by a number of authors (Feldman, 1988; Walsh & Rosen, 1988). Other examples of self-harm to gain control, or a perception of control, are referred to in the literature (Berger, 2003; Strong, 2003; Potier, 1993).

According to Strong (2003, p. 126), self-harm provides a sense of control. She states that however self-destructive the act of cutting seems ‘... cutters have moved from a place of passive helplessness to active control. Cutting is one thing they can control.’

A study by Potier (1993) on self-harm by women in Ashworth Maximum Security Psychiatric Hospital also found that self-harm was used by many prisoners as a way of gaining a perception of control. Research by McKay & Ross (1979) found that many people self-harm for the first time when locked up in institutions.

5.3 Self-harm and emotional regulation

A number of studies have identified an emotional regulation function of self-harm. (Linehan 1993; Arnold, 1995; Strong, 1998; Dieter et., al, 2000). Many of the theories of self-harm as emotional regulation account for this in terms of an ‘invalidating environment.’ As Dieter et.al, state: ‘The ability to experience, tolerate and integrate strong affect can not develop fully when strong feelings are met with punishment or derision’. Similarly, Linehan (1993), links self-harm with an early ‘invalidating environment.’ For example, Linehan suggests that if a child learns that strong

emotions are unacceptable and is responded to with abuse, they may not develop the ability to regulate emotions in a healthy way. Later self-harm may be used because it has important affect regulating properties.

Support for this emotional regulation hypothesis also comes from qualitative research such as that by Arnold (1995) and Strong (1998). In this research 'self-harmers' were asked about the function and meaning of their self-harm and many reported that affect regulation and subsequent relief of tension were important factors. Arnold (1995, p. 13) presented findings from a survey of 76 self-harming women that 57% of participants reported: 'overwhelming feelings of emotional pain, misery, sadness, grief, depression or hopelessness as at times leading them to self-injure.

5.4 Self-harm and communication

A number of authors have looked at the role of self-harm in communication (Gardener, 2001; Strong, 2003; Levenkron, 1998). Levenkron describes one function of self-harm as being about communication, when there is an inability in the individual to express themselves emotionally through the use of language. The function of self-harm as communication to self is also described by Miller (1994). It is proposed that self-harm provides concrete expression for the pain an individual feels inside. Strong (1998) also suggests that the expression and communication of negative emotions through self-harm is a common function. Strong suggests that cutting serves as a powerful form of communication for individuals who are unable to verbalise their feelings.

Babiker and Arnold (1997, p. 64) also point out the importance of communication and narrative, the capacity 'to tell ourselves or others a narrative about what is happening, on processing our experience through language'. Similarly, as Miller (1994) described if people cannot articulate the narrative of their past then they are prone to re-experiencing it in the present. Miller suggests that self-harm may be used in order to re-enact experience that can not be verbalised.

5.5 Dissociation

One way in which self-harm is used, is as a response to dissociation and depersonalization. Self-harm may be used as a way to achieve a feeling of being numb, 'feeling as if though one is not quite 'there', losing time, or feeling dead (Babiker et., al., 1997, p.78). It may also be used in the opposite way to feel something, rather than numb.

Farber, (2006) also describes a function of self-harm as a response to a dissociation of thought and emotion following trauma. As Farber (2006, p.80) says:

Because trauma dissociates thought from affect and mind from body, the body may repeat and relive that which the mind wants to forget. When the body weeps tears of blood, we need to wonder what terrible sorrows cannot be spoken. ...The body speaks of that which cannot be said in words, of secrets, lies, and trust that has been broken.

One theme that seems to be entwined through many of the different functions of self-harm is its use as a way of expressing something through the body that can not be expressed in words. In this sense it can be viewed as a somatic language. As Babiker et., al, 1997, p.144 says:

self-harm ' is a language which we as helpers are called upon to comprehend in all its meanings. It speaks of an individual's pain and struggle. It tells of the social, cultural and political circumstances in which they and we find ourselves.We are called upon to extend our understanding of self-injury to the paradox of how a person can use their body to preserve and express themselves, even as they are hurting and violating their body.

Chapter 2: Method

2.1 The research question

The focal question explored in this qualitative study is :‘Young women’s experiences of self-harm: An IPA analysis. The process of formulating the research question is emphasised in qualitative research (Ritchie & Lewis, 2004; Maxwell, 1996; Willig, 2001). The question is broadly framed because the aim of this study is to explore the subjective experience of self-harm, as opposed to trying to achieve an objective definition or test a hypothesis as in a quantitative study. Consequently, the research question needs to remain adaptive in the research process (Maxwell, 1996).

Reflexivity issues are recognised as crucial in the construction of the research question and in the design and development of qualitative research. Willig (2001, p. 148) stresses the importance of reflexivity and the need ‘to acknowledge that and preferably demonstrate how the researcher’s perspective and position have shaped the research’.

2.2 Rationale for selection of qualitative design

The qualitative approach was particularly appropriate for this study because in addition to the emphasis on reflexivity, qualitative research facilitated the exploration of the meaning and function of self-harm for the individual. It also emphasises the construction of knowledge as opposed to the quantitative stance of the objective researcher attempting to study complex behaviour and other phenomena as identified variables that can be measured (Coyle & Rafalin, 2000). Within the qualitative approach the concept of the objective, apolitical, value-free researcher is rejected and process issues are emphasised. The role of the researcher and the position taken in relation to the research is made explicit in qualitative research and this allows the exploration of other important aspects of the researcher-participant relationship.

Another important factor in my selection of the qualitative paradigm is the emphasis in qualitative research on ‘bracketing’ (Coyle & Rafalin, 2000) one’s own knowledge and remaining open-minded. It was necessary to achieve a balance between my own understanding of self-harm and how my research might add to existing research, yet

also remain open-minded. As Janesick (2000, p. 49) remarks: 'qualitative researchers need open but not empty minds'.

2.3 Rationale for selection of IPA

IPA is an approach to qualitative research formulated by Smith (1997), and was considered to be the most appropriate method for exploring the personal experience of self-harm for a number of reasons. Firstly, IPA offered the opportunity to gain an understanding of the participants' subjective experiences of self-harm because the focus is on the exploration of the individual's account, as opposed to an attempt to obtain an objective statement. As Smith (2003, p. 51) explains: 'this approach is phenomenological in that it involves detailed examination of the participant's life-world'.

Secondly, IPA was selected because it facilitates a dynamic approach to the process of research and interpretative activity and acknowledges the role of the researcher. It is accepted that the researcher will be implicated in the phenomenon being explored (Willig, 2001). Further, it is acknowledged that the use of this method requires the researcher to engage in a process of interpretative activity. As Smith (2003, p. 51) states: 'access depends on, and is complicated by, the researcher's own conceptions; indeed these are required in order to make sense of that other personal world through a process of interpretive activity'.

Thirdly, IPA enabled me to be reflexive and to explore the power dynamic in the participant-researcher relationship. This was important because feelings of powerlessness and lack of control have been associated with self-harm (Strong, 1998). I thought that insufficient attention to power issues in the interview setting might have a negative influence on the participants' willingness to provide authentic and detailed accounts. A number of researchers have commented on the potential negative impact of 'power imbalance', which, as Ritchie and Lewis (2004, p. 65) state, may not 'be conducive to open discussion'. I felt that my sensitivity to the power dynamic and my awareness of shared and different aspects of socio-economic and cultural experience was important in facilitating a sense of affinity and understanding with the participants.

Fourthly, IPA offered an approach that provided the best 'match' both in terms of the research objectives and in terms of my personal preference, skills and qualities. I consider the 'match' between the personal and professional skills and qualities of the researcher and the research method to be as important as the match between method and research aim. The process of gaining an in-depth authentic account of the participant's experience was facilitated through my ability to 'tune in' to the participant in a sensitive, responsive and adaptive manner. Other areas of 'good fit' between the requirements of IPA and my skills included my capacity to hear traumatic or horrifying personal accounts, to contain my own feelings and respond in an appropriate and compassionate manner.

The ability to use humour, where appropriate, to 'lighten' the atmosphere is another relevant quality. I was also able to draw on a range of relevant personal and professional experiences during the process of exploring this highly sensitive topic (Barker et al., 1994).

Finally, IPA foregrounds the phenomenology of the research participants. In this study ten young women were given status as 'experts' on the meaning that self-harm had for them and this gave them a 'voice', albeit mediated through my own interpretative processes.

2.4 Limitations of IPA

IPA has its limitations. It must be assumed that language is a representative and valid tool for communicating experience (Willig, 2001). Further, the richness of the data depends on the ability of the participants to authentically communicate their experience and the researcher's ability to access this to obtain an in-depth and detailed account. The worst case scenario is that IPA does not even lead to an authentic description, for there is a possibility that the content of the interview is a performance by the participant for the researcher.

Another concern in selecting IPA is that it attempts to explore the area of personal experience outside the context of a close, supportive relationship and this can lead to moral and ethical dilemmas. As McLeod (2004, p. 177) states: 'the application of

qualitative methods, which may involve the development of close relationships with informants, and the handling of sensitive personal information, can raise difficult moral issues’.

However, as Wing (in McLeod, 2004, p. 432) points out: ‘in every ethical problem that arises in research whether it involves the balance of good against harm, a decision to undertake a laboratory procedure or to give or withhold a treatment – also arises in everyday clinical work’.

2.5 Ethical issues

In this study there were a number of ethical issues that needed to be considered at different stages throughout the research process, many of these issues are integrated in the description of the procedure. A main concern was that talking about self-harm might trigger very painful memories in the participants. After consideration, however, it seemed more beneficial to find a way of managing any distress caused by the interview, rather than decide not to research the topic.

The potential for distress was addressed by providing access to a counsellor on the Sunday following the interview if the participant wanted this. Further, there was absolutely no coercion involved in recruiting participants, who were invited to make contact if they wished. The ethical decision to not include my clients, past or present, was taken to ensure that there was no pressure to participate.

In fact, many of the participants reported that being interviewed was a positive experience. Participants reported feeling relieved that they had been able to tell someone about their self-harm and relieved to discover they were not regarded as ‘mad, bad or manipulative’. Talking through the meaning of self-harm also provided more insight for some of the participants. Further, they were keen to help with research that might help others to become more aware of self-harm.

The potential therapeutic benefits of involvement in research such as this are discussed by King (1996). King suggests that research interviews can provide beneficial experiences for the participant such as increased insight and awareness.

In order for the potential therapeutic benefits to be maximised and the potential for negative experiences to be reduced, ethical issues were considered throughout the research process. Prior to the commencement of this study a proposal was drawn up and negotiated. On this basis, the informed consent of my research supervisor, Dr J. Farrants, and one other member of staff was obtained and an ethics release form (Appendix 8) was signed.

2.6 Sampling and participants

The participants were selected using purposive sampling based on a number of criteria. Participants were female and aged between 16 and 25 years old.

A great deal of the self-harm research focuses on a very broad age range and some studies state the age range. It is important to demonstrate clarity and consistency in stating the age of the sample population because studies that have included young people may produce findings that are not relevant to the experience of older adults and vice versa (Fox & Hawton, 2004). Only participants who were currently self-harming or had self-harmed within the past six months were selected.

2.7 The definition of self-harm

The definition of self-harm was that used in the national inquiry (Mental Health Foundation & Camelot Foundation, 2006). Again, it was recommended that the definition of self-harm used in further research was clearly defined. The definition includes the following behaviour: skin cutting, chronic scratching and picking, insertion of objects into the skin, biting, bruising, punching, hair pulling, burning or self-poisoning. It excludes other behaviour such as alcohol and drug abuse, and attempted suicide.

2.8 Recruitment strategies

Recruitment strategies included obtaining permission to post fliers (Appendix 2) and leave information sheets (Appendix 3) in four women's centres in London. Fliers and information sheets were also circulated at City University, two other London

universities and one college. An advert was also placed in the classified section of *Big Issue* magazine for a period of two-weeks. The publicity material invited self-harmers to make contact via phone, email or text message. The participants who met the criteria for inclusion and were located nearest to London were contacted. (This was for pragmatic reasons.) An information sheet was forwarded to them, in which the aims of the research and the terms on which they would participate were fully explained. An interview time and place were arranged.

2.9 Recruitment response

In total 41 individuals responded to the publicity material. I had not anticipated such a large response and this presented the ethical dilemma of what to offer the individuals who responded but could not be included. There was also the problem of participants who did not meet the criteria. Many of them desperately wanted to tell their stories. It was agreed with my supervisor that I would have a telephone conversation with them and offer to send them a resource pack (Discussed in Chapter 8, methodological concerns).

2.10 The interview schedule

The semi-structured interview was based on an interview schedule of six questions (Appendix 9). The questions were kept to the minimum required to achieve a balance between providing enough structure to 'open up the research area', while facilitating an in-depth account of the meaning for the participant. The aim was to 'follow', rather than direct the process. Having identified the research 'territory' using 'content mapping' questions, content mining questions were then used to gain 'access' (Ritchie & Lewis, 2004) and to achieve an in-depth account of the participant's experience. These were followed with responsive 'probes' 'to obtain a deeper and fuller understanding of the participant's meaning' (Ritchie & Lewis, 2004, p. 141). The same questions were asked in every interview, but the procedure was flexible and allowed the order of questions to be changed in response to the participant. This balance between structure and flexibility was a key issue in the interview process because it enabled me to 'follow' the participant as well as to 'guide' when necessary.

2.11 The interview procedure

A room was booked at City University. The location had both advantages and disadvantages. The university location gave me greater control over risk management and a greater assurance of personal safety for both researcher and interviewee. I also sensed that it gave 'credibility' to the research, which might not have been gained if a personal setting such as a home or car had been used. However, I was aware that by using a room in a university building I was not able to shift the balance of power towards the participant in the way that might have been possible if I was entering their 'territory'. The other disadvantage was that one participant was not prepared to travel to me despite my offer to reimburse expenses.

2.12 Procedure for gaining consent

Prior to commencing the interview a consent form (Appendix 4) was read to participants. The use of a consent form was intended to deal with some of the ethical dilemmas of research (McLeod, 2004). In stating that participation was voluntary and that the participant was aware of the procedures, it was assumed that personal responsibility was being taken. However, as McLeod (2004, p. 171) points out: 'the concept of informed consent is itself by no means straightforward'.

In the planning of this research, it was hypothesised that the main obstacle to obtaining genuine informed consent would relate to the competence of the participant. I decided that given the sensitive nature of the interview topic and the potential vulnerability of the participant it was important for me to be very sensitive, observant and alert to any signs of drug or alcohol use or distress at a level where the ability to give consent might be compromised. However none of the participants gave me any cause for concern in respect to this and it was not even necessary to discuss the issue.

2.13 Information given to participants

An information sheet was given to participants prior to meeting. On arrival prior to the interview participants were reminded that the recorded interview could last up to one

hour and that this would depend on how they felt. It was necessary to establish this time boundary at the start because of the potential vulnerability of the participants and the sensitive nature of the subject. The provision of a resource pack on self-harm was also mentioned and given out before the start of the interview.

2.14 Attention to the psychological well-being of participants

The psychological well-being of participants was an issue that required a great deal of consideration. A self-harm resource pack (Appendix 12) and contact details for the counsellor were given before the interview started, this seemed more appropriate than giving it at the end when it may have been viewed as a response to individual distress etc., rather than part of the procedure. The participant's state was continually monitored through sensitive observation. At times when a participant appeared distressed, this was acknowledged and when appropriate the option to suspend the interview or to terminate was mentioned. This happened on two occasions and participants were asked whether they wanted to have a break or finish the interview. On each occasion they said they would prefer to continue and that it was helpful to talk about their experiences. At the end of the interview the self-harm resource pack (Appendix 12) and contact details for the counsellor were given out. Participants were also asked if they would like a copy of the completed study.

In managing the ending, skills learnt on the counselling psychology training course were invaluable. As McLeod (2004, p. 176) says, the researcher has an ethical responsibility to 'invest as much care and attention into negotiating the ending of a research project as they would into negotiating access at the start of the study'.

2.15 Transcription

Most of the interviews were transcribed verbatim. Although the process of typing up transcriptions was time-consuming, initially I elected to do this because it enabled me to really get to know the text. Smith (1995) also advocates transcription by the researcher for this reason. However, during the transcription process I realised that ten participants was too many. I found it hard to 'get to know' all of the individuals and

became confused and 'over loaded' at one point. It became necessary to pass three partially completed transcriptions to be professionally transcribed. This is described in detail in 'Chapter 7, section 2.7., 'Methodological Concerns'. I think that it was largely through the process of transcription and listening again and again to the tapes that it was possible to later achieve 'thick description' (Bauer & Gaskell, 2000). The transcripts were then analysed using IPA (Smith, 1997; Willig, 2003).

2.16 The procedure used for analysing the transcripts

Analysing the data using IPA involves a systematic and detailed process in which the participants' transcripts are scrutinised in an attempt to gain a sense of the essence of the experience for the participants, as well as a sense of their cognitions and meaning-making (Smith, 1997). The outcome of this process of analysis, as Coyle & Rafalin (2000, p. 27) state, 'represents an interaction between participants' accounts and the researcher's interpretative framework'. According to Smith (1997), good qualitative research should demonstrate transparency of procedure. The procedure is systematically outlined in the following paragraph.

The procedure used for analysing the transcripts was that outlined in Willig (2001). This involved a process in which each transcript was read on a case-by-case basis starting with a detailed analysis of transcript 1 before proceeding to transcript 2. The procedure began with a free contextual analysis in which my initial thoughts in response to the text were recorded in the left margin. The transcripts were read three times and note-taking continued. Some confusion occurred during this process which is discussed in 'Section 4 : Methodological concerns'. A summary chart was then produced for each transcript. (Appendix 6) and examples of quotes from the original text were recorded on the summary charts so that I could ensure that the identified themes were grounded in the data (Elliot, Fisher and Rennie, 1999). This procedure was repeated for all transcripts.

2.17 The processes of identifying and structuring themes

Once all the transcripts had been analysed in accordance with the above stages, the third stage of the process involved an attempt to introduce structure into the analysis. During this stage I created various charts and diagrams of the themes to facilitate the grouping of themes and concepts into clusters or boxes that were labelled in the processes of integration and identification of super-ordinate themes. (An example of a chart is provided in Appendix 7). The task was then to identify super-ordinate themes that made sense of and characterised the whole content and meaning.

2.18 The process of developing and modifying the interpretive framework.

The initial interpretive framework for the emerging themes was the broad concept of 'self-harm as coping' which was the original focus of this research. This was conceptualised and illustrated in a chart (Appendix 1). However, during the process of analysis the resulting charts and diagrams became increasingly complicated as a result of the back and forth movement between the attempt to structure emerging themes and the initial transcripts. It was essential to ensure that the structuring of themes both reflected and made sense in relation to the participants' accounts. As Willig (2001, p.55), states 'this means that the researcher needs to move back and forth between the themes he or she attempts to structure and the text that generated the themes in the first place.'

The process of analysis did not occur in a 'tidy' linear manner, but involved a back and forth movement between the transcripts and my interpretation and attempts to develop a model. This back and forth movement and formulating, modifying, re-formulating characterised the research process and the development of the research as it evolved over time. This process is reflected in the sample of the research journal in Appendix 5 . Initial ideas were discarded and then returned to and some were transformed. Eventually a range of super-ordinate themes were elicited through the initial process of analysis .

2.19 Interpretation and evaluation of the themes

Next I moved to more detailed interpretation and evaluation of the themes. A number of models were developed during the process of analysis. First was the concept of a continuum. It then became evident that there was a striking polarisation in the approach to self-harm treatment where for example, self-harm is conceptualised as either a psychopathological behaviour or a functional and adaptive behaviour, or as attempted suicide or as a 'strategy to survive'. I was then curious to see whether this polarisation was reflected anywhere in the participants' accounts.

Following another analysis of the transcripts and themes it was surprising to discover that all of the original themes that emerged from participants' accounts had a polar opposite that could be identified. This polarisation could be seen within some transcripts as well as across transcripts. A model based on this 'polarisation' was then developed and later reformulated in the continual back and forth movement.

Eventually a new model was constructed. The model : Self-Harm Informed Functional Theory (*SHIFT*) and Function Informed Techniques (FIT) incorporated aspects of the previous conceptual models of self-harm. These include the original model of self-harm as 'coping', the model based on the 'polarisation of themes', the deficit and the compensatory models. All of these models represented a stage in the construction of the final '*SHIFT & FIT*' model. (Charts illustrating the various models that were constructed at different stages in the research are provided in Appendix 14).

2.20 Contextual information and participant's demographic information and characteristics

'Identifiers' have been changed to maintain confidentiality.

The ten female participants ranged in age between 16-25 years and were drawn from a community sample. They did not 'fit' the dominant stereotypes of the 'self-harmer' in research drawn from clinical populations. They were not 'revolving-door' psychiatric patients, 'deviant border-lines' or 'manipulative attention seekers' (Turp, 2003), but all regularly self-harmed.

The participants were from a variety of racial and cultural backgrounds. Laticia and Laura described themselves as 'Black/British', Steph, Kelly, Natalie, Veronica and Sarah as 'White/British', Elizabeth as dual British/ Caribbean heritage. Moira as dual Italian/Spanish and Nazra described herself as Asian.

In terms of income and employment two were in the category of 'service, shop and sales work', two in the 'category of management and professional' (International Standard Classification of Occupations, International Labour Office, 1990). Two were unemployed and in receipt of 'disability benefit'. Three were undergraduate students and one a post-graduate student.

In order to provide further information about the participants such as their social economic status, educational achievement, impact of self-harm on functioning etc., the 'self-harm population classification system' was used, but in a different way to that proposed by Walsh (2006). Walsh states that the 'self-harm population classification system' (ibid.), categorizes individuals who self-harm according to three distinct sub-groups of the self-harm population.

However, I would argue that Walsh's classification system of three sub-groups of self-harmers, do not represent sub-groups that are based on differences relating directly to self-harm. Rather, the criteria for classification seem to reflect the socio-economic and cultural context and the inextricable links with the individual and the experience of self-harm.

The three categories of 'self-harm population sub groups' proposed by Walsh (2006) are as follows: .

- 1) The mentally ill, who are substantially compromised in their level of functioning in the realms of relationships, work, and overall stability. These individuals frequently receive multiple psychiatric diagnoses. Not uncommonly, they have endured extensive histories of trauma;

- 2) Those that are functioning moderately well in society and are not incapacitated by their illnesses, but who nonetheless merit psychiatric diagnoses; these individuals may or may not have trauma histories;

3) The 3rd group is described as ‘ new emerging group of high functioning young people.’ As Walsh (2006, p.176) states :

These individuals frequently do not receive psychiatric diagnoses or tend to fall into the category of “adjustment disorders.” Many of these youth are quite successful academically and socially. Moreover, this group often comes from capable, caring families in which trauma has not been a problem.

2.21 Classification of participants into ‘population sub groups’

In this present study, the participants who met criteria for sub-groups 1 & 2 were working class, and mainly from minority ethnic groups. Two participants, Laura and Elizabeth met criteria for sub-group (1). Both had long term histories of mental health difficulties and contact with psychiatric services. Both had received more than one psychiatric diagnosis, and had been ‘substantially compromised in functioning.’ They reported significant difficulties across all areas of their lives. This included difficulties in relationships, poverty, employment and problems related to mental health issues and the associated discrimination and stigma (Proctor, 2002).

Laura described herself as black and working class, she was on ‘disability benefit’. She reported severe early sexual physical and emotional abuse in childhood and was removed into social services care as a child. Laura said that her experiences in childhood were related to her current self-harm and other problems. Her own two young children had been removed from her care by social services who classified her as ‘an unfit person.’ Her ‘compromised functioning’ could be accounted for in terms of the interplay between individual factors and socio-economic, cultural and educational disadvantage and discrimination. She had a history of mental health difficulties and long-term contact with psychiatric services. She reported a dual diagnosis of depression and alcohol dependence.

Elizabeth described herself as having dual British/ Caribbean heritage and was on 'disability benefit'. Like Laura, she had no educational qualifications and a long history of mental health difficulties. She could be described as having 'significantly compromised functioning across many areas of her life,' although the alternative view is that Elizabeth's 'compromised functioning' is a consequence of deprivation, disadvantage, poverty, racism and discrimination.

Nazra, Sarah and Laticia met criteria for Group 2) and could be classified as functioning moderately well in society and not incapacitated by mental health difficulties. (Whether or not they merit psychiatric diagnoses, is a highly controversial issue). These individuals all reported histories of trauma and had experience of a range of services including psychiatric treatment, psychotherapy and counselling.

Five of the participants could be classified as 'high functioning young people' and met criteria for inclusion in 'sub-group 3'. Natalie, Veronica, Kelly, Moira and Steph, were white, middle-class and from socio-economically and educationally advantaged backgrounds. They could be regarded as 'academically and socially successful' because they were able to function well academically on graduate and post-graduate courses, and two had professional careers. Two reported a history of adversity or trauma. None disclosed previous contact with psychiatric services but all had accessed alternative treatment such as private psychotherapy.

Chapter 3: Analysis

3.1 The themes

A range of super-ordinate themes were identified through the process of analysis and reflect the wide range of ways that self-harm was used by the participants to cope with many different aspects of interpersonal and intrapersonal cognitive, social and emotional functioning. These are listed below and explored in the following analysis.

A) Self-harm and early adversity

A.1 *Self-harm - victim and survivor*

A.2 *Self-harm , early abuse , adversity and emotions*

B) Self-harm and emotions

B.1) *Self-harm and emotional regulation and dysregulation*

B.2) *Self-harm and managing and expressing anger; anger directed inwards – anger directed outwards*

B.3) *Self-harm - and self-care : ' self abusing and self-soothing'*

B.4) *Self-harm and expression of internal experience; 'All feeling no thinking'*

B5) *Self-harm and alexithymia*

B6) *Self-harm and ambivalent communication*

C) Self-harm and the relationship to self and others

C 1a) *Positive accounts of self-harm*

C.1b) *Self-harm as a positive attachment*

C2) *Self-harm, self-identity and dissociation : 'good part – bad part'*

C3) *self-harm and the social context*

E)Participants' experiences of treatment

E1) *Self-harm: a phenomenon to be explored, controlled or eliminated?*

E2) *A treatment approach that participants wanted or thought might be helpful*

E3) *Negative responses and the impact of stigma*

B4) *Positive responses*

3.2 Analysis of Themes

Notation used in transcript excerpts:

Italics indicates participant/interviewer speech

] denotes the omission of text which is not necessary for the purposes of illustration

... denotes a pause in speech

Super-ordinate theme A : Self-harm and early adversity

A. 1) 'Victim – Survivor'

In the following analysis the super-ordinate theme 'early adversity' incorporates a range of childhood experiences including trauma, neglect, severe mental health problems in a close relative and death of a close relative. The strong association between self-harm and early adversity, abuse and trauma, reported in the main body of self-harm literature, was also reflected in the present study. The majority of participants reported early experiences of adversity and abuse. In response to being asked about their first experience of self-harm Steph, Laura, Sarah and Nazra all made a direct connection with childhood experiences of adversity. These included sexual abuse, physical and emotional abuse, neglect, death of a close relative and psychiatric illness in a parent. For example, when the interviewer asked Steph:

Can you remember anything about the time you first self-harmed?

Steph replied:

My father had died when I was 12. And I was being abused at home ... So I started harming myself (S, p.4 / 53).

Similarly, in answer to the same question, Laura replied that she began self-harming because she:

was being abused at home and relatives were dying as well. (La, p.1/47)

Sarah also connected her self-harm with childhood sexual abuse. When asked if she could say anything about her first experience of self-harm she replied:

Yeah. I was abused when I was 3 until I was 17... I didn't cope with it at all.

(S, p.1 /41)

When the interviewer asked Elizabeth about why she started self-harming she replied:

I don't know exactly what started it off, but my mum's schizophrenic (E, p.3 /131).

Elizabeth described how throughout most of her childhood her mother had been ill:

[] so most of my life [] I've known mum being ill [] And I think that's possibly to do with the way I behave and the way I do things (E, p.3/ 148-149).

However, although 'experience of early adversity' was a common theme, it was not present in every account, as Veronica pointed out:

They say it's to do with abuse but it can happen in any background obviously ... I've never had anything really awful happen that sort of led to it [self-harm]. (V, p.1/ 34-37)

As Veronica's comment indicates, it is important to avoid generalisations, and as will be discussed later, there are alternative accounts of the aetiology and a range of other factors associated with self-harm.

A2 Self-harm and specific functions related to early adversity

One function of self-harm that was directly related to the experiences of childhood abuse and adversity described by participants, was the use of self-harm to manage the emotions surrounding their experiences. For example Laticia described self-harm as a strategy for coping with feelings of guilt generated by the death of her father. She felt responsible for her father's death by drowning because she had asked him to go into the sea with her. Self-harm provided her 'punishment'.

Laticia said:

I was 14 when it [self-harm] started. I felt ... like I'd caused my dad's death and therefore I've got to be punished. And it was a way of punishing myself for that (L, p.3 /126-127)

Nazra used self-harm to cope with feelings of guilt. She felt guilty for hating her sister who physically abused her. Her sister had learning difficulties and behavioural problems and so in Nazra's view 'could not help it.' Nazra felt 'bad and guilty' and used self-harm to manage these feelings. She said:

I wanted to make it bruised and I wanted to make it look really bad. So I made it look worse than what she'd done [] I felt bad for hating her 'cos I felt I shouldn't ... it [self-harm] made me feel like the guilt didn't feel quite as bad (N, p.2 /62-63).

Super-ordinate Theme B: Self-harm and emotions

B.1. Self-harm and emotional regulation-dysregulation

Many participants reported using self-harm as a method of emotional regulation. Elizabeth described how self-harm provided relief from intense emotions. She described this function of self-harm to reduce the level of intensity and self-harms until the feelings have subsided.

I keep self harming until those feelings have subsided. It might just be a few minutes, 5 minutes. It might be half an hour. You know might just do two or three cuts, but I

might cut all the way up both arms and just carry on until there's no room left to cut (E., p. 5 /237-242).

Laura also described a build up of intense feelings and one function of self-harm was as a method of reducing the intensity and achieving a calm state. She said:

I'd be able to feel the feelings bubbling up inside me all the way home... physically I just get really, really hot inside. It's like I know how spontaneous human combustion happens (L, p. 13 / 637-641).

Laura explained how after self-harm she experienced relief from these intense emotions and felt calm enough to sleep. She said:

Afterwards yeah , its like a relief, like I was letting go of something I suppose.. [] I would often fall asleep afterwards (L , p.17 / 803).

Kelly also explained how self-harm provided a way for her to reduce or regulate overwhelming feelings Kelly said that her intense emotions often distracted her from studying for her degree. She described the use of self-harm to manage these feelings, so that she could get back on with her studies. Although sometimes she 'allowed' herself time to just feel 'numb.'

... before I'm doing it I just feel ... I feel overwhelmed... Sometimes I just get straight on and other times I just ... [] let myself be numb (K, p.5/ 203-205).

Sarah, described how self-harm numbed her emotional pain and made her feel calm.:
It just numbed the pain. It made me feel calmer. (S, p.2./ 52)

Some participants also described the use of different forms of self-harm for managing different emotions. For example, Steph explained that if she experienced a strong or 'major' emotion, as she described it, like anger, her self-harm would be immediate and take the form of hitting herself, rather than cutting which she used in response to other emotions. As Steph explained :

... Some of them (methods of self-harm) can be quite immediate and so if you're feeling really like angry about something ... like and it's just there ... then ... you'd be doing immediate things like you'd hit or something. .. and you've got your hands in order to do that, rather than having to delay it while you find something [] that would be for the major ones. Like if you're feeling really angry (Ste. p.5 /375) .

Laura also made a similar distinction between different forms of self-harm.. She described one form of 'cutting' as 'neat and tidy,' in contrast she said hers was very 'rageful,' in response to feeling angry with herself. She said:

It was very rageful ...very rageful ... cutting [] some people used to do it very neat and tidy but mine was quite rageful ... I was angry at myself, and I probably shouldn't have been angry, I hadn't done anything (L., p.5, 215–219).

B2: Self-harm and anger: ' anger directed inward and outwards'

The use of self-harm to manage anger was frequently reported by the participants who used it as a way to express , regulate and manage anger. For example, Steph referred to self-harm as a way of managing anger. Steph said she did not think it was the right way to deal with her feelings and tried not to use it. However , because it worked, and it made her feel better, she did. As Steph said:

I told myself I'm not going to do it any more and then one day I felt really angry and ...and did it. I just thought if I did this I'd feel so much better. I was saying no, this is not the right way to deal with it. You know, it's not really going to make you feel better. But I did it anyway. It made me feel a lot better.

Elizabeth also described the use of self-harm to express anger which she directed inwards through hurting herself, rather than outwards and hurting others. As she described :

I'd rather cut my arms or hurt myself in some way as opposed to punching someone's lights out. You know, I'd rather hurt myself than hurt the other person. I turn everything in on myself (E., p.12 / 574–577).

Elizabeth experienced her self-harm as a 'release mechanism' that enable her to manage anger. As she said:

It's just a release mechanism. When I get really pent up and angry I just end up hurting myself (E, p.2 /66 -68).

The function of self-harm in relation to anger is explained in various ways and from different perspectives in the self-harm literature. The various accounts will be considered in the discussion of results which follows in Chapter 4.

B3. Self-harm as self-care : 'self-abusing and self-soothing'

In talking about their experiences, many participants described another function of self-harm as a form of self-care and comfort. Many participants described how tending to their wounds or having them attended to provided experiences of comfort and care. For some this care and comfort came from others, for some it was self-care, following the self-harm. For example, Natalie described caring for herself after self-harm and described the self-care and self-comforting aspect of her self-harm as important to her.

Natalie described feeling comforted by putting on a dressing after self-harming and described achieving a balance between self-care and self-harm. As Natalie explained:

Looking after myself a little bit is quite important to me...it is quite comforting to put a dressing on or something and just feel kind of all wrapped up and made better (N, p. 4 / 160).

For Natalie self-care was an important aspect of her experience. As she said:

You feel I've done that [cut] now, I'll look after myself. It's a funny balance of the two.

(N. p.4. /173)

Moira described her use of self-harm as a strategy to get care and attention from others.

M: It [self-harm] was for attention a lot of it.

I: Can you say a little bit more about that?

M Yeah ... you're sort of cared for afterwards, [] a lot of people would be quite gentle with me afterwards (M, p.7 /13).

Laura also described how her self-harm was linked to a need or desire for care from others. She said:

L: Sometimes I just want to do it [self-harm] [] really really bad and just be the worst person ever to do it.

I: When you say the worst person ever do you mean to do it [self-harm] worse than anyone else?

L: Mm. Cos., I just ... want to be like the sickest little girl in the world. But I'm not a little girl, so I can't.

I: What do you think the sickest little girl in the world would get?

L: Looked after ... but I can't expect that now, can I? (L, p. 8/ 46)

Laura's desire to be 'the sickest little girl in the world' in order to get 'looked after' seems to be a commonly held belief. The view that one must be sick to deserve care is described in a number of accounts of individual experiences of self-harm (Babiker & Arnold , 1997). This belief also seems to be related to a difficulty in expressing emotions and needs which was described by many participants.

B4) Self-harm, expression of internal experience and emotion : ‘ All feeling – no thinking, action not language’

Many of the participants described difficulties with the verbal expression of emotion, internal experience and needs. Some described the use of self-harm as a way to communicate their need for care and attention.

As the accounts unfolded the use of self-harm as a strategy for coping with difficulties in expressing a range of needs, emotions and experience emerged as a key theme for many participants. As Sarah described :

It's just this not being able to tell people. (S., p. 9 /422)

Similarly, Moira explained :

I think one of the big things is talking to other people ... not about the feelings that I wanted to do it [self-harm], but just about being down [] I never used to talk to anyone, and just no one knew. You know everyone just thought I was happy no one ever knew that I could possibly be down (M, p 12. / 571-574) .

Kelly also used self-harm as a strategy for expression of emotion using action rather than language. She said:

There's issues that I've got to deal with but I don't like talking to people ... I see it [self-harm] as a lot easier than just talking or crying (K, p.14/ 688-689) .

B 5) Self-harm and alexithymia

Participants also described other ways in which they used self-harm to cope with emotions. Some participants reported a difficulty in their ability to identify and name emotions and described the use of self-harm to identify what they were feeling as well as to cope with how they were feeling. This state of not being able to identify emotions or to describe what one is feeling is referred to as alexithymia (Zlotnick, et, al, 1996)

and has been linked to self-harm in previous research (ibid., Zlotnick). In the present study a number of participants had difficulty in identifying and talking about their feelings. For example, Moira's difficulty in using language to talk about her feelings was very evident throughout her interview. It seemed the only way she could really identify what she was feeling was if she could see it. The following interaction reflects this difficulty:

I: What does self-harm do for you?

M: Everything sort of just ... don't know it kind of just builds up in a way and I suppose just the whole thing of like hurting yourself you can ... you sort of feel it

I: What's the feeling that you're talking about? What feeling is it?

M... I don't know it's just ... it's like a feeling of ... you know ... I don't know. And it sounds stupid because ... I don't really know. (M., p.3 /109 -115

Nazra described a similar difficulty in identifying emotion. She said:

If ever I felt any ... kind of emotion ... I've never actually worked out what it is ... I don't understand what I'm feeling and [] just find it really hard because I think I've always kind of numbed everything. ... as soon as I feel anything that I can't handle then I just want to self-harm (N, p.5 / 210-218).

Nazra's description seemed to 'capture' the sense of fear that Farber (2006) described in a recent presentation. Farber discussed how 'alexithymia' is also related to a fear of emotion and suggested some people who self-harm have an 'emotional phobia'. As Farber states, some self-harmers are '... phobic about experiencing emotion, so they dissociate and harm themselves instead' (p.81).

Kelly also described not knowing what she was feeling. She said:

I might not know exactly why I'd done it or how I was feeling at the time
(K, p3 /117).

Laura spoke of not knowing what to do with emotions, cutting was all she 'knew to do.'
As she said:

*It was habit by that time of I'm in pain so I cut myself because that was what I knew
what to do. I knew that that ... in a way it way it stopped me from feeling that pain, the
emotional pain (L p.3/ 145).*

B.6) Self-harm and ambivalent communication

Another phenomenon that emerged in participant's accounts was something I refer to as 'ambivalent communication.' This was used in their explanations of injuries. For example, Moira described how she used the 'cover' of making a sculpture out of barbed wire, to explain cuts on her arms. Although many participants, just 'blamed' the cat.

This ambivalent communication was described by one participant, Elizabeth as 'a way of saying it and at the same time not saying.' (E.,p. 18 /867). Elizabeth's comments suggest that one explanation might be a concern about the ability of others to cope with the topic of self-harm. The idea that ambivalent communication may serve as a way of 'testing' whether the other person can cope with it, or wants to hear it, is indicated in Elizabeth's account of her ambivalent explanation. She said:

*I said cat scratches which ... no cat scratches you with loads of little ones going like
that along your arm. And she was like 'they are not cat scratches' ... and I said 'Okay
fine I done it. (E., p. 18 /867-868.)*

Interestingly, this ambivalence in communication was also evident in the following interaction with Elizabeth in the interview. Interviewer commented on bandage on Elizabeth's arm because she had chosen to wear short sleeves which revealed this.

I So ... I can see you've got a bandage on your arm now.

R Ice skating.

I Really?

R Yeah.

[]

I How did you ... ?

R Don't know, just fell over.

I Fell over?

R Yeah. But um ...it's tubi-grip.

I Yeah. Does it hurt?

R Um...

I Okay... I mean if you don't want to answer a question that's fine you just say 'No, shut up! Don't want to answer that one, that's absolutely fine... No pressure ...I promise. If you feel that then just tell me to shut-up! I can take it (laughs).

R It's a self harm attempt (laughs).

I Yeah, well I can understand something about that. Can you say anymore about what it does for you?

R ... helps me feel able to get on with the day (E, p.1 /13-52).

This example of ambivalent communication was not explored further and it felt like a missed opportunity. However, there were clear boundary issues which made further exploration a complex and potentially difficult issue. (Discussed further as a methodological concern in Chapter 7).

This phenomenon of ambivalent communication is also a feature of the personal account of self-harm by Smith (2006). She describes her own use of 'ambivalent explanations' in her personal account of self-harm and, interestingly, she also 'blames' the cat. Smith (p. 40) writes:

... I was washing up, Kathryn said to me, 'What did you do to your arm?' I stopped mid-scrub and studied my arm as if seeing it for the first time. 'Cat' is all I said. 'Cat? Did that? ... Cat never hurt anything,' Kathryn laughed but she didn't question my explanation.

Strong, (1998, p.209) also refers to 'flimsy excuses' which could be viewed as another way of describing ambivalent communication. As Strong reported, the client 'told doctors she was wearing the shirt she was trying to iron, her parents don't know or pretend not to know.'

Another possible reason for ambivalent communication is that it serves to distract attention away from the underlying issues. A way of keeping the attention on the physical rather than the emotional issues (Conterio et.,al.,1998). This view is echoed in the following perceptive comment from Moira, in answer to the interviewer's question .

The interviewer asked :

I: Would the communication about how hurt you were be picked up by other people?

Moira replied:

Um, no, because in a way it distracts people ... then the attention would be on my arms and wherever I cut. And then it would distract people from the actual situation of what happened. ... It created a new drama to sort of take the focus off of the real reasons you know like the pain (M, p.7 /332-336).

Laticia's description of seeing a counsellor with an obvious self-inflicted injury is perhaps another example of keeping the counsellor focussed on the physical injury rather than the underlying issues. As Laticia said:

I was trying to tell him that the counselling isn't the major issue right now this minute, I need to get my leg seen to (L. p.5/ 244-245).

Super-ordinate theme C: Self-harm and the relationship to self and others

C1a. Positive accounts of self-harm

One of the most surprising findings to emerge, was the positive view of self-harm expressed by some participants. Some described self-harm in very positive terms and this reflected their experience of it as a 'eu-functional' phenomenon. This view of self-harm as eu-functional provided a polar opposite to the more commonly held or traditional view of self harm as a dysfunctional phenomenon. For some, self-harm provided experiences of euphoria, excitement and pleasure.

Natalie description of self-harm was very positive and she said it produced feelings of happiness and fascination. . She said:

I remember cutting myself and then feeling kind of really happy about me. Later on I got quite fascinated by seeing blood and so on. And so that was all part of it (N.p7,339-340).

Kelly described her initial experiences of self-harm as thrilling. And as something that made her feel a lot happier. She said:

It feels kind of weird like thrilling andOr it was in the beginning, now it's getting less- so. [] It's like I've got a rush out of it. [] Afterwards, I feel ... I do feel a bit happier. I don't know if the word happy is right. But I feel a lot happier (K, p.10 / 452-455).

For Stephanie, self-harm felt satisfying and good. She said:

It sort of picks you back up and makes me feel like everything is good for a while (. Ste, p. 5, / 240).

Stephanie also found self-harm satisfying, but hard to comprehend. As she said:

I love all the blood and whatever. It's kind of satisfying... actually kind of like it's putting yourself back together in a way. I know... it's so hard to believe that just hacking away at yourself can feel so good [] ... there's a sort of like satisfaction. (S. p.9., / 395-398) .

Laura also described it in positive terms. As she said:

I realised that it actually felt quite good ... I was doing something for myself. (L.p2.61-63)

Moira, described her self-harm as exciting. She said :

(Self-harm) ... it's actually quite exciting in a way. ...It creates another state if you like (M, p., 17 /809).

C.1b) Self-harm as a positive attachment

In addition to positive accounts of self-harm in relation to feelings and emotional states, some participants also described self-harm in other positive ways. Some participants referred to self-harm in positive terms of a special relationship. For some self-harm was described as an important 'attachment' in which the self-harm provided the security of knowing it was always there for them. For Laura, just knowing her self-harm was 'there', was comforting: As she said:

I knew it was there, that was kind of comforting (L., p.5 /225).

Other participants described their attachment to self-harm in relation to the equipment they used for cutting. They described this as having a special significance. For example, some said that just knowing the equipment was there for them to use whenever they needed, was really important. Others referred to special 'self-harm kits' which they kept their 'equipment' in. For example, Kelly described how she found it hard to concentrate and needed to check that she had enough razors blades available for her to cut if she needed to:

I tried to get back into my work [] I had to check that I had enough razor blades left, you know, that there was going to be enough to just like do it, just to cut you know (K, p., 13 / 632-635).

Elizabeth said that she kept her 'equipment' used for self-harm in a 'little tin' in her 'self-harm bag'. This 'self-harm bag' was something that she said she'd been trying to throw away, but could not. Her comments about her inability to part with this 'self-harm bag' suggested that for Elizabeth, the 'self-harm' bag, was as important as a favorite old Teddy bear might be to someone else. In response to being asked to clarify what she meant by her 'self-harm bag'.

Elizabeth said: *It's got bandages, tuba-grips, a little tin with all the blades, and a towel. And I've been trying to throw it all away but I can't. So I keep it in a cupboard, or you know carrier bag. It's just been there all the time, for a long time now* (E., p.6 / 250- 257)

Nazra described her 'self-harming box'. This box played an important part in her self-harming process. She described how just getting the box out provided a relief and was calming. As Nazra said:

Even though you might not have that much time, it's kind of more premeditated [], Specially ... you've got your box and like there's a kind of a ritual with it as well. Like I think it is quite calming. [] I always kind of feel ... getting the box out... it's quite a relief, but then ... it kind of feels like it's all over then. It's like ... like even though you haven't done anything you've kind of done it already (N, p10 / 414-418).

The significance of 'self-harm equipment' for some participants can be understood in terms of the concept of a 'transitional object' (Winnicott, 1958). Gardener, (2001, p.30), also suggests that the special significance of self-harm equipment, can be understood in terms of attachment. As Gardener states, 'I think the attachment to the implements of self-destruction, such as razors or knives, can be seen as a parody of the usual form of transitional object.' She also describes how razors used to self-harm, may act 'as a perverse transitional object' (p.30). It is important to consider the client's attachment to self-harm or to the 'equipment' used, because as will be discussed in the following chapter, there are important implications for both self-harm theory and practice (Farber, 2006).

C2) Self-harm, self-identity and dissociation

C2.a) 'good part – bad part'

In describing their experiences of self-harm, a surprisingly high number of participants described a separation of aspects of their personality in a way that some theorists have referred to as splitting (Kreisman et., al. 2004) or disassociation (Cole & Putnam, 1992).

Many of the participants described their self-harm as a either a secret, special place, or a 'secret bad part' of their personality that they kept separate from the 'good part'.

For example, Kelly experienced her self-harm as providing a 'separate place' for her :
[] cutting myself was like my little place where no one knew []. It was like my secret little world (K., p.3 /141).

Moira also described her 'self-harming part' as another part of herself . She referred to this as : My different persona ... my secret. (M, p.9/ 447)

Veronica referred to her self-harming as the 'horrible part' and as 'a rebellion' against being 'the nice caring one'. She said:

For me it [self-harm] is almost like a rebellion [] I'm always the mediator, I hate confrontation. I always try and be the nice caring one. (V., p.5, 218-220)

Veronica continued:

So it was like the horrible side of me that I quite like. (V., p.5, 225)

Veronica suggested that the separation of this 'horrible self-harming' part was related to issues of self- identity and said:

I have lots of issues around my identity []. I have to be nice and I have not to say no, because if I don't [] someone will be upset (V, p.5 / 232-238).

Natalie's self-harm also seemed to be connected to issues of self-identity and her need to be 'good'. Natalie explained how self-harm was often a response to feeling that she had not been 'good'. She said, she

...worried about not being good or upsetting other people. (N.,p. 4 /179)

Natalie explained further:

If I've done something wrong or not done something I should have done, I've not been a good girl in some way, then that'll quite often be a trigger. People getting angry at me is quite a trigger. Don't like it, don't want to make people angry at all (N, p. 4- 5 / 197-202).

Veronica described how secretly self-harming enabled her to 'act normal and happy'. She said:

And if I did that [cut]I could act normal and happy, like no one had a clue (V, p.3 /142)

Steph described a similar function of self-harm. For her the secret use of self-harm enabled her to manage negative feelings while in the company of friends. As Steph reported:

I used to do it in friends' houses [] I'd start to go into a mood and I didn't want to start freaking out in front of them. So I'd just sit there and I knew I had to do something about that []. They didn't know [] I just felt like I had to cut myself so I would go into their bathrooms, other rooms and find sharp objects. ... And just do something. I'd feel a lot better. [] When I went back [] everything was normal [] everybody would be doing what they were doing before I started cutting myself [] It didn't really change, the atmosphere [] it changed the way I was feeling, but they didn't suspect anything (S., p. 11/ 543-548).

The participants' descriptions of hiding what they perceived as negative or 'bad' emotions or unacceptable emotional states is directly related to their use of self-harm. For Veronica, Kelly, Natalie and Steph, self-harm was a way of managing or

expressing the side of them they perceived as 'bad', 'rebellious' or unacceptable. Their accounts suggest that having expressed this, they are then able to 'carry on as 'normal' as the Veronica who is not rebellious or confrontational, who 'does not say no' and puts on 'a brave face'. Or Natalie, who after self-harming can again 'act normal and happy.' Or Steph, who goes to the bathroom to deal with negative feelings and then goes back into the room with her friends 'as normal'.

Veronica also spoke about the difficulty of others 'knowing about this part of her', but she also seemed aware that acceptance of this part was important in order for her 'to get better'. She described her worst experience as being when 'it got out.'

I think the worst one for me ... it was still pretty secret [but] ... it got out on a night out with the girls, and they all knew and [] suddenly [] that was the worst, the hardest part, just in dealing with it and people knowing. And it wasn't a secret any more, I felt quite intruded. Like I wished they didn't know. And I knew they had to for me to get better. (V, p.6 / 284–287)

In a personal account of self-harm Smith (2006), like the participants, also describes the separation of aspects of her personality. Smith describes the separation of the sane 'good part' from the 'self-harming part'.

Smith (2006, p. 85) writes:

... There is my adult side, my sane side ... who wants to get it right. Then there is the other side. The manipulator, who just wants to be let loose and do all the things I shouldn't. I had tried to separate in my mind all the things I feel and do that could be due to the manipulator.

Smith (2006) also describes the battle she has with the ‘manipulator when she tries to throw away her razor blades. She writes:

Before long there is a heap of razor blades on the coffee table [] I can feel the manipulator running round its room banging on the walls sensing what is going to happen []. I am scared of the repercussions my next action will have, but this has to happen []. Then a door in my head clatters open and I feel the manipulator storm to the front of my head (Ibid., p.87).

The accounts of a relationship to self-harm described by the participants and Smith (2006), have important implications for theory and practice. As discussed in Chapters 4 and 5 of this present study, the different experiences and relationships to self-harm reported by participants, emphasise the importance of exploration in therapy and highlight the potential difficulties if the focus is only on stopping the self-harm.

Analysis: Section 2

Theme E: Participants accounts of their experiences of treatment

The next section of the analysis presents participants' description of their experiences of treatment services for self-harm. Services include psychiatry, psychotherapy, counselling and experiences of hospital treatment and contact with nurses, doctors and emergency psychiatric services.

E.1) Self-harm: a phenomenon to be controlled, eliminated or explored?

Participants were asked about their experiences of contact with treatment services. All participants reported negative experiences and dissatisfaction and many felt that the treatment was not appropriate to their needs. The main issue that participants cited in their experiences of treatment that was inappropriate, was the focus on stopping self-harm. This was a frequently reported feature of the treatment experience that participants were unhappy about. As Natalie commented:

It always seems that there is lots of focus on that you must stop, you must stop. And actually every time I've tried to stop it's just made things worse []. It just led me to kind of lie about it ... which I don't think is helpful (N, p.9 /402).

Natalie said she just wanted to see somebody who understood and did not use a no-self harm contract. As she said:

Somebody who would understand it. A counsellor or a psychiatrist, no contracts (N., p. 9 /412-414).

Similarly, Moira said:

If I was just able to work with somebody who said 'You don't have to stop' I'd probably over a few years maybe be able to go to other things [] nobody's ever said [] it's just a coping mechanism like other things (M, p6. / 282 - 285).

E.2) A treatment approach that participants wanted or thought might be helpful

Participants were clear about the type of intervention that would be helpful. In response to being asked about a treatment approach that might be helpful, many participants replied they would like opportunities to talk about and explore their self-harm and to be actively encouraged and supported in this process by an informed and respectful clinician.

Sarah was clear about the help she wanted. She wanted the opportunity to talk through the issues around her self-harm with someone who could help her to explore the her feelings. As she said:

... Someone who could talk it through... I think generally talking about the feelings behind it would help a lot of people. But there's not that kind of help around very often (S, p.8 /355-356).

Sarah described her experiences of psychiatric intervention following self-harm. Again the need to be encouraged to talk by someone who seemed interested and willing and able to engage was emphasised:

Someone came in, like a psychiatrist and said 'Would you like to talk about anything?' and I said 'No' – he went back out again. And that was it, I got sent home ... []. I just thought 'Oh that's what I expected' (S, p.12 / 559 -568).

Sarah also mentioned the importance of being encouraged to talk. As she explained:
It was too hard for me to actually say it outright, but if he'd actually asked then I would have said [] (Sa, p .7 /303) .

Most participants described how they wanted to explore the underlying meaning and functions of their self-harm, but were not given the opportunity or encouraged. Interestingly, rather than the client trying to divert the clinician's attention away from

the emotional issues as described by Moira earlier, here it was the clinicians who were 'looking the other way'.

Nazra described her experience of psychotherapy. She said:

N: I did it in front of her as well, but she didn't say anything. [] I don't know if she noticed.

I: You were sitting in a session in front of her... How did that make you feel when you were doing that in front of her and you felt like she hadn't noticed?

R: I think it annoyed me [] I just wanted to feel like she was like looking after me (N. p..11 /534-567).

E. 3 Negative experiences of treatment

Elizabeth described not being encouraged to talk about her self-harm and feeling 'dismissed' by her psychiatrist's approach.

I: Have you been able to get into discussions with your psychiatrist about what the self-harm means to you?

E: No ... he knows I self-harm but he don't ...

I: Does he see the scars?

E: Yeah. He's seen them. He sees them when they're fresh cuts.

I: And what does he say about the cuts?

E: He doesn't say anything. I suppose he just dismisses it (E. p. 13 / 622).

The experiences of psychiatric treatment Elizabeth reported, did not explore her self-harm, the focus was on her personality disorder and depression, as Elizabeth commented :

My psychiatrist never really says much about the self-harm issues. You know it's the depression, or like personality disorder (E, p 16 /747-748).

Laticia also reported a negative experience of a therapist not actively engaging with her or exploring the self-harm. She started therapy in order to resolve her self-harm , but found the 'passive' approach of the therapist unhelpful. Laticia said:

He would just sit there and stare at me and I asked him 'Well what should I be saying to you?' And he said 'I don't know' and I ended up saying 'If you don't know, why are you doing the job?' []. I just couldn't figure him out because he didn't seem to be doing anything (L, p5-6./ 250-258).

The participants' experiences of treatment seems to reflect a frequently inappropriate or unhelpful approach to self-harm. Some participants also reported a very judgemental and negative response from professionals. For example, Elizabeth tried a different treatment approach, but described how after a trial period of psychotherapy, she was told that she was not suitable for therapy because of her 'personality':
She []said no I wasn't suitable because of my personality (E. p. 25 /1181-1182).

The stigma associated with self-harm was also evident in participants' accounts .
As Natalie said:

The way that doctors and official people treat – that's been really really upsetting. I feel that's caused many more problems than the self-harm itself (N, p6 /290-292).

Similarly, Sarah commented:

They think they're very much wasting their time in hospitals, you know. They're seeing people with real illnesses.

When asked about the response of the doctor at the hospital Sarah replied:

He didn't really have time to be dealing with me because he had more important things to be worrying about with people who actually had illnesses and things (S, p.4 /159-161).

The random nature of the treatment for self-harm was summed up by Natalie :

It's just this random thing in the NHS where you end up with whoever you end up with, and what their opinion is, is what you get (N., p. 9 /412-414).

Elizabeth also described a random response from staff in her experiences of treatment.

As she said:

Some of the staff are very good and deal with it, you know without judgement and stuff. Then there's other staff that are just 'What are you doing that for to yourself?' You know they're questioning all the time 'Why have you done that?' (E, p. 18 /878)

At [] my local hospital, they're a bit more understanding. But it just depends what staff's on duty (E, p.18 /888-893) .

Elizabeth's account, like Natalie's, reflect a lack of cohesiveness in the approach to self-harm treatment. This suggests that clear treatment guidelines such as those developed by NICE (2004) are not always followed by staff. The lack of understanding of self-harm reported in participants' interactions with professionals, also indicates a need for more training . This was pointed out by Elizabeth who said that while some staff seemed to understand others did not. Elizabeth said:

Some (staff) had a pretty good understanding but there's still the general staff in A&E that get a bit funny with you if you've self harmed.

I ...*Why do you think that is?*

E: *I think because they don't understand, they don't comprehend why people do these things to themselves []. I think um ... they're just not that educated I suppose (E, p. 20 / 946-951).*

E.4 Positive experiences of treatment

Some positive experiences of treatment were reported. Elizabeth reported a recent more positive experience from staff who she felt had ‘ a pretty good understanding’ of self-harm. She said:

The psychiatric unit's got a brand new building and there's EPS.

(Emergency Psychiatric Service).if I just needed someone to talk to they'd be there just to talk to. If I needed being admitted they would admit me. If I needed medication they'd give me medication and then discuss that through the chap that we have in the department. So they've got a pretty good understanding (E, p. 20 /946-951).

Kelly also described a positive response from a therapist: Kelly said :

She said she didn't want me to wear a dirty bandage and []. She was showing me that she cared (K. p.5 /213)

However, there were very few positive accounts of treatment and the response of others generally reported by participants, was negative, stigmatizing and sometimes punitive and potentially damaging.

E.5 Stigma and negative responses from others

Participants spoke about the damage caused by the stigma associated with self-harm.

As Natalie said:

The whole thing about perceptions of other people have really caused me a lot of problems (N p.5/237).

Natalie continued:

Because I'm a teacher ... it's important that people don't find out [] I was told [] I really shouldn't be a teacher because it was obvious I was going to harm other people if I was harming myself. (N.p5.244-245)

Natalie described how she felt about being asked by a friend about her self-harm:
She was just asking me about it. ... And I wouldn't mind if people did that because [] it's not something that I mind talking about. Because it'd be good if people understand – then there'd be less of a stigma attached to it.

Elizabeth also thought it was important for people to understand self-harm. She said:
I think it's so important for people to know more () because they don't understand, they don't comprehend why people do these things to themselves

Interviewer: *That's one of the reasons why it's so important to do this sort of research.*

Chapter 4: Discussion of Results

Introduction

The following discussion of the results of the analysis is divided into two main parts. In part 1., the themes that were presented in the analysis will be briefly discussed with reference to relevant theory and research. In part 2., of this discussion the participants' experiences of self-harm treatment will be explored. The participants' accounts and experiences have important implications for self-harm theory and practice and these are addressed in Chapter 5.

Part 1 : The themes and functions elicited from participants' accounts of self-harm

4.1.1 Early adversity and self-harm

The majority of participants reported a history of childhood adversity or abuse and the theme of 'childhood adversity and the relationship with later self-harm' emerged frequently. This finding is also reflected in a great deal of research that has explored the links between early adversity and the later use of self-harm (Linehan, 1993; Levitt, Sansone & Cohn 2004; Dieter, Nicholls & Pearlman, 2000; Yates 2004). A great deal of this research accounts for the relationship in terms of the experience of early adversity, trauma, or abuse which interacts with individual development and functioning and results in the later use of self-harm in various ways as a coping strategy or an adaptation. (Linehan, 1993; Levitt, Sansone & Cohn 2004; Dieter, Nicholls & Pearlman, 2000; Yates 2004).

A particularly interesting finding to emerge relates to the concept of there being various associations between self-harm and the different functions served. The association that has been most widely researched is the link with early adversity. However, the findings of this present study indicate that there are many other associations. For example, those participants, who did not report an adverse or abusive background, described the main function of their self-harm in terms of self-identity. All referred to feeling the need to be 'good' and to hide what they described as their 'bad self-harming' part from others.

Further, the functions of self-harm described by participants who reported the most extreme abuse and adversity were different to the functions described by participants who experienced other forms of adversity such as the death of a parent. For example, the functions of self-harm described by participants who reported sexual abuse tended to be related to managing and expressing intense feelings such as anger.

The participant who experienced death of a relative, used self-harm as a form of punishment because she felt responsible for the death of her father. Similarly, the participant who described physical abuse from a younger sister, also described self-harm as her punishment because she felt she should not blame or hate her sister. One of the major implications of this finding is the importance of differentiating between different types of self-harm, based on the specific functions served, when investigating the etiology. In the following part of this discussion, the focus will be on the exploration of the specific functions of self-harm reported by participants.

4.1.2 Self-harm and managing and expressing anger: 'anger directed inwards – anger directed outwards'

Many of the participants described how self-harm functioned as a method for venting anger and frustration. The difficulty participants reported in expressing anger and other 'negative' emotions has been explained in from various theoretical perspectives. For example some accounts emphasize an adverse early environment where the individual has learnt that anger is bad or unacceptable. It is suggested that here self-harm may be used to express anger or direct anger inwards.

4.1. 3 Function of Self-harm as self-care; 'Self-abusing and self-soothing'

Another related function of self-harm reported by participants was its function as a method of self-comfort and self-soothing. This has been accounted for in different ways from various theoretical perspectives. This association between being sick and receiving care or deserving care is discussed by Babiker & Arnold (1997, p. 78) who explain that:

... The period following self-injury may, for some people, provide their only opportunity to experience physical caring and comfort. Whether or not there is physical pain, the person feels they have been through something and so now 'deserve' some special caring.

4.1. 4 Self-harm and expression of internal experience; 'All feeling no thinking' – Action not thought

The difficulties participants reported in accepting and expressing needs has also been explained with reference to the concept of an 'invalidating environment'. For example, Linehan (1993) argues that the development of a belief that needs can be safely experienced, expressed and satisfied in relationships is likely to be distorted in an 'invalidating environment.'

4.1. 5 Self-harm as a response to alexithymia,

Many of the participants emphasised their difficulties in identifying and articulating their emotional experience and described their use of self-harm to communicate experiences that they were unable to articulate through language. Zlotnick et al. (1996) suggest that alexithymia, is a condition in which the individual can not identify emotions and suggest that this is an important factor in the use of self-harm to identify, manage and express emotion. It is suggested that 'rather than use words to express feelings, an alexithymic's communication is an act aimed at making others feel those same feelings' (Zlotnick et al., 1996, p. 72).

4.1.6 The use of action rather than language to communicate

Many participants spoke of their difficulties in articulating their experiences. A number of researchers have argued that this can be explained in terms of a deficit in the ability to communicate using thought and language. It is suggested that self-harm provides a way to communicate through action and concrete expression using injuries (Dieter et.al. 2000; Conterio 1998, et.,al.). Again there are a range of explanations as to why an individual may be unable to communicate verbally to her and others.

The inability to use thought and language, rather than action to process and articulate internal experience, has been related to self-harm in a number of accounts (Farber, 2006; Conterio et., al.1998, Dieter et.,al, 2000; Bateman & Fonagy, 2004). For example Dieter et.al., (2000) , describe self-harm as the use of action rather than the use of processes such as language, thought, identification of emotion and awareness of feeling sensations to communicate experience.

It is interesting that this description of a lack of a capacity to process internal experience is very similar to the deficits in reflective function recently identified by Bateman & Fonagy, (2004) and Holmes (2004) , as important factors in self-harm. The concept of self-harm as an adaptation to underlying dysregulation, is explained in terms of a dysregulation in the processes underlying the ability to process experience and to use thought and language to regulate and articulate emotion and internal experience. Bateman & Fonagy, (2004) propose that a disruption in the capacity to mentalise, may result in the use of self-harm as a compensatory adaptation. Further, Bateman & Fonagy, (2004) propose that increasing the capacity to 'mentalise', reduces the need to self-harm (In Nathan, 2006).

The process of is described by Smith (2006). In her 'insider account', of self-harm and the therapeutic process, Smith (2006) describes interaction between herself and her therapist which seemed to capture the essence of the capacity to mentalise. In her account of an interaction with her therapist, Smith describes how the therapist helped her to process internal experience. She writes (ibid, p. 83):

She [therapist] carries on my train of thought as if she can read my mind ... she passes the thoughts back to me ... it is the pull between the two different sides that can be so hard ... she catches it, holds it carefully and says the manipulator is very strong.

4.1. 7 Self-harm and ambivalent communication

A surprisingly high number of participants reported the use of 'ambivalent communication' when talking about self-inflicted injuries. However, in an extensive review of the literature it was found that the phenomenon of ambivalent communication was only referred to briefly in Conterio et. al., (1998), Strong (1998), and in an article by Rutter (2000). However, in this study it emerged in the conversation between interviewer and participant as well as being frequently reported in the participants' accounts, it also emerged in the conversation between interviewer and participant.

There are other explanations for the use of ambivalent communication. It may be related to the stigma attached to self-harm which many of the participants mentioned as one reason why they kept their self-harm secret. Rutter (2000) identifies feelings of shame and of being 'bad' because of self-harm as a possible reason why explanations for injuries may be ambivalent or why injuries are frequently passed off as accidents.

4.1. 8 Self-harm and the attachment function

Many of the participants referred to their self-harm in terms of an attachment. For some this provided an important source of comfort and security. Gardener (2001) also found evidence of a similar attachment relationship between self-harmers and self-harm. In her account of therapy with clients who self-harm she provides an account of why equipment such as razors used for cutting may become 'transitional objects'. This she explains is because the 'objects' feel in the 'control' of the individual and provide relief or comfort. As Gardener (2001, p. 30) states:

If there is some change and the young person does feel relieved or altered by her use of the object, then the object itself will become further imbued with transformative properties, and her attachment to it will increase. The object becomes seen as a reliable friend, a constant companion that can ease the pain.

Strong (1998, p. 126), also refers to self-harm in terms of attachment and 'transitional objects' and comments 'razors become the transitional object and security blanket. It is always available, it can soothe or punish. It can be counted on unlike people.

Similarly, Conterio and Lader, (1998, p.21.), refer to razors in attachment terms

Strange as it may sound to the uninitiated, self-injury represents a frantic attempt by someone with low coping skills to "mother herself"...she feels alone, with no hope that a soothing presence will come "make it all better" Bodily care has been transformed into bodily harm; the razor blade becomes the wounding care-giver.

4.1. 9 Self-harm, attachment and neurobiological research

Neurobiological research has recently focussed on the impact of attachment on internal intrapersonal and neurobiological structure. For example, Schore (2003) is currently establishing the neuroaffective basis and processes underlying early 'attachment' experiences and identifying ways in which emotional and social interaction influences brain development. Schore's research suggests that adverse early experience has a

corresponding impact on neuroaffective structure and further, that this may be implicated in self-harm (Schoore 2003, in Gerhardt, 2004).

Recent research from various fields such as psychoanalysis and neurobiological research, now indicates that a 'real' relationship experience with a therapist can change attachment patterns and corresponding internal intrapersonal and neurobiological structure (Gerhardt, 2004; Schoore, 2003; Holmes, 2004).

For example, very recently, research from an integrated attachment paradigm (Holmes, 2004) has also associated early adversity such as inadequate interaction and care and touch in infancy, with disruption in the neurobiological and psychological systems that regulate attachment behavior and later self-harm. This is of particular relevance because it stresses the importance of the therapeutic relationship and its role in re-working past patterns and modifying neuro-affective structure (Schoore 2003, in Gerhardt, 2004).

It is also important to explore the individual's relationship to self-harm and consider the possibility of a special 'attachment'. As Farber (2006), points out:

... in spite of her view of the self-harm as negative and crazy, this secret part of the self is precious, and so anyone who tries to take it away from her will be met with ferocious resistance, and sometimes even more violent and dangerous symptoms. We need to understand the nature of the attachment to self-harm if we want to keep these patients from developing careers as mental patients, going from therapist to therapist, hospital to hospital (p.82).

4.10 Self-harm, dissociation and the separation of 'good-part-bad-part'

For some participants, self-harm was experienced as a 'secret bad part' of their personality that they kept separate from the 'good part'. In describing their experiences of self-harm some participants spoke about separating aspects of their personality and talked about their self-harm as a part of themselves that they kept separate, hidden and secret. Interestingly, although some participants referred to a 'secret bad part' of their

personality that they kept separate from the 'good part', some also referred to the 'bad self-harming part' as a part of themselves that they liked.

The separation of a 'self-harming part' of the self described by the participants and Smith (2006) is referred to in the literature as a form of dissociation (Cole & Putnam, 1992; Farber, 2000). There are various definitions of dissociation in the literature. For example, according to Bloch (1998, p. 113), dissociation is the process of 'separating, segregating, and isolating chunks of information, perceptions, memory of events, motivations and affects, thus preventing the integration of such information into a single body of knowledge and experience'.

Similarly, Farber (2006) suggests that this phenomenon of separating the self into a good self and a bad self-harming part, is

... The behavioural component of a part of the self with a set of needs, feelings, and perceptions that have been dissociated from the patient's total self-experience. It meets the needs of a part of the self that is at odds with the patient's ordinary experience of herself (p.83).

However, I feel that the concept of dissociation does not fully explain or truly capture the essence of the experience that participants described, if dissociation refers to an aspect of the self that is totally separated and not part of the individual's experience of self. These participants did not seem to be describing an experience of dissociation, because they described their relationship with this aspect of themselves. Furthermore, some felt a special attachment and described it in positive terms.

It can be argued that given the complex nature of the relationship to self-harm revealed by the participants, the concept of 'dissociation' does not fully account for the participants' description of the separation of a 'good part' and a 'bad self-harming' part. However, it may be possible to understand this separation of the 'self-harming part' using a broader conceptualization of dissociation. It is suggested that in order to account for the participant's experience, the concept of dissociation would need to include the experience of relating consciously to different aspects of the self that are experienced as separate.

This separation of 'good and bad' which many participants describe can also be accounted for in other ways that help to explain the relationship between childhood abuse and later self-harm. For example, Babiker & Arnold (1997, p.65), in their discussion of the separation of good and bad aspects, refer to this as a common phenomenon among children who experience abusive care. One explanation is the need to 'invent' an 'ideal parent' and to remove from awareness 'bad' parts of the parent's personality. Drawing on work by Bollas (1995), Babiker and Arnold (1997, p. 65) suggest a disruption in the process through which the child learns that both they and their parents/carers have a 'mixture of good and bad aspects'. One reason suggested is that when the real experience of a 'carer' is extremely bad, the child may not have ever experienced the carer as both good and bad and may not have the sense of 'safety' it needs in order to be able to explore ideas of good and bad. Or the child may need to locate the 'badness' in themselves in order to preserve the image of the 'good parent'. It is suggested that as a consequence of such experiences the individual may have a diminished capacity to fully integrate 'good and bad' aspects within a 'good enough' concept of self or other.

It also seems crucial to consider the role of the social context, in discussing this separation of 'good and bad' and the participants' need to present only a 'good image' to others, as well as concepts of 'good -girl' bad-girl'. It can be argued that this can not be adequately explained only in terms of individual psychological factors. As many authors have argued, self-harm is not only a personal and individual behaviour and needs to be viewed in relation to the social context (Babiker & Arnold, 1997; Conterio & Lader, 1998; Miller, 1994).

4.11 Self-harm and the social context

The importance of understanding self-harm with reference to the socio-economic and political context as well as in terms of individual and psychological factors was emphasized in this study. For example, as was previously argued, the classification system of individuals who self-harm that is based on categories such as 'level of social and academic functioning', can not be considered in isolation from the social context

and socio-economic factors such as economic and educational access, and disadvantage and discrimination.

As Babiker and Arnold (1997, p.37) say:

The language of injury [] may be a means by which some individuals 'speak' about what are social and political, as well as personal experiences. If we are to fully understand and work effectively with people who self-injure, we need to address the contribution of social and political factors to their situation and to the forces which drive them to express themselves by hurting their own bodies.

The importance of incorporating a feminist perspective into the understanding of self-harm is also emphasised by Hartman Mc Guilley (2004, p.80). She argues that what is a feminist analysis might 'shift the interpretation of psychiatric symptoms from one of dysfunction to one that translates their meaning into acts of survival, if not resistance' (In Levitt, J, Sansone, R & Cohn, 2004).

Discussion Part 2 : *Participants' experiences of treatment for self-harm*

4.2.1 Summary of participants' experiences of treatment

Most participants reported that their experiences of treatment had not been positive or useful. Three main themes relating to the participants' dissatisfaction with treatment emerged from their accounts. The themes relating to dissatisfaction with treatment which are discussed below were as follows:-

- 1) A clinical focus on stopping self-harm and in particular, the use of 'no self-harm contracts'.
- 2) A negative response from many clinicians in which a lack of understanding of self-harm and failure of empathy were central features.
- 3) A lack of cohesiveness in the treatment approach which was experienced as 'random' or 'hit & miss' by some participants.

4.2.2 Problems with a treatment emphasis on clinical methods to control self-harm and the use of 'no-harm contracts'

A major problem with an emphasis on self-harm control is that the no-harm approach may include very 'controlling' methods, particularly in institutions. As O'Donovan & Gijbels (2006, p.47) report, the 'no harm' approach is often based, on 'controlling' methods such as 'removing sharp objects from a person's possession and requesting that the patient remained in his or her nightclothes'. Further, the potential negative implications of a clinical focus on control may not be limited to the clients; staff may also experience negative consequences. O'Donovan & Gijbels (2006), found that the emphasis on methods to control self-harm had negative implications for the psychiatric staff who implemented the 'treatment', as well as for the clients. They also found that some of the psychiatric nursing staff 'were uncomfortable with this practice', but took part in it because 'it's hospital policy' (Ibid., p.47).

Another problem with the focus on self-harm control is that it may be inappropriate or contra-indicated for some clients. One of the reasons why it is argued that a clinical focus on control of self-harm may be inappropriate or contra-indicated, is because self-harm may be used to experience a perception of control. As some participants described, self-harm was used to provide a sense of control over events, over their own bodies and over others. For some it also represented an attempt to deal with experiences of extreme invalidation and feelings of powerlessness resulting from childhood physical and sexual abuse. For these clients attempts to control their self-harm may lead to unhelpful battles over 'control' or may result in further experiences of disempowerment (Strong, 1998; Alderman, 1998).

Most treatment programmes also include a sanction when the 'no harm contract' is broken. For some this may be experienced as punitive or as a punishment.

No self-harm contracts that are not negotiable also remove the validating power of being able to choose. The power of choice is important, as Alderman (1998, p. 3) points out:

... When an individual maintains the right to choose, choices are much more powerful and effective ... Telling an individual not to injure herself is both aversive and condescending.

Further, as many of the participants pointed out, self-harm may be experienced as an essential coping strategy. Pressure to stop self-harm before the individual feels ready, or compliance to contracts to please the therapist, may result in self-harm being hidden or substituted with something else equally harmful.

The focus on clinical methods to control self-harm and the use of 'no-harm contracts' continues to be dominant in self-harm treatment. This is in spite of research that suggests that for some self-harming clients it is inappropriate and may be contra-indicated (Strong, 1998; Harris, 2000; O'Donovan, et., al. 2006). The question this raises is why is the focus on clinical methods to reduce or eliminate self-harm still so dominant in treatment?

From a clinical perspective, professionals may experience a difficult challenge with clients who self-harm for a number of reasons. Current pressure in mental health services for evidence-based practice and an emphasis on practices where outcomes can be easily measured may lead clinicians to use the reduction of self-harm behaviour as a measure of the effectiveness of the treatment.

Further, as Korner (2005, p18) discusses:

Clinicians can be invested in clients not harming as a way of seeing that the work we do with our clients is making a difference. If we are too invested in getting our clients to not harm themselves before they are ready to stop then we will burn out because we will feel like we failed. Instead, learning to accept the client's pace and goals instead of our own is essential in any type of therapeutic encounter.

Professionals also have an ethical and legal duty of care and the use of 'no-self harm contracts' may provide reassurance to the professional. However, the dilemma is that for some clients such contracts may not be useful and may even be counter-productive and increase the risk of self-harm. Further, it can be argued that effective 'risk management' procedures may be more effective than the use of a 'no-harm contract'.

4.2.3 Why is there so frequently a negative response from clinicians?

Many participants reported a negative response to their self-harm from clinicians. Participants described an unwillingness to engage in an exploration of the meaning or function of the self-harm and a lack of empathy and compassion. Maintaining a stance of compassion and engagement can be very difficult when working with a client who self-harms. As Solomon and Farrand (1996), point out 'the power of an act of self-harm as a means of dealing with difficult emotions and experiences makes clinical management particularly difficult.

Korner (2005) sheds further light on the issue of negative responses in his discussion on an aspect of the clinical encounter with a client who self-harms. Korner (2005, p.18)

suggests that self-harm may be disturbing because 'it takes us beyond the zone of human comfort'. Further he suggests that self-harm may be presented as a behaviour with limited verbal communication that demands action.' Korner (2005, p.18) states that:

The likely response when we are presented with this is that we apply a technical approach: we may want to remove it or disarm it with available technologies.

As Korner (2005) argues, when looked at self-harm as a condition to 'fix' there is an expectation of 'cure' from physical treatments. In contrast, if self-harm can be understood as having a meaning or a function, it may be easier for the clinician to maintain an empathic engagement in a joint search to identify the meaning. A further explanation for the frequency of negative responses from clinicians is suggested by Korner (2005,p.18) who states:

When confronted by patients who act in self-destructive ways or impinge upon us as therapists there is a tendency to blame the patient and often the term 'personality disorder' is used in that way. This often masks the genuine suffering that affects these people and those around them."

4.2.4. A lack of cohesiveness in the provision of treatment

A lack of cohesiveness in the provision of treatment was also evident in some accounts. Natalie described her experience of treatment as 'random'. She believed that the nature of the service provided depended more on the particular view of the clinician, than on a specific model, guidelines or other informed treatment approach.

As Natalie said ;

It's just this random thing in the NHS where you end up with whoever you end up with, and what their opinion is, is what you get. (N. p.11./521-54).

The lack of a cohesive and informed approach was also identified as a serious problem in research by O'Donovan & Gijbels, (2006). This also found ' no consistent pattern to practice' and a ' lack of clear local and national policies and guidelines' (p.47).

4.2.5 Why does the treatment approach lack a comprehensive theoretical model of self-harm to guide and inform practice?

It can be argued that the participants' experiences of inappropriate treatment also reflect the lack of a comprehensive and cohesive theoretical model of self-harm that can inform and guide practice. Rather, it seems that the current treatment approach is being directed by a few 'theory-driven' models (Arnold, 1995). The theory driven approach was evident in the experiences of treatment reported by the participants who felt that their self-harm was ignored, or dismissed. As the participants described, when treatment is 'theory driven' and developed from theories of self-harm that conceptualise the 'self-harmer' as disordered or attention-seeking, it tends to result in a non-engagement with the self-harm and no exploration of the meaning and function of it for the client (Smith, Cox & Saradjian, 1998).

This 'dismissive' response may stem from the underpinning behaviourist theory, based on the view that function of self-harm is to gain attention and that withholding attention serves to eliminate this external 'positive reinforcement' (Tantam & Whittaker (1992) .

However, there are obvious problems with such an approach. Firstly, it is based on the assumption that self-harm serves only one function which is to gain attention. Secondly, it can be argued that withholding attention may lead to further self-harm if the function is to gain attention because the individual is failing to receive what they need. Further, experiencing others as withholding of attention may have a negative impact on the individual's self-concept and sense of self-worth and an increase in negative emotions, which are as likely to result in an increase in self-harm (Smith, Cox & Saradjian, 1998).

Another example of a 'theory driven' approach to self-harm is the view that all acts of self-harm can be conceptualized in terms of the degree of suicidal intention and according to this concept, can be located on a continuum with suicide. At one end, self-harm with no intent to die is located and at the other end there is self-harm as suicide (Fox & Hawton, 2004). This theory may result in a corresponding treatment intervention that may be more of a reflection of Fox and Hawton's views, rather than the experience of the individual.

A further example of the theory driven approach, is the view that self-harm is a symptom of personality disorder that may not be changeable and requires management. These theories all continue to inform treatment in the current 'theory driven' or 'one size fits all' approach and have led to the inappropriate treatment reported by so many participants.

4.2.6 The treatment intervention that participants said they would find helpful

In response to being asked about a treatment approach that might be helpful, many participants replied they would like opportunities to talk about and explore their self-harm and to be actively encouraged and supported in this process by an informed and respectful clinician. Participants were clear about the type of intervention they wanted.

They wanted less focus on stopping self-harm and contracts and a more informed, empathic and engaged response from clinicians. However, this was not the treatment approach they reported. In fact, many of their accounts of treatment reflected the continuing tendency of professionals to not ask, not listen and sometimes not look. In

short, some participants suggested that the clinicians did not give any recognition to them as individuals who had insight into their own self-harm or any willingness to engage in a collaborative exploration of its meaning and function.

In the light of participants' reports of treatment, it is argued here, that the approach to self-harm needs to be informed by an understanding of the many different functions of self-harm and the specific function/s for the client. If the therapeutic intervention is not based on an exploration and identification of the function, then the treatment response may be inappropriate for the clients whose self-harm does not 'fit' the specific function dictated by the clinician's theory. For example, when treatment is based on the theory that self-harm is on a continuum with suicide and that all self-harm presents a risk, then the corresponding technique is often a focus on self-harm risk management or control. However, if the self-harm is not associated with suicide, this is not an appropriate response to self-harm that is associated with wanting to survive, or to feel better as Laticia said. Her self-harm made her feel better:

It makes me feel better [] I don't want to die [] I just want to feel better.

(L., p.4 / 183)

Conversely, if the self-harm is associated with suicide then suicide risk management strategies may be appropriate. In short, the therapeutic response needs to fit the identified function of self-harm. Further, it is argued that the therapeutic approach needs to remain adaptive and to change or evolve in response to the corresponding changes in the function served by the self-harm.

4.2.7 The need for a comprehensive and cohesive framework for self-harm theory and practice

The experiences of treatment described by participants have highlighted the need for a more cohesive approach drawn from a more comprehensive and informed theoretical understanding of the many functions of self-harm. It is suggested here, that what is also needed in addition to guidelines and policies, is a unifying conceptual framework that can also draw from diverse sources to inform and guide practice. There is a great deal of current research that may add to the knowledge base for understanding self-harms

and it seems pragmatic to draw from this. Current research from diverse fields such as affective neuropsychological, psychoanalysis, developmental psychopathology and psychology may have a lot to offer in the development of a more comprehensive model of self-harm. However, at present this is not being currently utilised. This became more evident following a review of the most recent developments in treatment programmes designed for self-harm, where similar problems to the ones reported by the participants were identified.

4.2.8 Evaluation of new developments in treatment programmes designed for clients who self-harm

There have been a few treatment programmes that have been developed specifically for clients who self-harm. These include 'S.A.F.E' (Self-Abuse-Finally-Ends) developed by Conterio and Lader (1998). Conterio et. al., (1998, p.2) describe 'S.A.F.E' as the 'first self-injury treatment program offering groundbreaking help for a dangerous and increasingly wide spread syndrome'. However, one of the problems with this treatment programme is again the requirement of a commitment to a 'no self-harm contract.' The client is required to sign the following statement before acceptance onto the S.A.F.E programme :

I recognize that self-injury interferes with all aspects of my life.....I agree to no self-damaging ...failure to comply may lead to dismissal from the programme (p.297).

The S.A.F.E. approach seems, like many others, to regard all clients who self-harm as a homogeneous group rather than basing treatment on the different functions that the self-harm serves for the individual. Further, S.A.F.E. is based on the assumption that all self-harm is dangerous. As Conterio et. al., 1998, say ' ... we continue to believe that the best way for the care provider to view self-injury is as a dangerous, ultimately futile, action symptom that disrupts lives' (p.200).

Interestingly, in a somewhat contradictory statement, given the stated view of self-harm as dangerous and to be treated with a contract, Conterio et. al., (1998, p.200) also advise against putting self-harmers in to one category. They state that:

We believe that ‘lumping self-injurers into one category would lend credence to the view that the behaviour is a homogeneous, monolithic problem or disorder that can be understood in isolation. In turn, this would make it more difficult for self-injurers to get the holistic, individualised treatment they need. The risk is that people would try to develop one-size fits-all medical recommendations for the population, ones that would overlook the context in which the behaviour developed.

4.2.9 The ‘harm reduction approach’ (Pembroke, 1998,2007)

An alternative approach is the ‘harm reduction approach’, advocated by Pembroke (1998; 2007). According to Pembroke, this approach is based on an acceptance of self-harm and an acknowledgment of its importance as a coping strategy. As Pembroke (2007) says: It is about accepting the need to self harm as a valid method of survival until survival is possible by other means. This does not condone or encourage self-injury; it’s about facing the reality of maximising safety in the event of self-harm

This approach has been misrepresented in the media where it has been described in terms such as ‘NHS cutting rooms’(See Appendix 13). This misrepresentation has suggested all that is offered is a ‘safe place to cut’ and safe equipment to cut with. However, as Pembroke (2007) argues, the ethos is very different. One particularly, interesting aspect of this approach is as Pembroke (ibid.) says:

That it promotes thinking about limiting the damage, attempting compromises with oneself, and prevention where that is possible. It promotes self-management, which is pretty crucial in the area of self-harm because many people do not find appropriate support within NHS services.

As Pembroke points out, thinking about self-management and self-care is another important aspect of this approach. In addition to the harm- minimisation aspect of the

'harm reduction approach, there may be other less obvious therapeutic benefits. These include the acceptance, validation, informed choice and empowerment, as well as the focus on self-care. Furthermore, the focus on thinking, perhaps initially thinking about risk minimisation, and the introduction of a time gap in which to think before acting, may develop other important capacities.

The importance of time for thought before action and opportunities and the capacity to reflect have been emphasised in recent self-harm research (Fonagy & Bateman, 2006;; Holmes 2004). It is possible that this research, such as that on (Fonagy et al 2006) and reflective function (Holmes, 2004), could be drawn on to further develop the theoretical base and treatment based on a 'harm minimisation approach'.

Again, this highlights the need for collaboration and a sharing of information across disciplines and perspectives. If researchers and clinicians, the 'experts by profession', could collaborate with 'experts by experience' and share and synthesise information, this could offer a way forward from the current polarisation that is evident in both self-harm theory and practice. At one extreme are those who view self-harm as a sane response to an 'insane society', and as Arnold et., al, (1997) point out, do not acknowledge the negative aspects. At the other extreme, are those who have not moved forward from the traditional stereotypical assumptions about self-harm.

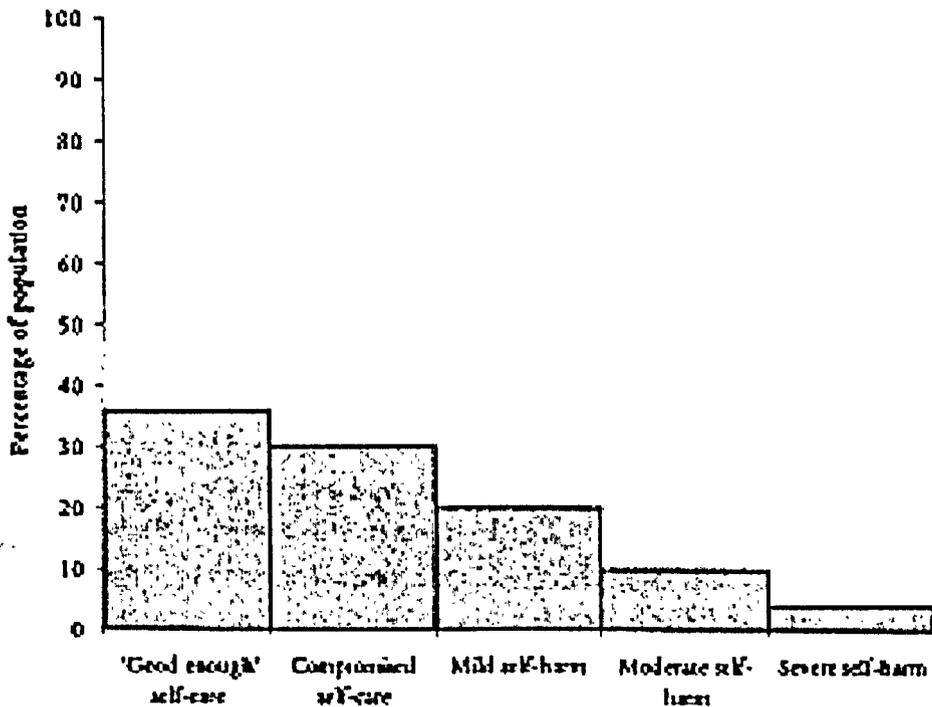
There is a need for the development of self-harm theory and practice that offers new ideas and approaches . As Turp (2003, p.30), states:

Many practitioners express strong support for this perspective, echoing and expanding on my desire to create a conceptual space in which to discuss behaviour which expresses self-harming tendencies but falls outside current stereotypes of self-harm.

4.2. 10. A continuum model of self-harm (Turp, 2003)

In an attempt to offer an alternative conceptualisation of self-harm, Turp (2003) proposes a 'self-care continuum' of self-harm. (See figure 1 below). At one end of the continuum is 'good enough self-care,' across to 'compromised self-care' to 'moderate self-harm' and finally to 'severe self-harm'.

Figure 1: A continuum model of self-harm



It would seem, as Turp argues, that there is a great need for new theories of self-harm that offer alternatives to the current approaches to treatment. However, I would argue that the self-care continuum (Turp, 2003) restricts the function of self-care to just one function. As the participants in this present study have demonstrated, self-harm serves

various functions other than self-care. Furthermore, the 'self-care continuum' does not include attempted and actual suicide, although self-harm is generally not associated with suicide, sometimes it is.

Self-harm may be associated with suicide. Further as the client material in this portfolio demonstrates, the functions of self-harm for the individual may shift rapidly from suicide to other functions such as control, communication or self-care. (See Section C). It seems important for this to be reflected in a conceptual model of self-harm, especially in one such as Turp's continuum that is developed to inform and guide treatment. It is argued that an appropriate treatment response for self-harm where the function is self-care, is likely to be different to the response required when the function is suicide. Here self-harm risk management and methods of clinical control may be essential, whereas if the function is control, this approach may be contra-indicated (Strong, 1998).

It can be argued that a model that offers an approach to self-harm treatment needs to be conceptualised in a way that reflects the wide range of functions, including self-care and suicide. Currently, there is not, to my knowledge, a model that can account for the range of potential functions and offer corresponding therapeutic interventions based on the identified functions of self-harm for the individual client.

In response to what is seen as an urgent need for a new way of conceptualising self-harm, as well as and the need for a more comprehensive and cohesive framework, I have developed a new model of self-harm: Self-Harm - Informed Functional Theory (*SHIFT*) & a corresponding therapeutic treatment approach : Function Informed Technique (FIT) (See figure 2, below.)

Chapter 5

5. A new model of self-harm: Self-Harm- Informed Functional Theory & Function Informed Technique (SHIFT & FIT)

This present research has highlighted the need for a new model of self-harm to guide practice. It has been argued that a new approach to treatment based on an exploration and identification of the ‘function’ of self-harm would provide an alternative to current approaches that emphasise stopping self-harm. The *SHIFT* model presented in this Chapter aims to provide a framework for treatment based on the identification of the function of self-harm for the individual. The model is outlined below and is followed by an account of how it can be used to guide and inform the therapeutic approach.

5.1 The SHIFT continuum

The main concept of ‘*SHIFT & FIT*’ is of a broad *SHIFT* continuum shown in figure 2.

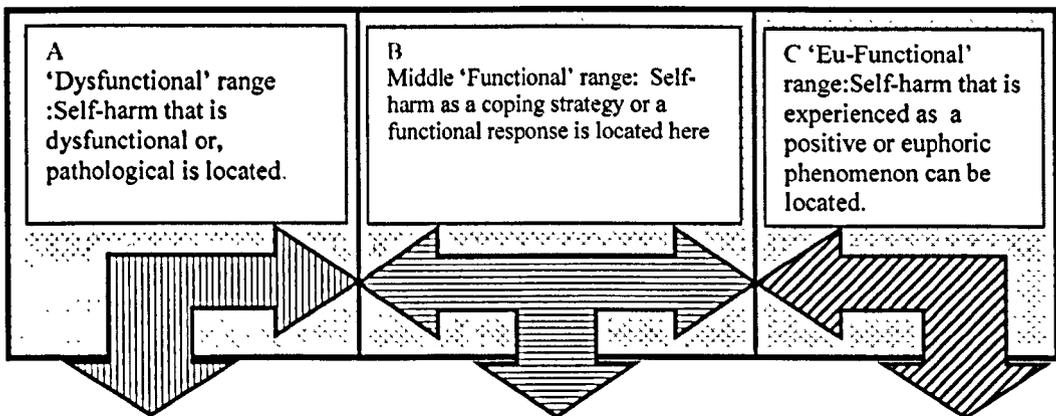


Figure 2: The SHIFT continuum

In *Figure 2*, the section of the *SHIFT* continuum that has an arrow shaded with horizontal stripes (B) represents the middle range of the continuum where self-harm that serves a function for the individual is located. Functions of self-harm that can be located here include self-harm as a coping strategy or a functional response to a deficit

in dysregulation. One example could be self-harm that is used as a strategy for 'self-soothing' in response to a deficit in this capacity (Gallop et. al., .2001). Self-harm that functions as a form of emotional regulation (Linehan, 1993), can also be located in this middle range of the self-harm continuum. This functional range on the *SHIFT* continuum, could also incorporate the category of 'episodic' self-harm proposed by Simeon & Favazza, 2001).

The arrow shaded in vertical stripes (A), is where self-harm that is dysfunctional or, pathological is located. This includes examples of mutilation (e.g., auto castration, self-nucleation) that tends not to be repetitive and is often linked to a psychotic episode. This range of the *SHIFT* continuum can also accommodate the categories of 'stereotypic and major' proposed by Simeon & Favazza, (2001).

Compulsive self-harm could be located on the *SHIFT* continuum, between functional and dysfunctional. This could include self-harm that is experienced as 'addictive' or compulsive such as compulsive skin picking or trichotillomania. may not be experienced as functional, but is different from self-harm at the dysfunctional end such as auto castration. At the other extreme where the arrow shaded is diagonal stripes (C), self-harm that is experienced as a positive phenomenon can be located. This includes self-harm that is experienced as a pleasurable, exciting or euphoric experience phenomenon.

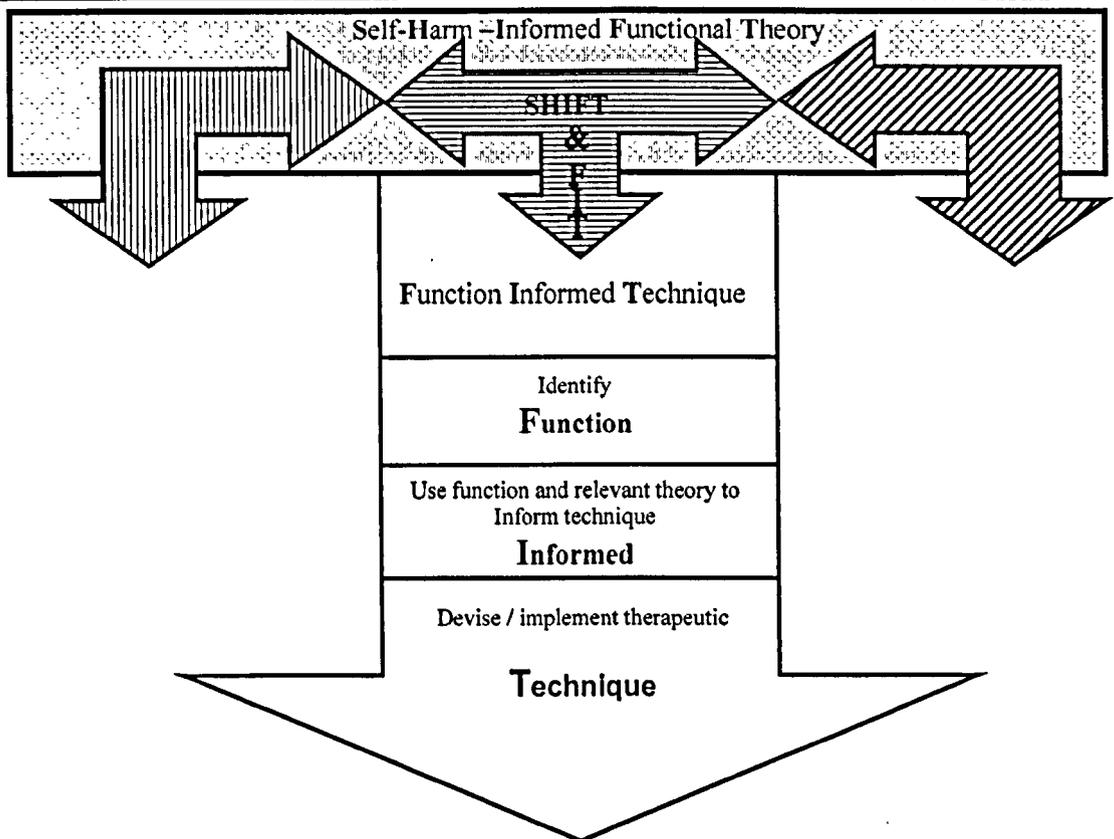
The *SHIFT* continuum can also accommodate changes in the experience of self-harm. For example, self-harm that is initially a functional coping response may become increasingly experienced as an addiction or out of control and less functional for the individual. This can be represented in terms of movement along the continuum from the middle of the functional range towards the dysfunctional range.

On the *SHIFT* continuum, other categories of self-harm such as that categorized by Suyemoto ET. al, (1998) as 'socially sanctioned self-harm' can also be located. Socially sanctioned self-harm includes body piercing which is separate from self-harm such as cutting, which is not regarded as socially acceptable. (Suyemoto & Kountz 1998, In Yates, 2004.

5.2 Function Informed Technique (FIT).

The *SHIFT* & FIT model also provides a base from which therapeutic techniques that correspond with or fit the identified functions of self-harm can be developed: Function Informed Technique (FIT). From the perspective of the *SHIFT* model, the suggested approach to self-harm is to initially explore the meaning and function/s of the self-harm. Once a function has been identified it is possible to develop corresponding therapeutic techniques.

Figure 3 below illustrates the stages in developing a Function Informed Technique



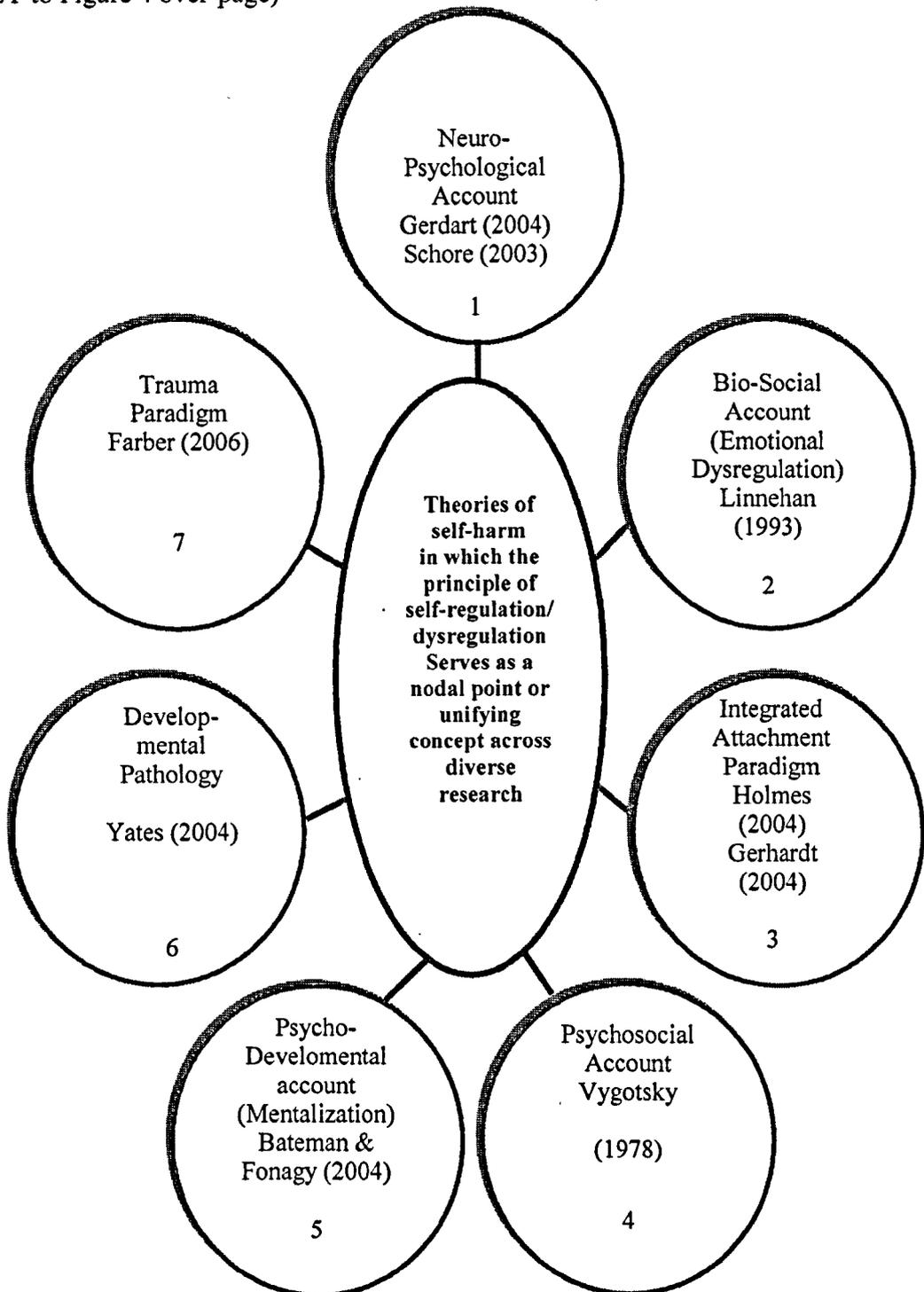
The process of identifying and or developing a 'FIT' can be guided and informed by relevant theory and research from diverse fields, because the model is not constrained by any one theoretical paradigm or research perspective. The *SHIFT* framework can also utilise research from diverse perspectives such as that of the individual self-harmer, feminists, academics, psychiatrists, psychologists and researcher-practitioners

5.3. The theoretical principles that underlie the *SHIFT* model

The conceptual framework of the *SHIFT* model is broadly based on the principle of self-regulation and dysregulation. Self-harm may function as an adaptive response to a dysregulation in the self-regulatory processes that underlie behavior. It can also be a dysfunctional or eufunctional phenomenon. The general perspective of *SHIFT* is 'phenomenological' in the sense that it does not have a base in a specific theory or perspective and self-harm is explored from the individuals' perspective. However, as this present study found, in addition to the need to understand self-harm from the individual's perspective, there is also a need for a cohesive conceptual framework for self-harm. Here the principle of self-regulation/ dysregulation was utilized because it serves as a unifying concept, or nodal point for a wide range of self-harm research. (See Figure 4 and key below).

Figure 4: Theoretical principle of self-regulation/ dysregulation utilized in 'Shift & Fit' model which serves as a unifying concept for diverse research

(KEY to Figure 4 over-page)



Key

Theories of self-harm in which the principle of self-regulation/dysregulation serves as a nodal point across diverse research

- 1, 6 Dysregulation in neuropsychological, cognitive & emotional functioning
- 1, 5, 6 Dysregulation in processes underlying capacity to process experience
- 1, 6 .7 Dysregulation in processes required to maintain a cohesive sense of identity
- 4 Dysregulation in psycho-social functioning
- 1,5,6 Dysregulation in impulse control
- 1,3 Dysregulation in attachment behaviour
- 1,2,7 Emotional dysregulation

Self-regulation is difficult to define succinctly because the definition differs across the various theoretical perspectives. (Carver & Scheier, 1998; Vygotsky, 1978). For example, Carver & Scheier (1998, p.2), define self-regulation in psychobiological terms as an 'internal guidance system which is inherent in the way that living beings are organized.' Whereas, from the socio-cultural perspective of Vygotsky, (1978), self-regulatory processes are seen as higher regulatory capacities that are developed through interaction with others. These regulatory processes enable an individual to respond in an organized way to the flow of information (Vygotsky, 1978). Self-regulatory capacities, according to Vygotsky, enable one to intentionally respond and process information in relation to its meaning and relevance to functioning in interaction with one's socio-cultural and historical context.

Other definitions define self-regulation in terms of specific function such as the regulation of attachment (Holmes, 2004, Bateman & Fonagy, 2004). In terms of the *SHIFT* model, a combination of the socio-cultural, biological and interpersonal definitions of self-regulation, seems the most relevant because this broad based definition can accommodate the research from diverse fields which relate self-harm to various disruptions in the neurobiological, behavioural, cognitive, social and emotional

processes that enable an individual to regulate experience in interaction with the environment.

Self regulation is a key principle in Yates' (2004) account of self-harm which presents a developmental account of self-harm from a trauma paradigm. Here the underlying concept of self-harm is as compensatory regulatory strategy that is an adaptation to trauma. Yates (2004) suggests that self-harm functions as a compensatory regulatory and relational strategy as an adaptive response to trauma and the related impact on various areas of functioning such as motivation, emotions, and interpersonal relationships.

Emotional dysregulation is also identified as a key principle by Linehan, (1993), in her bio-social account of self-harm. According to Linehan, (1993), the interaction between an innately vulnerable individual and their interaction with an 'invalidating environment' results in emotional dysregulation. Linehan, proposes that in the absence of an effective emotional regulatory system, self-harm provides an alternative method of emotional regulation (Linehan, 1993).

From a neuropsychological perspective, research by Schore, (2003) has shown that both environmental adversity and trauma shape the development of neurological structures and have a corresponding impact on the underlying neuro-affective and biological processes. Again a dysregulation in various neuroaffective and biological processes are implicated in self-harm (Gerhardt 2004; Schore, 2003).

From an integrated attachment theory paradigm, which is based on a synthesis of neurobiological, psychological and psychoanalytical theory, it is also proposed that insufficient early emotional and social interaction results in dysregulation of attachment. According to Holmes, (2004) and Gerhardt (2004) the dsregulation of attachment behaviour is the consequence of disruption in both neurobiological and psychological processes that regulate behaviour and is related to the use of self-harm in an adaptive regulatory capacity (Holmes, 2004).

The concept of self-harm as an adaptation to underlying dysregulation, is also identified by Bateman & Fonagy, (2004) in relation to . The concept of refers to the self-regulatory processes underlying the ability to process experience and to use

thought and language to regulate the emotional response. Bateman & Fonagy, (2004) propose that a disruption in the capacity to mentalise, may result in the use of self-harm as a compensatory adaptation. Further, Bateman & Fonagy, (2004) et al., propose that increasing the capacity to 'mentalise', reduces the need to self-harm (In Nathan, 2006).

A similar concept to is the notion of the 'reflective function' (Holmes, 2004). This is also based on the principle of a disruption in the regulatory processes that enable an individual to process experience using thought and language, rather than action. The inability to use thought and language, rather than action, has been related to self-harm in a number of accounts (Farber, 2006; Conterio et., al.1998, Dieter et.,al, 2000).

From the developmental paradigm of Vygotsky (1978), it is proposed that self-regulatory capacities are developed in interaction. However Vygotsky considers the interaction of the individual in relation to the wider social cultural and historical context. According to Vygotsky, self-regulatory abilities originate in social interactions and only later become internalized and independently used (Vygotsky, 1978).

Vygotsky suggests, that if the individual's social contexts does not facilitate the development of self-regulatory capacities, the individual will be incapable of intentional actions and caught in a pattern of responses to ever-changing external stimulation.

Vygotsky does not have a model of self-harm, but his theory can be drawn from in developing a psychosocial account of self-harm as an adaptation to dysregulation.

It is suggested that social forces and social processes may result in dysregulation in the processes that enable an individual to maintain a cohesive sense of self and self-identity. For example, in the present study, the participant's described a function of self-harm in relation to self-identity which it is argued is inextricably linked to the social context. Veronica described the need to be 'good' to be compliant and 'never say no'. It is suggested that the need to 'be good', may be related to the social pressure to conform to the gender stereotype of the 'good-girl' who is passive and compliant. Veronica said that she 'always had to be the nice, caring one who never said no' and she described the separation of 'good and bad parts of herself. Self-harm then functioned as the 'bad-part' which was kept secret from others.

The accounts of self-harm briefly referred to above are all based on the key principle of self-regulation. This has clear implications for the development of self-harm theory and requires further research to explore the mechanisms and processes involved.

5.4 Exploration of the functions of self-harm and identification of relevant theory to inform treatment

Relevant theory can also be utilised to inform the development of a FIT. From the perspective of the *SHIFT* model it is proposed that the therapeutic approach begins with an exploration of the function and meaning of self-harm from the client's perspective, rather than from a specific theoretical perspective.

It is suggested that by exploring the specific functions of self-harm and identifying the ways in which it is used in a regulatory capacity, or as a way of coping, or compensating for a developmental disruption, it is possible to develop an appropriate intervention or Function Informed Technique. (FIT).

After a function/s has been identified, one could then draw from the most relevant theory and research in order to inform and guide the treatment focus. It will then be possible to identify or devise therapeutic interventions to fit the function and address the underlying dysregulation, or promote development in a specific area of functioning. In this sense the *SHIFT* model aims to move away from 'the one-size fits all' approach that currently characterises self-harm treatment (Turp, 2003). This model 'fits' the therapy to the individual client, rather than trying to 'fit' the client to the therapy, which as the participants in this study reported, leads to inappropriate treatment.

5.5. Therapeutic interventions and techniques based on the identified function of self-harm

As outlined earlier in this research the primary assumption of the *SHIFT* model is that it is the individual's experience and perceptions of self-harm that are central to understanding and further it is this that guides the approach to treatment, rather than the clinician's interpretation or specific theory or perspective. The identification of

appropriate therapeutic techniques based on the functions reported by the participant's are outlined below.

5.6 An outline of Function Informed Techniques (FIT's) based on the functions of self-harm identified by participants

From the unifying perspective of the *SHIFT* model, having identified a potential function of self-harm it is then possible to move to a focus on specific strategies that fit the function, or offer a way to promote development in a specific area, or compensate for a deficit. For example having identified a deficit in (Fonagy, et., al., 2004), an appropriate intervention to help the client develop this capacity can then be developed .

5.7 Techniques for use when the function of self-harm is comfort and self soothing

An important part of therapy for clients who use self-harm to achieve comfort or self-soothing is to explore alternative self-soothing. For example, Farber (2000) describes a range of alternative techniques that the client can be encouraged to experiment with. These include techniques such as those that stimulate circulation such as those showers with alternating hot/cold water, or rubbing skin with a body brush, massage. Alternatively, relaxation strategies may help to produce the calming sensation that many participants referred to as an important function of their self-harm.

5.8 Techniques for relaxation

Other techniques that promote self-care and self-nurture include experiments with diet and 'making smoothies' etc. Techniques for relaxation such as 'bubble baths' exercise, yoga, deep breathing may also be strategies clients have not tried and could experiment with. However, as with all therapeutic techniques it is important that these are tailored to the client. The whole area of body focussed self-care is sometimes very complex for individuals who self-harm, particularly if their experience of care is linked to abuse, as the case material on 'Tracey' illustrates. (See case study in 'Section C' of this portfolio).

Some clients may not be aware that they have not developed a capacity for self-care because neglect and 'self-neglect' may be what feels 'normal' and some may not know what the experience of self-care is. One suggested initial strategy is to explore the concept of self-care using the continuum outlined by Turp, (2003). Then in collaboration with the client, identifying manageable areas for development may be an effective next step. For clients for whom self-care is extremely compromised and for whom an initial focus on body focused techniques may be experienced as too challenging, alternative tailored techniques will be needed. Thus for some clients, self-care might need to begin very gradually with opportunities to just explore and imagine how self-care might actually feel. As a number of authors have pointed out, in some cases, establishing self-care can be a long and complex process (Gallop & Everett, 2001).

5.9 FIT's for 'anger turned inwards'

A common feature of anger turned inwards is the presence of an internal negative 'voice' or self-hostile dialogue which can help to maintain the self-harming behavior. Here, cognitive-behavioural approaches can be utilised to focus on the client's 'inner scripts', in other words, the habitual thought patterns about self and self in relation to others, such as the belief that 'no one would love me if they really got to know me'.

Techniques such as learning to replace this negative 'voice' with a supportive, encouraging, nurturing one, can also be very effective alongside teaching and encouraging acceptance of negative feelings

5.10 Regulating and expressing anger : Alternative strategies for the effective management and expression of anger.

There are a range of strategies that can provide an alternative to self-harm as a method of management and expression of anger. Cathartic strategies may be appropriate, as well as training to identify emotions such as anger and the sensations associated with it. Clients may need help learning to accept negative emotions and in using language to communicate these as well as help in identifying the specific causes and 'triggers' for their anger. Other techniques include modeling and communicating that the whole

range of feelings, both positive and negative, are acceptable to the therapist, and that safe forms of expression can be found, as well as exploring the possible reasons for the difficulties in expression of anger.

5.11 Difficulty in the ability to identify and name emotions (alexithymia)

Alexithymia is viewed as a developmental deficit and has been related to self-harm (Zlotnick et al., 1996). Some participants described a difficulty in identifying emotions and, as they reported, self-harm was used to compensate for this.

One of the aims with clients who find it hard to identify emotion is to use strategies such as those outlined by Linehan (1993). As Farber (2006) suggests:

... helping them to write down their thoughts and feelings in the therapist's presence during a session is a very powerful intervention. It can promote freer associations, help them identify and tolerate affect states, and provides containment for their impulses, and promotes more reflective thinking (p.82).

In developing techniques to promote the ability to identify emotions, it may also be helpful to ask the client to focus on the physical sensations of the emotion. Sometimes even these cannot be identified – or the sensations can be felt but there is no translation into understanding emotional states. If this is the case then it may be useful for the therapist to help the client to articulate the experience.

5.12 Use of alternative forms of client-therapist interaction and communication that require the use of thought and language, rather than action

Examples of techniques that may facilitate the development of the capacity to mentalise, include the use of other forms of client-therapist communication that require thought and language, rather than action. For example, the use of telephone or e-mail contact in addition too or instead of session contact may promote the ability to use reflection, thought and language to process experience, rather than action.

5.13 Self-harm as manipulation

When the communication is directed at others, the self-harm is often seen as manipulative. However, it can be argued that manipulation is usually an indirect attempt to meet a need. Therefore if the client has the opportunity to learn that direct requests will be listened to and addressed, it is possible that the need for manipulation or indirect attempts to influence behaviour may no longer be needed.

5.14 Self-harm and relationships to self and others

Some participants talked about their self-harm in positive ways as a 'eu-functional' behaviour that provided experiences of euphoria, excitement and pleasure. Others reported a positive relationship to their self-harm. This has important implications for treatment, and again emphasises the problems of an approach that focuses mainly on stopping self-harm.

5.15 The 'attachment' function of self-harm and indicators for the therapeutic relationship with clients who self-harm

Some participants described how their self-harm functioned as an 'attachment' and razors became 'transitional objects' (Gardener, 2001). From the perspective of the *SHIFT* framework, having identified the function as 'attachment-related', relevant theoretical perspectives and research can be identified and utilised to guide and inform the therapeutic approach and identify a FIT. For example, the treatment approach could be informed by drawing from the 'integrated attachment theory paradigm' (Holmes, 2004).

Holmes (2004) regards self-harm in terms of disordered attachment, or as dysregulation of attachment. By drawing on this theory, the corresponding treatment approach indicated could be to focus on the therapeutic relationship whereby the therapist could function as a 'regulatory partner'.

Some of the identified functions of self-harm indicate the need for a therapeutic relationship in which new patterns of relating can be developed. There are certain

therapist characteristics that seem to be important in establishing a compensatory relationship which facilitates the development of a secure attachment (Holmes, 2004). For example, a number of researchers have emphasised the need for a therapist who is available to the client to facilitate the development of a safe and secure attachment (Holmes, 2004). This contrasts with the traditional approach to clients who self-harm advocated by many clinicians who use withdrawal of attention to avoid re-enforcing the behaviour. Likewise, attempts to maintain therapeutic 'distance' and 'objectivity' may not be appropriate for clients who need the experience of 'real' interaction with an engaged and engaging therapist that results in structural change (Gerhardt, 2004).

However, when forming and interpreting this relationship, as Babiker & Arnold (1997, p. 137) advise, it is important not to 'address self-injury primarily in terms of "transference interpretations" or suggestions that this behaviour is directed primarily at the therapist as these are not particularly helpful in this type of work'. A similar point is made by Holmes, L., (2007), who advises against encouraging a focus on the transference, especially when clients have experienced abuse or neglect, because this may result in the therapist being overwhelmingly experienced as the abusive or neglectful parent. (Private conversation)

5.16 FIT Integrating aspects of the personality

The separation of the 'bad self-harming' part revealed by participants, again indicates possible therapeutic intervention. For example, therapeutic interventions that provide a new experience of interpersonal relating may facilitate a greater sense of self-coherence and facilitate the integration of separate 'parts' if appropriate. A technique that may be effective is an extension of Transactional Analysis (Berne, 1968). Here the client describes and names different aspects of her personality and then gives them a 'voice', or lines to speak as if they were characters in a play. It is then possible to focus on the client's ability to control or self-regulate state changes.

Siegel (1999) makes suggestions for interventions with children with dissociative disorders that can be adapted for working with self-harming clients. According to Siegel (1999, p. 336), 'interpersonal processes can facilitate integration by altering the restrictive ways in which the mind may have come to organize itself'.

Recommendations include the use of Gestalt or drama techniques to facilitate the expression of opposing feelings which may stimulate greater self-integration.

5.17 SHIFT and the implications for border line personality disorder (BPD) and self-harm

The *SHIFT* model may also provide a new approach to thinking about self-harm and BPD and it may be possible to generate a range of alternative therapeutic interventions. From the psychiatric perspective self-harm is regarded as a symptom of personality disorder, but it can also be accounted for in terms of self-regulation and dysregulation. The behaviour and difficulties associated with a BPD diagnosis have been accounted for in various research in terms of dysregulation. This includes: dysregulation in the processes that enable the individual to regulate emotion (Linnehan, 1993); Dysregulation in the ability to regulate relationships (Holmes, 2004); Dysregulation in the regulation of behaviour and impulse control (Bateman & Fonagy, 2004); Dysregulation in the regulatory processes underlying the ability to process experience and to use thought and language to regulate affect (Bateman & Fonagy, 2004). The difficulties related to self-identity in BPD can also be accounted for in terms of dysregulation in the processes that enable an individual to maintain an integrated and stable sense of self.

It can be argued that if one regards self-harm in BPD in terms of regulatory processes, it may then be possible to identify a range of corresponding therapeutic interventions and techniques based on the identified function of self-harm in BPD. This is important because there has been a tendency to see self-harm in BPD as a symptom to be managed rather than changed and consequently the treatment approach has been limited (Turp, 2003). However, if the behaviour associated with BPD, such as self-harm, is seen as a method of self regulation, then this may encourage the development of new treatment initiatives.

5.18 'Mentalization' and BPD

As discussed, the recent research on by Bateman & Fonagy, (2004) and the 'reflective function' (Holmes, 2004) indicates a deficit in the regulatory processes underlying the ability to process experience and to use thought and language to regulate affect. This dysregulation may be linked to self-harm as well as other behaviour associated with BPD. In terms of the *SHIFT* model, having identified the function of self-harm and the underlying dysregulation or deficit, it is then possible to implement an appropriate therapeutic response. For example, the treatment approach such as that devised by Batemen et., al. (2004) could be adapted.

5.19 Self-identity in BPD and dysregulation

It is also suggested that it is possible to account for other aspects of BPD functioning in terms of the principle of dysregulation such as the 'unstable sense of self'. This constitutes a key criteria in the DSM 3 (r) diagnostic classification system (APA, 1994), but like self-harm can also be explained in terms of dysregulation.

5.20 SHIFT and the concept of 'backlash'

The *SHIFT* model also offers an alternative to the generally negative approach to phenomenon such as 'backlash'. From the perspective of *SHIFT* the focus would be on the exploration of the function and meaning of 'backlash'. For example it may relate to the pace of progress and change and can provide an indication of the need to consider and possibly adjust the pace. Or it may be an important part of the process because for many clients movement forwards is not linear and forward steps may be followed by regressions or collapses.

A positive approach to set-backs or 'backlash' is important in working with clients who self-harm because it may be necessary for the client to resume self-harm for a while and the danger is that this may be interpreted only in negative terms such as resistance or non-compliance. For example, in DBT or the SAFE approach, if self-harm is resumed or increased during therapy it tends to be seen in negative terms such as non-compliance with 'no harm' contracts, or 'therapy interfering behaviour' such as an

attempt to sabotage or undermine the therapist (Linehan, 1993). The consequences are often negative too such as enforced breaks from therapy and termination of treatment (Linehan, 1993; Conterio & Lader, 1998). Further, there may be other negative consequences for both therapist and client such as feelings of failure, disappointment and rejection.

5.21 Implications of SHIFT model for a range of other proposed strategies for working with self-harm

The *SHIFT* model has some clear implications for practice and emphasises the importance of techniques that are informed by a understanding of the function of self-harm. For example, the use of ‘cathartic methods’ is a common strategy used by therapists working with a client who self-harms. One example is the use of cathartic methods such as breaking plates, or ripping newspaper. However, it can be argued that while this strategy may be useful if the function of self-harm is identified as ‘expression of anger’, this strategy may be counter-productive for those whose self-harm is not related to difficulties in expression of anger.

Another example is that a cathartic strategy may be inappropriate if the function of self-harm is related to a difficulty in using language and thought, rather than action to express emotion. If this is the function then the capacity that needs to be developed is using thought and language to manage and express emotion. As Conterio, Lader and Kingston Bloom (1998) point out, if techniques based on action rather than language are used, the message that may be conveyed is ‘that every time a patient feels something she should act’, rather than think or talk.

SHIFT also has implications for a range of other proposed strategies for working with self-harm. A range of interventions for self-harm have recently been suggested (Williams, 1997), such as holding ice-cubes or drawing wounds on the skin with a red marker. However, it can be argued that these may also be counterproductive for some individuals unless the function of self-harm is ‘expression of emotion’. Again, if the function of self-harm is communication, then strategies such as this may reinforce the idea that only action can be used to communicate, rather than promoting thought and language. Similarly, if the self-harm is associated with suicide then risk management

strategies and techniques for behavioral control may be appropriate.

5.22 An introduction to 'Shift' in practice

The *SHIFT* model highlights the importance of individually tailored treatment interventions based on an understanding of the function of the self-harm and in the following Chapter of this research project the practical application of *SHIFT* is illustrated using client material. The client material is an extract from part of a session and highlights the importance of exploring the function of self-harm for the individual. This is then followed by an overall evaluation of the research project in Chapter 7.

'SHIFT' IN PRACTICE: The practical application of the 'SHIFT & FIT' model in work with 'Carlos'

6.1 Introduction

The following extract illustrates the practical application of *SHIFT* with 'Carlos' a client who self-harms. Carlos is 19 and self-referred because he wanted counselling in order to become more stable and to be considered 'a fit person' and gain sole custody of his baby son. The context of the work is a day centre in London for homeless people between the ages of 16 and 21 years. Carlos had a psychiatric diagnosis of border line personality disorder (APA, 1994). The aim of the initial work with Carlos was to address his chronic self-harm and impulsive high risk behaviour.

The DBT model (Linehan, 1993), provides quite a comprehensive treatment package for clients who have BPD (Barlow, 2001). However, I found that the DBT model was not particularly appropriate and had a number of limitations. Consequently it was necessary to modify the DBT approach. The need to modify DBT led to more and more modifications in an attempt to develop an approach specifically appropriate to the needs of clients who self-harm. Gradually through the combination of modifications in practice and as a result of the research presented in Section B, a new model evolved: '*SHIFT & FIT*' that is illustrated below in the following extract from a session with Carlos.

6.2 Appearance and behaviour

Carlos is of South American decent and appearance with thick dark hair, olive skin and brown eyes. He was small and slightly built and looked much younger than his age. He was unkempt, unwashed with dirty torn clothes, sores on his face and cuts that looked infected, on his hands. For most of the assessment session he looked down and alternated between picking at cuts on his knuckles and rubbing the sore on his mouth

with his very dirty hands. He occasionally gave eye-contact which was sustained while he appealed for help to 'sort his life out'.

My first impression of him was as a vulnerable 'street child' and I experienced a strong need to care for him physically as well as emotionally. However, I was aware that acting on this counter transference feeling (Casement, 1992) was likely to encourage dependence and I knew Carlos needed to feel empowered.

6.3 Background and family history

Carlos was born and brought up in London. He is the youngest of a very large family of 7 brothers and 3 sisters. His mother died in a house fire when he was 10. He was physically abused by his father and his brothers on a regular basis. He was also sexually abused by a brother who was 7 years older than him. When he was 8 he learnt that he was the product of the rape of his mother by a stranger. At 15, he was placed in a residential care unit following a very severe physical assault by his father.

Carlos left 'care' at 18 and went to live with a woman of 27 who had two children and then together they had a third child who at the time of Carlos' referral was 4 months old. During the first year that Carlos was in this relationship he suffered severe physical abuse in which he was stabbed and badly beaten. Carlos left his partner's home and an injunction was served. His partner ignored and made contact with Carlos. This contact included informing Carlos that she was pregnant again, with his second child.

Carlos had been given a psychiatric diagnosis of BPD and his presenting problems reflected the range of behavioural, cognitive, affective and interpersonal difficulties associated with the BPD diagnosis (DSM 1V-R, APA, 1994). These included an unstable sense of self, affective instability and depression, inability to manage anger and feelings of emptiness. He also experienced difficulties in his interpersonal relationship in which he had been physically abused by his partner and engaged in self harming behaviour such as cutting his arms and burning himself.

6.4 The need to modify the DBT approach and the specific limitations of DBT for this client

The DBT model (Linehan, 1993), provides quite a comprehensive treatment package and has a well documented high level of treatment efficacy with in-patient clients who have BPD (Barlow, 2001). However, I have found that for many of my clients who may exhibit behaviour associated with BPD and self-harm, the DBT model was not appropriate and I found a number of limitations in my attempts to use it.

6.5 The DBT approach and the focus on stopping self-harm.

Firstly, the major difficulty I had in using the DBT approach was the DBT focus on stopping self-harm. This is a treatment priority in DBT and if client continues to self-harm, the consequence is a 'vacation from therapy' (Linehan, 1993) in other words, enforced breaks or termination of therapy for 'non-compliance'.

I have found it necessary to remove the emphasis on stopping self-harm because it was not appropriate for Carlos or 'fit' my commitment to empowerment and validation. The focus on collaboration, validation and empowerment is particularly important for clients who have experienced abuse and the 'invalidation' and disempowerment that accompany this. As Lewis-Herman (1994, p. 133) comments: 'the first principle of recovery is the empowerment of the survivor'. In relation to the issue of the DBT emphasis on stopping self-harm, I also agree with Babiker & Arnold (1997, p. 136) who comment:

The view that it is a necessary starting point for therapy for the patient to be told that her self-mutilating is 'unacceptable', far from being validating, this form of authoritarian control seems at odds with Linehan's own approach.

6.6 The DBT premise of the individual as vulnerable, rather than resilient.

Linehan (1993) accounts for the development of BPD in terms of the interaction between an invalidating environment and a vulnerable individual. The major premise in DBT is that border-line personality disorder is essentially a dysfunction of the emotion regulation system. This is seen as resulting from the interplay between an 'invalidating environment' and an innately vulnerable individual and the interaction over time.

I did not think that Lineman's account of the development of BPD provides a sufficient account. A main reason for this is that I could not think of clients like Carlos as innately vulnerable. Like so many of my clients who self-harm, a very traumatic history is often reported. I believed that these clients are incredibly strong and adaptable in order to survive as intact as they are. Further, I consider that an account that draws on the concept of innate vulnerability is not personally empowering for the individual because again the emphasis is on the individual as vulnerable or deficient in some way, rather than a more positive focus on their resilience.

6.7 An alternative case conceptualisation

As with all my clients who come with a BPD diagnosis I used a questionnaire devised by Spitzer et al. (1987) that has converted the DSM 1V-R diagnostic criteria for borderline personality disorder (BPD) (APA, 1994) into a series of questions (In Bell 2003). As predicted, Carlos scored highly suggesting that the BPD diagnosis was accurate in describing a range of behaviours. Although the DSM 1V-R diagnosis provided a starting point, its value beyond this has been questioned by many researchers (Lewis -Herman, 1994; Bell, 2003; Beck et al, 1990).

My main problem with the BPD diagnosis generally is that it does not provide a comprehensive account of the development of BPD, or of factors that could produce change. As Bruch & Bond (1998, p.2) state, it is 'merely descriptive and further there can be considerable overlap between categories.'

It was necessary to draw from a wider theoretical base to inform the case conceptualisation. This is in line with the *SHIFT* approach and it was possible to

account for the 'borderline' difficulties Carlos presented, in terms of his experiences of severe trauma throughout childhood. Carlos' particular cognitive, affective, behavioural and interpersonal difficulties which meet the criteria for BPD, also matched the criteria for complex post-traumatic stress disorder (Lewis-Herman 1994). There was also a great deal of overlap with the descriptive categories of sexual abuse sequelae outlined by Smith & Bentovim (1994) The categories they used to describe the observed range of sexual abuse sequelae, could be directly matched to Carlos' difficulties. These were :

- a sense of powerlessness; depressed mood; pervasive anger ; low self esteem; poor mood and emotion regulation; relationship problems and self harm.

The link between Carlos' current behaviour and earlier abuse can also be understood from a developmental psychopathological perspective, in terms of disruptions in three related areas of self development: self-integrity, self regulation and social development (Cole & Putnam 1992, In Christo, 1997).

6.8 DBT and BPD diagnosis associated with this and the negative impact of stigma

There is also a stigma associated with the term BPD and the negative impact of stigma on the individual can be very damaging (Proctor, 2002; Lewis Herman, 1994) . In fact this has led many theorists such as Lewis Herman, (1994) to argue that it should be abandoned. However, as Bell (2003, p.8) points out 'whatever term took its place may become equally stigmatised . I was also concerned about the frequency with which this diagnostic label is used to label individuals such as Carlos and with the accuracy of the diagnosis. I questioned whether Carlos could more accurately be described as 'battered' rather than 'borderline'. According to Beck et al. (1990) 'the misuse of this diagnostic label has long been criticised. Originally, this term was used when the clinician was unsure of the diagnosis' (p.177).

6.9 DBT and Boundaries

Maintenance of boundaries was another difficulty I found in using the DBT approach. I felt that the important issue of boundary maintenance is not adequately addressed in DBT. For example, Linehan (1993) states that there are no context free, correct boundaries. Linehan (1993, p.135) argues:

The term boundaries is used as if it has a non-arbitrary meaning, independent of the effect of the patient's behaviors on the therapist. A therapist often sets such boundaries as if there is a "correct" placement for them. .. There are no context free, correct boundaries.

However I disagree and believe that although there needs to be flexibility in the setting of boundaries rather than a rigid approach, there are certain boundaries that must be set at the outset. Although maintaining boundaries may be a struggle with some clients, it is important as many authors have stated (Hunter, 2001).

6.10 Lead into Transcript

The following transcript from part of a session begins with Carlos describing an experience in an A & E department where he presented for treatment because he had deep self-inflicted cut on his arm. He explains how staff stitched the cut up and was so considered about the risk his self-harm posed that they recommended a psychiatric admission.

6.11 Transcript extract

Client 15

In the hospital they recommended a 28 day stay

Counsellor 16

Did they ? Why did they recommend a 28 day stay?

Client 16

'Cos they tried....., they gave me a quick risk assessment

Co: 17

Yeah ?

Client 17

And what it was ...was when I was in hospital I got my lighter, you know the metal bit of the lighter?

Co: 18

Yeah.

Client 18

I took that off and just started using that

Co: 19

When you say that? What were you using that for?

Here following the *SHIFT* approach, I am trying to get a clear description of the behaviour in the initial exploration of the self-harm

Client 19

They put the stitches in. I started taking them out.

Counsellor 20

Ok, so you didn't want to be stitched up at that point!?

Here I make a mistake in relation to SHIFT because I used a 'closed question' as opposed to an open style of exploratory question. Consequently get the corresponding yes/no response follows.

Client 20

No

Realising my mistake I correct the technique and return to an open question to facilitate exploration. As the following response from Carlos illustrates, the use of 'open' questions, facilitates the exploration of the function of the self-harm.

Counsellor 21

Why? Tell me why you were taking the stitches out?

Client 21

Because like when I cut myself there was like all that pain and shit just sort of got released.

Counsellor 22

Yeah .

The tone of my voice, facial expression and nodding are all used to convey my acceptance and understanding of this. I think I was successful in this because in the following comment Carlos adds 'you know what I mean'. The manner in which he said this communicated to me, that he felt understood.

Client 22

Then I got stitched back up you know what I mean there was still pain left there?

Right that's really important ... and in a way it's a way of communicating that pain. ...
Are there other ways that you can communicate that pain ?

Here I make two mistakes in relation to the SHIFT model. Firstly, I make an assumption about the function of self-harm that Carlos is communicating pain rather than encouraging Carlos to identify the function that it served for him on this occasion. Further, I did not even offer it as a hypothesis, and assumed this was the function. Secondly, Carlos has already clearly stating that the self harm served as a way to release the pain.

In the light of this mistake I am planning to modify the approach and intend to develop a blank copy of the SHIFT continuum on which the client can record and locate the function/s of self-harm when as they are discovered.

In addition to modifying the model in the light of mistakes such as this, I believe it is essential for the therapist to continually reflect on such mistakes and record these for discussion in supervision. It often seems to be the mistakes and the way they are managed that provide useful insights for both therapist and client.

6.12 Finding a therapeutic technique based on the identified function of the self-harm : A Function Informed technique (FIT)

Having identified the function of self-harm as a way to release pain, it is then possible to find a technique that may offer an alternative method for pain release or other techniques to manage pain – A FIT. This could include encouraging client to describe or draw the pain. The techniques could also include some psycho- education such for example information sheets on why and how self harm comes to be used as a method of emotional regulation using sources such as Williams (1997); Kennerly (2000); and Bell (2003).

In answer to my last question 'are there other ways that you can communicate that Pain?'

Carlos replies:

Client 23

What I'm doing now. I'm just enjoying myself.

Counsellor : 24

Ok, but let's go back to... I think its really important if you feel pain like that that you find, or we work on some other ways that you could communicate, so you've got it there as a strategy. So that next time you feel like slicing your arm up you try something different (pause) and can you think of any other way of communicating that sort of pain to someone?

In this interaction, I avoided a really important communication. In answer to my question 'are there other ways of communicating pain? Carlos responded with 'what I'm doing now. Just enjoying myself'

He made a non verbal gesture to signify he was referring to what was happening between us and put his arms out towards me. He then drew them back towards his chest in an inclusive manner. I ignored this reference to what was happening now and the intimacy in that moment and focused immediately on getting back to work and the task of finding alternative strategies.

I did not attempt to explore or clarify what specifically he was referring to e.g., perhaps time with someone who is interested or the enjoyment of interacting and talking. Sadly, a potential insight that was missed. However, the freedom from constraint by any one theoretical paradigm when using the SHIFT model, enabled me to draw from a psychoanalytical paradigm and utilise the concept of 'unconscious communication'(Casement 1992). This was valuable in facilitating my understanding of the following response from Carlos.

Client 24

No not really 'cos no one can really relate to someone in that way.

I hypothesised that this was a form of unconscious communication from Carlos, (Casement 1992) relating to my previous intervention and my inability 'to meet him' or to relate to him in an intimate way or on a deeper level.

Counsellor. 25

You feel that? That you can't relate to someone on a level that they will understand the pain you're going through?

Client 25

BASICALLY! (Silence) His tone was loud and sounded angry and was followed by a long silence.

A silence that was only broken when I eventually intervened and apologised for my failure to offer him an experience of being related to on a deeper more intimate level.

This acknowledgement and apology was possible only after I had picked up the 'unconscious communication' (Casement, 1992) from Carlos. I was then able to sense at an intuitive level that I had not been letting Carlos communicate on a different level or in another way.

Counsellor 26

Perhaps that is a new experience or sorry an experience that you haven't had that, that you have been able to communicate (long pause) in another way.

My avoidance of intimacy was reflected on and discussed in supervision because it is important to constantly reflect and be aware of how ones issues and vulnerabilities may impact on the therapeutic process. This is well documented by Pearlman & Saakvitne (1995), who state that 'the client's and therapist's experiences will often overlap and a therapist's awareness of her own vulnerabilities will protect her and her client' (p.186). Baldwin (2000) extends this view with a discussion of the value of vulnerability. Rather than seeing areas of personal difficulty only as a 'therapeutic liability'. Baldwin takes the view that they may play a valuable role in our ability to relate to another and she 'reminds us of the way in which our human frailties and vulnerabilities play a role in our effectiveness as healer' (p13).

I then return to a focus on the task of identifying alternative strategies for communicating pain. In line with the SHIFT approach I try and suggest ways in which Carlos could experiment with writing as an alternative strategies for managing and expressing pain .However, I suddenly remembered that Carlos had problems with reading and writing and it was therefore not an effective strategy.

Counsellor :27

Can you think of any other way of managing that pain or expressing it ... What about writing... Or did you say you had problemswriting?

Client 27

A lot I mean I was supposed today go and learn how to spell all the months in the year But I got so fucking drunk last night I totally forgot

Counsellor. 28

Ok so writing things down at the moment is not going to be an effective strategy! What about (silence) talking have you, have you got a tape recorder ?

Client 28

No but (sense of desperation) like what I'm doing now and what I done last night as well.

Carlos' comment 'like what I'm doing now' was accompanied by the same gesture he used previously in which he put his arms out towards me and then drew them back to himself as if to signify something between us. This time I do not ignore it but encouraged him to tell me more. He does not expand on this but he is encouraged to communicate in another way at another level – something he had not done before.

Having picked up his 'communication it takes a simple encouraging 'yeah go on' from me, and he is able to go on to communicate a very meaningful experience.

Counsellor 29

Yeah go on

Client 29

When I've got a bit of time, when my friends crashed out, like my room looks out on some gardens.

Counsellor 30

Yeah...

Client 30

And there's a ledge outside the window

Counsellor 31

Yeah.

Client 31

And another ledge you can sit on. I just sat there and looked out there, just spoke to God man, made me feel better

Counsellor 32

That 's really important. ... What were you looking at? What was out there?

Here I was encouraging Carlos to explore his experience which was a very different experience to anything he had described to me and it proved to be very relevant to our exploration of the function of his self-harm. I had also not heard him speak in this way before.

While he was talking Carlos looked and sounded sad. I was also aware of feeling his sadness during this interaction. I also focussed on keeping some distance. This need for a balance between being 'open' and affected by the client while maintaining separateness is summed up in the following statement from Baldwin, who says :

I try to feel what they feel with enough distance that there is separateness as well. It means opening myself up to pain...I try to provide nurturance and warmth through unspoken emotional arms' (p. 199).

Client 32

Just gardens and trees and stuff like that I continued to experience a deep sadness. I found myself feeling close to tears as I related what he was describing to an earlier interaction in which Carlos told me about caring for his baby, in a way that he could not care for himself.

Counsellor 33

Do you know what that reminds me of? You told me a few weeks ago about when your little baby cried you picked him up and took him to the window do you remember saying that?

Client 33

Yeah I do

Counsellor 34

To show him something, you said to show him something different to ... to change the scenery for him. and we talked about how that was something that you needed to do for yourself as well, to find a way of changing your scenery of making yourself feel better and that's brilliant, you've done it! You've done it! That's *one* strategy.

Here Carlos is able to arrive at his own alternative self-soothing strategy and use it effectively. He 'changed the scenery' and focused on looking out through the window and 'talking to God'. This made him feel better and it was a new experience for Carlos. He had used an alternative strategy to self-harm for managing pain. I felt the 'joy' that Winnicott (1971) describes with reference to the importance of encouraging clients to find their own solutions and answers.

Winnicott, (1971), writes:

If only we can wait, the patient arrives at understanding creatively and with immense joy, and I now enjoy this joy more than I used to enjoy the sense of having been clever....the principle is that it is the patient and only the patient who has the answers' (Winnicott, in Casement 1992).

6.13 Discussion of the of *SHIFT* model in work with Carlos

This extract has been used to illustrate the use of *SHIFT* & FIT in practice. *SHIFT* offers an alternative to existing models because it has been specifically developed for clients who self-harm and does not have any treatment selection criteria. The client is not required to demonstrate his or her suitability to treatment; rather the treatment is matched to the client. *SHIFT* does not have a central focus on controlling self-harm and the emphasis is on exploring the meaning and function of self-harm.

This case study has demonstrated how following the exploration of the client's experience of self-harm it was possible to identify the function it served. Having identified a function it was then possible for the client to identify a corresponding

Function Informed Technique - a FIT. Carlos recalled an effective technique he had first used to soothe his crying baby. This was simply 'changing the view' and looking out of the window, he then described doing this himself, to make himself 'feel better.' This was an important development for Carlos who had relied so heavily on self-harm to relieve emotional pain and distress.

6.14 Evaluating *SHIFT* in work with Carlos

In terms of evaluating the efficacy of *SHIFT*, there are a number of problems relating to how this is conceptualised or measured. A main issue that has emerged in the use of *SHIFT* with Carlos is related to the need to develop more appropriate and effective measures of treatment efficacy. Many of the factors that seemed to be important in the

work with Carlos such as a positive therapeutic alliance are difficult to measure using available outcome measures. The current methods of treatment efficacy seem to be most appropriate in cases where cause and effect can be more easily measured such as in DBT. As Maine & Chenail (1999, p.14), point out ‘... at present, existing outcome measures are most appropriate in cases where cause and effect can be more easily measured.’

Currently, the main measure used in studies of efficacy in self-harm treatment, is the reduction in self-harm. This focus seems problematic in view of the findings from this present research and other studies which indicate that a focus on reduction may be contraindicated in many cases. While the use of reduction of self-harm as a measure of treatment efficacy in DBT may be appropriate, it does not seem appropriate as a measure of treatment efficacy for the *SHIFT* approach.

In order to measure the efficacy of *SHIFT* it may be necessary to develop indicators for evaluating treatment that can conceptualize and measure the more complex therapeutic processes such as those illustrated in the work with Carlos. Further, it can be argued that a measure of treatment efficacy needs to take pre-treatment client characteristics and the link with treatment requirements or selection criteria into account. For example, the impact of client characteristics and treatment requirements may be a factor in the

high level of treatment success found in studies of BDT. In BDT there is a pre-therapy process to assess that the client has a sufficient degree of commitment.

In contrast, *SHIFT* does not require clients to meet selection criteria, but aims to fit the treatment to the client. This is important because it offers an approach to clients like Carlos and Tracey (Section C client study) whose particular difficulties meant that initially they were unable to demonstrate a commitment. Further, both Carlos and Tracey, like many of my clients, tend to respond to an early request for treatment compliance, or adherence to boundaries as if it was abusive control. It was the need to modify these aspects of DBT that led to the development of *SHIFT* as an alternative more appropriate model.

A further issue in the assessment of treatment efficacy is that many of the factors that were important to Carlos may not be valued by others or seen in terms of success. For Carlos, success may be the ability to engage in a relationship that is not characterized by abuse. The opportunity to focus on his needs and having time and space and encouragement to explore what was important to him might also represent success.

Another indicator of success for Carlos, may be is that he moved from a position of being unable to organise his day and keep appointments or even think about the hour ahead let alone commit himself to anything. He continued to come to sessions and developed a commitment and maintained motivation to achieve his goal of becoming 'stable'. Over time he developed the capacity to be reliable and punctual and experienced the positive aspects of appropriate and effective boundaries. Boundaries could be negotiated and became associated with safety, rather than persecution or abusive control.

Carlos did not stop self-harming, but he sometimes chose to not self-harm and to use another strategy. He also stopped presenting to A&E and repeating some of the painful experiences of his childhood. He became stable enough to maintain a hostel place but ironically was then moved to another hostel too far away to continue attending counselling.

6.15 Concluding remarks on the use of 'SHIFT' with Carlos

This work with Carlos and many similar clients has resulted in my own personal and professional development and I agree with Baldwin (p.142) who remarks that:

Certain clinical relationships can be so challenging or congenial, or in other ways reinforcing or provocative, that they provide a clinician with an unusual learning opportunity. Such therapeutic alliances may support steps towards a practitioners own desired growth'.

In particular, through working clients who self-harm and meet criteria for BPD, I have recognised how essential it is to engage with the client in a way that they experience as special and unique to their relationship (Nathan, 2006). As Nathan (2006, p.331) says,

'this implies that they are engaging with the patient's 'personal signature' and that it is one worthy of emotional engagement.'

Chapter 7:

7.1 Evaluation of research project

There are both strengths and weaknesses in this study. Some of the weaknesses relate to the specific research context. The limitations imposed by 'real life' beyond the research such as availability of time, money and competing demands of work and family, prevented any further work to further develop the theoretical basis of *SHIFT*. This resulted in aspects of the underpinning theory remaining underdeveloped and I believe this constitutes a weakness in the final model presented here.

Another limitation is my failure to adequately define and describe the treatment referred to by participants. Rather, broad concepts such as therapy or psychiatry were used rather than detailed descriptions.

A further area for development is the inclusion of more diagrams, graphs and charts. For example a chart to illustrate the range of functions of self-harm and the different experiences of adversity and accounts of aetiology would be useful. This could also include any associations between the two function and aetiology. However, this has been included in the recommendations for further research.

Another criticism of qualitative research in general and this present study is that it is not 'neutral, or value free. Although I have attempted to make my personal assumptions transparent and to consider the influence of these assumptions on the collection, selection, and analysis of data, this does not achieve value free research. As Smith (2003) states, 'research has to be seen as a joint product of researcher and researched. Farrants (2001, p.182), also points out that 'research is not a neutral process in terms of being value and context free. Nor is it neutral in terms of feelings and moods, the research being influenced by the researcher's affective states at various points during the process.'

This is evident my choice to research self-harm and the methodology selected, the populations used, the findings drawn and the theory constructed are inextricably linked to my own value system, the socio economic, cultural and historic context of my life and my personal assumptions. However, as Farrants, (2001, p.183.), says, 'one practical implication of accepting the inevitable role of the researcher in the research process is that this should be highlighted and revealed in the documentation of qualitative research'.

7.2 Criteria of quality in qualitative research

In an attempt to be transparent and as explicit as possible a number of criteria for quality have been incorporated. The selected criteria used are 'grounded' in the epistemological approach of qualitative research. A number of authors have discussed the need for qualitative research to be evaluated against criteria that are 'functionally equivalent' to the accepted criteria of reliability, validity and generalisability used to evaluate quantitative research (Bauer & Gaskell, 2000; Henwood & Pidgeon, 1992; Robson, 1993; Elliot et al., Willig, 2001; Yardley, 2000).

I have incorporated criteria of quality developed by Bauer & Gaskell (2000) such as 'transparent documentation of procedures', 'thick description' of results, and 'colleague validation'. In addition other criteria of quality such as 'situating the sample' (Ritchie & Lewis 2004) and 'grounding in examples' (Elliot, et al., 1999) have been incorporated. I also designed and incorporated a system to evaluate reflexivity (Willig, 2001) and bias in the interview and the subsequent analysis of transcripts.

7.3 Reflexivity (Willig, 2001).

I have attempted to make my personal assumptions transparent and to consider the influence of these assumptions on the collection, selection, and analysis of data (Ritchie & Lewis, 2004). A number of factors have motivated me to give a great deal of consideration to ensuring that this research provides a 'transparent' and trustworthy account of the process. Firstly, I had great encouragement from my research supervisor to Dr. Jacqui Farrants who encouraged me to 'tell it like it is'. Secondly, I have a strong personal commitment to ensure that this research is grounded in the participants' experiences and as 'close to the bone' as possible (Farrants, 2001).

I felt this sense of commitment very powerfully as I listened to participants' describing encounters with 'helping' professionals who did not seem to listen or want to hear about their experience of self-harm. Encounters in which they felt 'dismissed' by the clinicians who said nothing about the 'fresh cuts' they were shown, or 'did not seem to notice' when the client cut in front of her. I heard too many accounts of 'helping' professionals who failed to provide the validating experience for the client of 'being met as a person' (McCluskey, 2005).

7.4 Reflexivity and initial motivation for the research

This initial motivation for this research stemmed from my concern at the high level of self-harm among my clients in a day centre for young, homeless people. At a pragmatic level this research represented a response to the lack of an appropriate, effective and empowering therapeutic approach designed specifically for individuals who self-harm. An approach that accepted and acknowledged the possibility that self-harm may serve an important function, where the focus was on exploration rather than the elimination of self-harm.

It was essential to find a positive approach that focused on individual resilience rather than pathology, dysfunction or innate vulnerability. What was needed was a compassionate, therapeutic approach which considered the individual in relation to the socio economic and political context and aimed to empower and validate rather than pathologies and stigmatize.

7.5 Reflexivity and analysis of transcripts

In the analysis of the transcripts, I critically examined the impact of my own interactions on the content. In order to facilitate this evaluation, a system was devised for checking, recording and reflecting on the interactions in the interview. In the development of this system, research by McCluskey's (2005) was drawn on. She has devised a system that classifies detailed features and patterns in interaction and communication and the response and impact of these on the continuing interaction, process and content of the communication..

In this present study, I used a system based on McCluskey's in order to identify 'failed interactions' as McCluskey, (2005) has called them. Examples include hearing what I expected to hear rather than what was said. or shaping the content by asking leading questions. Initially I was disappointed by my 'failed interactions', but having identified these it was then possible to evaluate the possible impact on the data and compensate for bias if necessary

7.6 Analysis of transcripts and transparency of procedure/thick description (Bauer & Gaskell, 2000)

Each stage in the research process is clearly documented. A research journal provided a method of checking the accuracy of this description. Email contact with my research supervisor provided another valuable source of documentation of the research process.

As mentioned under methodology section, most of the interviews were transcribed verbatim. Although the process of typing up transcriptions was time-consuming, initially I elected to do this because it enabled me to 'really get to know the text', as Smith (1995) recommends. Ten participants turned out to be too many, on reflection; eight would have been more manageable. In order to achieve 'thick description' (Bauer & Gaskell, 2000), I had to return again and again to keep ten participants 'alive as social actors' in my head in the manner described by (Bauer & Gaskell, 2000). Thick description as Bauer and Gaskell (2000, p. 13) state:

Provides the reader with insights into the local colour, the language and the life world of the social actors ... just like good theatre, brings the reader into the milieu of the social actors.

I also found as Smith (1997) mentioned, that the transcripts 'I really got to know' were that those I had transcribed myself. I returned to the other transcripts to see if I had missed themes and discovered I had. However, I believe that some of the time spent on transcription in order to 'get to know the text', could be utilised more effectively using other methods such as listening to tapes of participants and reading the transcripts. I think I would use a system of 'dual transcription' in future research. This would involve

the use of a professional service to transcribe 50% of the transcripts. I would transcribe the other half. I could then compare the level of 'thick description' achieved in self-transcription using the dual two transcriptions compared to and those I do not transcribe with those I do not transcribe. Other methods of getting achieving 'thick description' could then be used if necessary, such as listening to audio recordings of interviews

During the transcription process I became confused at one point, especially when it was necessary to change pseudo-names. It was necessary to change the pseudo-name of one participant because I had a new client with the same name and I did not want this to become confusing in any way. I also gave three pseudo-names to participants that began with the same letter. During the process of coding and referencing transcript material I found this confusing so I changed another name during the process of analysis. I did not realise the impact this would have on my ability to keep the 'character of the participant alive' and this required me to spend more time returning to the transcript to resolve the confusion.

7.7 Analysis of transcripts and colleague validation (Bauer & Gaskell, 2000)

I asked colleagues for critical feedback and accepted and incorporated this. I was also very aware of the possibility that my personal experiences and rather negative views of aspects of professional practice might cause bias in the selection of extracts from the transcript. In an attempt to reduce any bias I asked a colleague to validate. Following her feedback which indicated a slight bias in the selection of examples of quotes, I returned to the transcript and achieved a more balanced account.

7.8 Ethical considerations

Before embarking on this study I gave great consideration to the ethical issues that arise in research such as this. As McLeod (2004) cautions, 'the application of qualitative methods, which may involve the development of close relationships with informants, and the handling of sensitive personal information, can raise difficult moral issues' (p.177).

The confidentiality and anonymity of the data was maintained by using a coding system and deleting 'identifiers'. There was no pressure to participate and published material invited participants to make contact. The terms on which they participated were fully explained in the information sheet for participants and the aims of the research were outlined (Appendix 3). Ethical issues such as the maintenance of confidentiality and the right to withdraw at any point without explanation were clearly stated in the information given to participants. Participants were informed that no one would have access to their transcripts before identifiers had been removed. They were also informed about how the research would be used. Participants were offered a copy of the completed study which will be available on request.

Another ethical issue that arose was how to respond to the vast number of respondents who answered the advert and were keen to talk about their experience. It was decided that telephone contact and the offer of an information pack constituted an ethical response. Although this was time-consuming and exhausting, it seemed essential. In addition to my feeling of personal responsibility to the respondents, there was a broader issue of social responsibility. It was important that my response provided a positive experience of contact with a researcher. As McLeod (2004, p. 176) states: 'there is an ethical responsibility on researchers not to spoil it for others'.

7.9 Impact and importance (Yardley, 2000)

I believe that another criteria for assessing research is in terms of its pragmatic value and share the view of Yardley (2000), who states that an important principle in assessing the quality of qualitative research is 'impact and importance.' Yardley argues that 'however well a piece of research is conducted, a key test of its validity is whether it actually tells us anything useful or important or makes a difference' (In Smith, 2003, p.234).

The value of this research is that it represents a response to an urgent need for an alternative approach to self-harm theory and practice. In response to this identified need, I have developed and presented a new model: 'Self-Harm- Informed Functional Theory (*SHIFT*) which offers a more cohesive and comprehensive model of self-harm.

This study could also be used as a basis from which training material could be developed. The National Inquiry has recommended that all staff that come in to contact with people who self harm, should be given appropriate training. Further, these guidelines state that this training needs to include ‘an exploration of some of the meanings and motives for self-harm’ (Mental Health Foundation & Camelot Foundation 2006, p.42).

Chapter 8: Overview , Summary of main points, research recommendations and concluding comments

8.1 An exploration from the perspective of the self-harmer

Through this exploration from the perspective of the self-harmers it was possible to generate this more flexible and broad conceptualisation of self-harm as a continuum. Here self-harm can be located for example, as a functional response to dysregulation, a dysfunctional behaviour or as some participants reported, even a eu-functional behaviour.

8.2 SHIFT & FIT: a model based on the unifying principle of the self regulatory function of self-harm

This research presents a model for self-harm that can draw from a range of theoretical paradigms where the principle of regulation serves as the nodal point where various accounts meet.

8.3 The lack of a cohesive approach to treatment for self-harm

One of the central issues that emerged very strongly from participants' accounts of services was the lack of a cohesive approach to treatment for self-harm and the lack of a unifying conceptual base from which to draw or guide therapeutic interventions. This is particularly problematic for a number of reasons that have been addressed in this research. It has been argued that the absence of a cohesive explanatory framework is one reason for the lack of considered attributions about the function of self-harm. It is suggested that it may also be a factor in the generally negative approach and polarisation that characterises current self-harm theory and practice. It is also reflected in the current approach to treatment where the tendency to understand self-harm from one theoretical perspective has led to the corresponding interventions being restricted and too theoretically based rather than tailored to the particular needs of the individual client..

It has been argued that the view of self-harm from the traditional psychiatric paradigm focuses on the identification and classification of self-harm as a symptom of underlying psychopathology and so the corresponding approach has been to control or eliminate it.

8.4 The positive benefit of early intervention with young people who self-harm

There is evidence that suggests that young people, whose self-harming has not become 'entrenched', often respond very positively to counselling interventions (Turp, 2003). Given the positive benefit of early intervention with young people who self-harm, this indicates an urgent need to develop appropriate treatment for young people.

8.5. Self-harm and BPD diagnosis

Many individuals who self-harm are given a BPD diagnosis without consideration of the context of their lives (Miller, 1994; Turp, (2003). As Proctor (2002) argues, the potential negative effects of a BPD diagnosis are serious. What seems to go hand-in-hand with the BPD diagnosis, as Proctor comments, is a "life of stigma, social exclusion and discrimination which would be a struggle even for the emotionally resilient" (Proctor, 2002, p.7).

8.6 The tendency to pathologise the individual self-harmer

Sadly, the accounts of the participants in this present study reflect the continuing tendency to disregard self-harm and to conceptualize self-harm in very negative terms such as a symptom of personality disorder or attention-seeking manipulative behavior. Further as many of the participant's accounts demonstrate the major focus in treatment is still on risk management, stopping or ignoring the self-harm rather than attempting to engage, explore and understand it.

8.7 The value of research from the perspective of the individual who self-harms

The research presented here has demonstrated how from the starting point of the individual self-harmers experience, it was possible to generate new ways of conceptualising self-harm, to construct a new unifying model of self-harm and devise

more innovative, appropriate and effective therapeutic approaches and techniques for working with self-harming clients. These interventions FIT the client rather than trying to make the client fit the treatment and regarding the individual as an 'unsuitable case for treatment' if they don't.

8.8 SHIFT: A model that is not restricted to a particular theoretical paradigm or therapeutic orientation

The SHIFT model does not have a basis in a particular psychological or therapeutic orientation, but can accommodate the range of identified functions of self-harm. The model also provides a unifying framework that can draw from diverse theories to inform the development of a range of different treatment approaches.

8.9 The SHIFT model: A broader more flexible and integrated conceptualisation of self-harm

Through this exploration from the perspective of the self-harmers it was possible to generate this more flexible and integrated conceptualisation of self-harm as on a SHIFT continuum that reflects the diverse experiences of self-harm as a functional response to dysregulation, a dysfunctional behaviour or as some participants reported, even a eu-functional behaviour.

8.10 Recommendations for further research

In the light of the findings of this study some clear recommendations for further research emerge. There is a need for further research that explores the underlying regulatory functions or processes underlying self-harm. These include the processes involved in the capacity to make sense of intrapersonal experiences, to control impulses and to express thoughts and feelings in words rather than action (Bateman et al., 2004). The Processes that facilitate the development and maintenance of a coherent, stable and integrated sense of self and the process that underlie the capacity to identify, express and regulate emotions (Linehan, 1993).

8.11 A need for research that differentiates between the different functions of self-harm

The findings also suggest a need for further research that differentiates between the specific function of self-harm. The idea that an association between self-harm and aetiology may be related to specific functions of self-harm emerged in the present study. This indicates that in future research into the aetiology of self-harm, it may be useful to differentiate between the different functions of self-harm.

8.12 A need for research on self-harm in different groups and the development of alternative classification systems for self-harm

There is a need for research within different sample populations and the development of a new classification system of population sub groups, which considers the social context. In addition, to a research focus on a range of groups, further research is needed on issues relating to individuals from black and minority ethnic groups. As Macaulay (2005, p.6) states:

Although many of the factors, especially experience of physical and sexual abuse are cited in white women's experience of self-injury, it is crucial that the specific issues connected to women from black and minority ethnic groups are taken into account.

8.13 A recommendation for further research into the type of help individuals who self-harm think would be most useful to them

There is a need for further research into the type of help individuals who self-harm think would be most useful to them. Many of the experiences of treatment described by the participants reflected a continuing lack of understanding of the meaning of self-harm in their lives. One of the important factors in the development of new theory is the need for research to make use of 'insider perspectives' in understanding the processes underlying self-harm.

8.14 The need for more self-harm research from various perspectives

A great deal of existing research and practice has developed from a specific theoretical approach or from the perspective of the academic or clinician. Although there has been a small shift forward in research from different perspectives, there is still only a very small amount that has explored subjective experiences of self-harm, and how those who engage in self-harm experience the support, care and treatment available to them. In order to develop services, the service user's view is crucial (Harris (2000; Pembroke, 2007). As the present research has shown, from the different perspectives of individual self-harmers very different accounts emerge and may be valuable in the continuing development of self-harm theory and practice.

8.15 The need for research into therapist /client experiences of therapy with clients who self-harm

In the present study, the participant's comments also emphasise the need for a more positive focus on working with clients who self-harm and increased awareness of the potential of this to be a growth promoting experience for the therapist as well as the 'self-harming' client. It is suggested that there is an urgent need for a more collaborative, informed, balanced and optimistic view of clients who self-harm that includes a focus on clients' strengths and resilience to counter the former focus on individual dysfunction and or vulnerability.

It seems evident that what is needed is a greater understanding of the meaning of self-harm in the lives of individuals and the development of range of more effective counselling strategies based on this understanding. It is seems essential for research to give more consideration to the socio-economic, cultural and political context of their lives and how this may be expressed through self-harm.

8.16 The need for research into the development of alternative systems for criteria of quality for use in I.P.A analysis

Another suggestion for further research arising from this study, is the need to develop alternative criteria for quality relevant to IPA. analysis. One idea suggested is to research and develop a system similar to that devised by McCluskey, (2005). McCluskey's system identifies and classifies detailed features and patterns in interaction as well as the impact of these on the communication. It is suggested that a similar system could be developed for use in the analysis of transcripts. This may also provide another method for evaluating quality in IPA

8.17 A need for the development of new more appropriate measures of self-harm treatment efficacy

There is also a need for the development of new more appropriate measures of self-harm treatment efficacy , rather than a focus on reduction in self-harm as the measure of success. There is a need for outcome measures that are relevant to particular therapy models and specific therapeutic techniques.

8. 18 Concluding comments

This research also highlighted the need for a more unifying conceptual framework for self-harm . A framework that can accommodate research from diverse fields and pull together accounts of the aetiology , causes and complex processes that may be implicated in or underlie self-harm. It has been argued that the lack of a cohesive and comprehensive model of self-harm to inform practice is one reason for the current random 'hit & miss' approach to treatment that participants described. Many participants also found the treatment for self-harm inappropriate and ineffective

The *SHIFT & FIT* model was developed in response to this need and provides an alternative to current models because it is based on the concept of a broad continuum that can accommodate the range of functions and diverse experiences of self-harm.

The *SHIFT* model provides a cohesive theoretical framework for self-harm. based on the unifying theoretical principle of self-harm as a method of self-regulation. Consequently, research from various theoretical perspectives can be drawn on to guide and inform the therapeutic approach.

SHIFT can guide and inform the development of a range of therapeutic interventions that 'fit' the client . This offers an alternative to the 'one size' fits all' approach that characterises current approaches because therapeutic interventions are based on the functions of self-harm for the individual..

The participant's accounts illuminated the ways in which the 'individual' experience of self-harm is inextricably intertwined with socio-economic, cultural and political experience. The *SHIFT* model of self-harm can incorporate a psycho-social account of how experiences such as oppression, stereotyping, disadvantage and discrimination mediate and shape the 'individual' experience of self-harm.

In contrast to the tendency to individualise self-harm and pathologize and stigmatize the individual, an alternative view is presented here. It is hoped that the findings of this research offer a different view of the individual who self-harms.

This research has highlighted a great need to shift public and professional opinion towards a greater understanding of self-harm and to improve the treatment given to self-harmers. Currently, the dominant focus in treatment programmes is on methods to control or eliminate self-harm. However, in this study the participant's views of what would work for them, suggest a new perspective and approach is needed. It is argued that in order to develop new therapeutic ways of working with self-harm we need to start with the client and a collaborative exploration of the meaning and function/s of self-harm for the individual. However, to engage in a process of exploration, it may be necessary to tolerate not knowing, this as Bion points out, can be difficult :

We find it hard to tolerate not knowing. Faced with distress and uncertainty, we find ourselves drawn towards premature conclusions and ill-founded generalisations that side-step the complexity of human experience and human behaviour. As I have noted elsewhere, some contributions to the self-harm literature fall into this trap and are marred by an overzealous search for 'one-size-fits-all' explanations of self-harming behaviour (Bion, In Smith, 2006, p.1).

In developing new approaches to self-harm we also have to look beyond attempts to control the behaviour and give the control back to the client (Pembroke, 2007) . We need to acknowledge and respect the client's ability to know what will work for them, to offer choices and to allow them to find what 'fits.'

SECTION C: Case Study

An unsuitable case for treatment ?

Or an unsuitable treatment for Tracey?

In the following case study names and 'identifiers' have been changed to maintain confidentiality.

1.1. Introduction

In this clinical work, a modified version of Dialectical Behavioural Therapy (DBT) (Linehan, 1993) was used as a framework for intervention with 'Tracey'. The context of the work is a community 'drop-in' centre for female sex workers. Tracey is a twenty-nine year old gay woman who at the time of referral was homeless and selling sex to men in order to survive financially and to buy drugs and alcohol which she used on a regular basis. She has a childhood history of sexual abuse and neglect, and a DSM 1V-R diagnosis of Borderline Personality Disorder (BPD) (American Psychiatric Association, 1994).

The case material presented provides an overview of the therapeutic approach and techniques and an overview of the therapy, which is still on going. The main focus is on the use of a modified DBT approach to self-harm and a transcript of part of a session is used to provide a verbatim account of this approach in action.

1. 2 Referral and presenting problems

Tracey was referred by a support worker in the 'drop-in centre. The reason given for Tracey's referral was her escalating level of self-harm and the increasing staff anxiety about her safety. Tracey's emotional and physical state had deteriorated and she was 'sleeping rough' after being permanently excluded from all the available hostels because of her unacceptable and violent behaviour.

Tracey's presenting problems included chronic self-harm such as cutting her arms, legs and chest and inflicting deep bites. She had frequent angry and violent outbursts and experienced constant crises in her life. Her problems were exacerbated by her use of alcohol and drugs and she engaged in compulsive sexual behaviour with both men and women which later confused and distressed her. She experienced extreme swings in mood and at times suffered intense but brief periods of extreme emotional distress. At these times her self-harm became more associated with suicide and would take a different form such as cutting arteries and over-dosing. She also had very low self-esteem and described herself as 'just a bad-lot'.

1.3 Appearance and behaviour

Tracey presented a tough exterior with a shaved head and was dressed in army clothing and army boots. The message she gave off was 'don't dare come anywhere near me and don't mess with me'. I sensed immediately that her exterior hard image and her aggressive posturing was an attempt to hide her vulnerability. When I asked her about the person behind the 'tough front' she began to cry.

Tracey had scars all over her body both from self-inflicted injuries and from assaults by others. In addition to many scars from years of chronic self-harm, Tracey's face had been seriously disfigured by her partner Carole, and this required future reconstructive surgery. Her chest, which she showed me, in spite of my obvious discomfort and attempts to convince her that I did not need to actually see it to believe her, was also covered in scars and bites that Carole had inflicted.

1.4 Background and family history

Tracey described her childhood as miserable. She was an only child and from a young age believed that her parents had wanted a boy. She was sexually abused by her father from the age of about five until the age of 17 years when she left the family home. Her mother refused to have contact with her since she disclosed the abuse 12 years ago and 'came out' as a lesbian (although Tracey has never been sure about her sexuality).

Tracey does not want contact with her father but ‘endures’ an occasional telephone call from him in the hope that one day her mother will speak to her.

Tracey’s view of her problems was that her partner, ‘Carole’, was causing most of her difficulties. In response to being asked how Carole was causing her difficulties, Tracey replied ‘Carole is killing me emotionally, physically and sexually’. She explained that she had two lesbian relationships. One partner Carole repeatedly abused Tracey and in the other Tracey was the abusive partner.

1.5 Counsellor’s initial hypothesis and case formulation

Many features of Tracey’s initial presentation reflected those frequently associated with borderline personality disorder (American Psychiatric Association, 1994).

However, I did not think that Lineman’s account of the development of BPD provided a sufficient account in Tracey’s case. I drew from a wider theoretical base in order to gain greater understanding and flexibility and my case conceptualisation was informed by Smith and Bentovim’s (1994) review of the sexual abuse sequelae and the developmental pathological model of sexual abuse (Cole and Putnam, 1992). If viewed from a developmental psychopathological perspective (Cole and Putnam, 1992), the link between Tracey’s behaviour and earlier abuse could be understood in terms of disruptions in three related areas of self-development: self-integrity, self-regulation and social development (Cole & Putnam 1992, in Christo, 1997).

1.6 Relevance of theoretical framework in relation to work with this client

Dialectical Behavioural Therapy (Linehan, 1993) was initially selected because it has been specifically designed as a treatment programme for BPD. I assumed that given her diagnosis and the ‘border-line’ behaviour displayed by Tracey it would be appropriate. However, although the DBT model served as a framework, it was necessary to adapt the approach to meet Tracey’s needs and these involved significant modifications to the DBT treatment approach. These modifications are detailed throughout this case study.

1.7 Contract and counselling plan

Linehan (1993) suggests a minimum of a one-year contract and places emphasis on gaining commitment during the initial 'contracting phase'. The requirement of obtaining commitment to a year of work in the contracting phase seemed impractical given Tracey's difficulty in thinking beyond the present moment and her difficulty in committing to anything. Tracey was also so wary of entering into a relationship that I did not want to even mention a 'commitment contract' because it may have felt too threatening. We negotiated a flexible contract in which she could 'test the water' with no pressure to commit. However, I made a commitment to be available for a minimum of one year and offered the possibility of extending this time frame as well as extending from one to two sessions a week if required. It was also necessary to allow greater flexibility over appointment times. Tracey was unlikely to have initially engaged, or remained in therapy, without these modifications.

1.8 Modifications of DBT in relation to drugs and alcohol

I also found it important to adapt the DBT model in relation to drugs and alcohol. Linehan (1993, p. 24) states that 'clients should not come to sessions under the influence of drugs or alcohol'. Here the impact of the context of counselling on counselling practice was highlighted. In the drop-in centre women who were under the influence of alcohol and/or drugs were welcomed. I therefore felt that it would be difficult to insist that my clients were drug and alcohol free during sessions, even if I had thought it was appropriate. Further, given that Tracey had such a high level of psychological dependence on alcohol, this also seemed unrealistic. My emphasis was therefore on encouraging Tracey to limit the amount she drank prior to sessions.

1.9 The therapeutic alliance

The early work with Tracey focused on reducing the risks to her safety caused by her lifestyle. Initially my role felt more like that of a caring social worker and involved things such as liaison with housing advice workers to obtain a hostel place. This is accepted as an important role for the therapist in DBT in which the therapist acts a

‘consultant for the client’ (Linehan, 1993). I also believed that if I could offer Tracey some practical help this might facilitate the development of trust. I also knew that she had experienced positive contact with social workers in the past and so this seemed a sensible starting point.

However, it was difficult for Tracey to establish a positive relationship and to trust me. There were many months in which she oscillated between the two extremes of desperately wanting to be able to trust me and to have a positive relationship and wanting to reject me. It was also difficult for her to establish a collaborative relationship, but this gradually developed through constant validation and attempts at empowerment.

1.10 Interpreting behaviour

At a time when it felt like we had managed to establish a positive collaborative relationship, Tracey then went through a period where she would arrive on time and put her head round the door saying she would be back in a minute. She would then sit outside the counselling room for periods ranging from 15 to 45 minutes. This behaviour could be seen as an example of what Linehan (1993) refers to as ‘therapy-interfering behaviour’ and according to the model is second in the DBT hierarchy of behaviours that must be focused on immediately. The DBT model outlines a ‘therapy-interfering behaviour protocol’ in which the therapist conducts an in-depth behavioural analysis of the therapy-interfering behaviour and a problem-solving approach is developed. If the client refuses to modify their behaviour, a ‘vacation’ from therapy is suggested until the behaviour is changed. I did not think that a vacation from therapy was appropriate in this instance with this client because it was likely that it would be experienced as ‘punishment’. I believed that Tracey would respond more positively to acceptance, validation and attempts to understand and interpret the behaviour.

1.11 Accepting and working to understand the behaviour

Accepting and working to understand the behaviour, rather than extinguish it, proved useful and with input from discussions with my supervisor I was able to generate a range of possible reasons for the behaviour, which I discussed with Tracey. It emerged

that Tracey had become quite literally too scared to enter the room and to stay in the relationship. We discussed how this change in which she stayed outside for most of the session followed a period in which she seemed to have established a positive relationship with me and did not oscillate between wanting to see me and rejecting me. We talked about how it was at the point where she was discovering that she wanted a relationship with me and was beginning to believe that I could be trusted and would not abuse her that she felt most scared. This for Tracey was more threatening than the more familiar experience of being rejected and being hurt. We discussed the way in which her relationships seemed to be characterised by care and abuse, and how her attending the session briefly and then remaining outside was symbolic of her ambivalence and fear of the relationship and intimacy.

In this instance, the use of interpretation did not conflict with the DBT model because while it suggests a specific cognitive-behavioural protocol for working with therapy-interfering behaviour, it does not rule out interpretation of behaviour. Rather, Linehan (1993, p. 268) outlines criteria for behaviour that it is useful to interpret and suggests that the 'most effective insights are those pertaining to the patient's behaviours as they occur in interactions with the therapist'. Research by Marziali (1984) also provides support for the potential value of focusing on behaviour that occurs in the client-therapist relationship. Further, Marziali's research suggests that 'the greater the extent to which interpretations are focused on in-session behaviours, the more positive the treatment outcome' (in Linehan, 1993, p. 268).

1.12 Exploring the functions of self-harm

Gradually, with a great deal of encouragement and validation, Tracey was able to come into the room and stay for the entire session. We were then able to explore the self-harm. Tracey wanted help with her self-harm and having explored the functions of her self-harm we were able to identify a range of functions it served. Tracey described how she used self-harm at times when she felt intense emotional distress and pain.

Sometimes cutting her skin would provide relief and distraction from the emotional pain. For Tracey, the physical pain was easier to understand and to cope with than the inner emotional pain. Tracey also used self-harm as a strategy for dealing with anger. If she felt angry with herself or with others, Tracey would cut herself.

Sometimes Tracey's self-harm took the form of cuts to her wrists and other arteries and could be viewed as a suicide attempt. The distinction was not always clear-cut between Tracey's self-harm that served a 'coping function' and self-harm where the intention was suicide. As Tracey said, even when she cut her arteries, she was not always certain that her intention was to die, she was often ambivalent. However this posed difficulties relating to risk management, because when her self-harm was associated in any way with suicide, Tracey was at high risk of accidental death, if not intentional death.

Tracey, also used self-harm as a way of communicating her emotional pain and her emotional needs to others and her self-harm frequently provided a means of communicating her need for care. Tracey's difficulty in expressing her needs directly is a common problem for individuals who have been neglected or abused. As Safran & Muran (2000, p. 103) state :

... When an individual has had a developmental history in which the instinctive needs for nurturance and love are responded to with neglect or punishment, she often becomes critical of her own needs and to varying degrees dissociates from them. This can make it impossible for her to express her needs directly.

1.13 Exploring alternatives to self-harm

Having explored and identified some functions of the self-harming behaviour it was then possible to look in more detail at these functions and the meaning and purpose served. In the initial stage of this exploration, I used Lineman's (1993) strategy of a conducting a 'chain analysis' used for exploring other types of behaviour in DBT (ibid.). We looked in detail at the sequence of events that occurred before and after the behaviour. This is referred to as a chain analysis because the aim is to link these events to one another. Through this process, we could then generate hypotheses about the factors that may be influencing the behaviour. Following this, a solution analysis (Linehan, 1993) was used to generate alternative behaviours that could be tried as an alternative to self-harm.

1.14 Identifying alternative strategies

Tracey and I conducted a 'chain analysis' (ibid.,) and identified that her use of self-harm to manage intense emotions was frequently preceded by a period of intense emotional distress in which she would have extremely negative and abusive thoughts about herself. We referred to these as her 'self-harming' thoughts which were followed by self-harming behaviour as a way of coping with her painful emotional state. We generated and agreed an alternative strategy which was to try and 'capture' the self-harming thoughts in writing or through drawing and to bring them to the session for us to explore. This strategy was intended to offer another form of expression and to provide a perception of control over the self-harming thoughts.

Further, even if Tracey only managed to write a few words before using self-harm' this would provide a space between the feeling and the response. This 'time-gap' is important because it allows time for thought before action and is an opportunity for the client to try and focus on and identify the feelings and internal experience.

This view is shared by Conterio and Lader (1998), who emphasise the importance of helping the client to recognise the difference between thought and feeling and to develop awareness of the process that translates a feeling into thought and into action. As they point out (ibid., p. 271):

... When you are caught in a repeating cycle of destructive thinking and behaviour, there is no time to slow down, figure anything out, or cope. There is no room in this cycle for anyone to intervene or for any dialogue to take place.

The development of the ability to express thoughts and feelings in words rather than action is also important for clients such as Tracey who impulsively self-harm and who can be described as 'all feeling no thinking' (Bateman and Fonagy, 2004).

The use of strategies such as using thought and language first and writing or drawing as an alternative to self-harm (that functions as expression), was also discussed in a report of a presentation by Farber (2006, p.83) who said:

When they cannot speak of their emotions, I have found that helping them to write down their thoughts and feelings is a very powerful intervention. It can promote freer associations, help them identify and tolerate affect states, and provides containment for their impulses, and promotes more reflective thinking.

Other strategies used to provide an alternative to self-harm that functioned as emotional expression and communication included exploring and practising identification and expression of feelings and needs in sessions and also practising talking to others about internal experience and feelings. We also identified some emotional self-soothing strategies, such as having a bubble bath that Tracey agreed to implement.

1.15 Introduction to the transcript

The implementation of some of these alternative strategies is demonstrated in the following transcript from a session. Tracey arrived in a very distressed state because she had written down her feelings so that she could bring them to the session. Tracey had managed to write down her thoughts and feelings before self-harming as agreed and I sensed that she felt proud of this achievement and was keen to show me what she had written. Her partner had found this and read it. Her partner, who is also a user of the Centre, photocopied the contents and threatened to show everyone in the Centre that evening. The theme that ran through all Tracey's experiences of relationships was of care and abuse being linked. If she experienced one the other would follow. This pattern had been repeated. Her positive experience of writing something down as she said 'for me to read in the session' had also resulted in abuse, in the abuse and violation of her privacy.

This extract begins 42 minutes into the session in which Tracey had been extremely distressed throughout. It begins with me asking how much she cares for herself. I also ask about the other alternatives to self-harm and other strategies we had agreed that she would try.

1.16 TRANSCRIPT of Session 14

[Co = Counsellor; T = Tracey; (...) = silence]

1 Co: How much do you care about yourself?

1 T: I don't care for myself.

2 Co: That's what we need to change, isn't it? Because all of this, too, comes down to this, whether you can find and get the care that you need without the abuse. And (...) did you manage to do any of the (...)

Here my intervention would have been more effective if posed as a question to Tracey, to emphasise that the change is something we both want. The reference to 'we need to change' perhaps emphasises our collaboration and we have had many previous sessions in which we have discussed Tracey's desire to find ways to care for herself.

I also refer to Tracey's belief that care and abuse are linked. This has been her past experience and this theme runs through all of her close relationships, here some cognitive modification is required because as Linehan (1993, p. 293) states: 'more effective behaviour is inhibited by faulty beliefs'.

2 T: No

3 Co: You couldn't identify (...) did you identify any of the negative thoughts?

3 T: No. Cos I've had (...) well we did have a bath together me and 'Claire' like a bubble bath and everything.

4 Co: That was a bit of being nice to yourself?

Here, rather than talking in DBT language about self-care strategies, I used a more 'Tracey' friendly language which I think has been useful in establishing a positive

rapport between us. It is for this reason that 'Tracey friendly' language is used throughout the transcript, examples include a later reference to Tracey 'getting pissed and out of it' as opposed to the use of a term such as 'intoxicated'.

4 T: Yeah.

5 Co: How was that?

5 T: That was nice.

6 Co: Is there (...) can somebody find you a hostel to stay in tonight where you could have a bubble bath?

Here I missed the opportunity to validate the fact that Tracey had implemented the agreed self-care strategy and that she reported a positive experience of self-care that did not involve abuse. The fast pace also reflects my anxiety about her safety when she left the session that night.

6 T: No. There's nothing around.

7 Co: Is there anywhere you could go to keep Tracey safe? Just for one night?

Sensing that my initial attempt to focus Tracey on safety and self-care was not working, I became more direct in this intervention because of the risk to her safety that night. This is in line with the DBT approach in which establishing safety is a priority in Stage 1.

7 T: No.

8 Co: Where do you think you're going to stay?

8 T: Nowhere.

9 Co: You've got to stay somewhere. Have you got some ideas?

Here I am challenging Tracey. This is not my preferred style of relating to clients but I felt the need to communicate that it was essential for her safety to find somewhere to stay for the night.

9 T: *I got nowhere no more.*

10 Co: *What's going to happen to you if you are totally pissed down at *** by 9 o'clock tonight?*

10 T: *Be in hospital put it that way.*

11 Co: *Is that something that might be helpful?*

Tracey is referring to a common pattern in which she self-harms in public in order to be taken to hospital. Sometimes the intention is to communicate a need for care; sometimes the self-harming is more associated with thoughts of suicide. My question about whether this behaviour would be helpful was intended to make Tracey focus on her past use of this strategy of self-harming and being taken to hospital because it had not been helpful to her. It frequently resulted in Tracey being 'stitched up' and discharged back onto the streets feeling more rejected.

11 T: *(.....) I've done it before. There's my stitches there (shows me cut on arm) I'll do it again. (Starts to cry, continues for the next 5 minutes.)*

12 Co: *I'm just wondering if before you do that [self-harm] you could think about an alternative way?*

Here I am placing emphasis on alternative strategies. This is part of the process of conducting what Linehan (1993) refers to as a solution analysis, 'an active attempt at finding and identifying alternative solutions' (Barlow, 2001, p. 497).

In my interventions, I do not directly acknowledge Tracey's distress, which some therapists may be critical of. However, I think that this focus on strategies, rather than on her distress, was intended to reduce Tracey's level of emotional arousal. A focus on her feelings at this point may have increased her emotional distress. What was required at this point was encouragement to think and to problem solve. Tracey sobs and sighs for a few minutes.

12 Co: (.....) *There are places that you can go Tracey. There are (...) have you got a bus pass?*

I am trying to encourage her to think about alternative strategies, but I stop mid-sentence because I realise that she may not have the means to go anywhere. It is important to remain aware of how the particular socio-economic circumstances of the client's life may impact on counselling interventions and practice generally.

12 T: *No.*

13 Co: *I'm just very concerned that you're hurting so much and wanting to hurt yourself.*

13 T: *Cries. Best way to do it, hurt myself.*

14 Co: *Yeah. But I think that there are other options. Perhaps it's a new start for you to see that it's possible to get out of this terrible painful state. Yeah?*

Here the emphasis is on thinking of an alternative to self-harm as a way for Tracey to manage emotional distress. Tracey continues to cry.

15 Co: *And get some care and then gradually start taking on that care yourself. I think at the moment (...) you need the care, perhaps from the outside before you can find it in the inside*

Here I was referring to the view that before a client can care for themselves they need to have experienced care from someone (Gerhardt, 2004). For some clients this may come from the therapist initially and through learning that the client's needs are important. Over time this care from 'the outside' may promote self-care, especially if it is learnt in a relationship where the client experiences that their best interests are paramount in the therapist's mind. Rather than the reverse, which had been Tracey's childhood experience of relationships. Her experience of care had also been associated with abuse in childhood and was re-enacted in her adult life (Herman-Lewis, 1994).

An example of Tracey's re-enactment of her childhood experience in relationships can be seen in the following interaction in which we refer to Tracey's frequent 'care-seeking' from medical staff in a busy Accident & Emergency Department that frequently ended with Tracey feeling abused.. Her experiences include being 'stitched up without pain relief by a nurse who commented that there was no point because she obviously liked pain. She was then 'sent on her way' feeling abused, neglected and rejected.

This re-enactment or replication of the pattern of her childhood has been identified as part of the adult sequelae to childhood abuse. As Davidson & Foa (1993, p. 223) state 'repetitive phenomena have been widely noted to be sequelae of severe trauma. Survivors of childhood abuse are at increased risk.'

Herman-Lewis (1994), also refers to the replication of abuse. Which she says is common in 'survivors':

They may become engaged in ongoing, destructive interactions, in which the medical or mental health system replicates the behaviour of the abusive family (Herman-Lewis, 1994, p. 123).

15 cont. And you're talking about hospital. Has your experience been that they would be caring if you went to hospital with a self-inflicted cut?

15 T: (Sobs) (...) They'd send me on my way.

Tracey responds in a positive way by reflecting that this behaviour was not effective. However, rather exploring the possible consequences of her strategy of self-harm followed by care-seeking, I re-focus too quickly on alternative strategies.

However, this was because it was late evening and I was aware that when the session finished Tracey would be alone on the streets that night, unless another solution was found. This is another example of how the context of the work and the client's socio-economic environment can impact on counselling practice.

16 Co: *They send you on your way. So perhaps that's just repeating the abusive pattern. There are other places you could take that emotional pain this evening and get some help. Have you ever had any contact with the Samaritans?*

16 T: *No. They don't help (...) (Cries)*

17 Co: *Do you know that they have a walk-in service?*

17 T: *They don't help at all (...) they don't understand gay people. Nothing like (...)*

18 Co: *Have you spoken to them before?*

18T: *Yes. They don't under- (...) (sounding angry)*

Here Tracey has become angry probably because I am not responding to her emotional distress or acknowledging her comment that no one can help or understand her. Although my response may seem harsh and lacking in empathy, I believe that continuing to focus on the task, rather than on her feelings, was an appropriate response because there was an immediate risk to her safety. This focus on establishing safety as a priority over exploring feelings is also in line with Stage 1 of DBT.

19 C: *Which branch did you speak to?*

19 T: *Don't know what branch it was.*

20 C: *Was it in (...).*

20 T: *Yeah (...)*

21 C: *Do you know that they have different branches everywhere?*

21 T: *No. They don't understand what's going on ... (Cries)*

22 Co: *Because I think it's safety is the thing that we need to be thinking about. Yeah? (long silence) And that you are worth it. And to end up putting yourself in danger is going to (...) what's going to happen? Come on, all right. Let's (...) let's (...) lets*

Here my own anxiety about Tracey's safety and my search for a solution was evident in the concerned tone and in my words 'Let's (...) let's (...) lets' in the previous interaction.

22 T: *I'll tell you one thing. I wanna get rid of my life, that's it. (Cries)*

23 Co: *Okay, that's how you're feeling at the moment but ...*

Here I responded very briefly to her feelings and used a more comforting and reassuring tone as I tried to remind her that what she was feeling was what she was feeling at this moment, but that painful feelings do pass. However, Tracey's level of distress had risen and she was reverting to a way of expressing her extreme distress that had often got the response from another person that she wanted. By saying that she wanted to die or 'just get it over and done with' Tracey was trying to tell me how she was feeling in one of the few ways she had, but she was also increasing her own distress. This was a difficult situation where I was torn between wanting to help her to manage her feelings and validate her pain, while also feeling the need to help her calm down.

23 T: *No (crying) I want to get it over and done with. Just get it over and done with. No one will miss me or nothing. Get it over and done with.*

24 Co: *That's what you feel now. Have you got anybody at the moment?*

24 T: *No one. (Cries)*

25 Co: *Nobody you feel cares? (...) I care, are there other people here that care? (...) Have you got anyone?*

In this intervention I again focused on the behaviour and on challenging the faulty belief, rather than on her distress because establishing safety remained a priority.

Tracey continues to cry.

25 T: *No, my family don't want to know.*

26 Co: *What about if I phoned the Samaritans on your behalf and asked if there was somebody there that could understand a young gay woman? (...) Gave you a bus pass. Mm? Yeah? How about that? How would that feel? Because they (...) they are open till 9 o'clock. They also have other contacts such as there's a women's crisis service in (...) and I think that getting help and getting care is the adult part looking after the vulnerable hurt part.*

Here I use what is referred to in DBT as the 'environmental intervention strategy'. Within DBT the 'consultant-to-the-client strategy' is the preferred case management strategy. However, during crises such as this the environmental intervention strategy is used when the client is at substantial risk of harm. As Barlow (2001, p. 502) states:

... the 'consultant-to-the-client strategy' is the dominant case management strategy and is used wherever possible. There are times, however, when

intervention by the therapist is needed. In general, the environmental intervention strategy is used over the 'consultant-to-the-client strategy' when substantial harm may befall the client if the therapist does not intervene.

In talking about the 'adult' part of Tracey, I am utilising the concept of ego states from Transactional Analysis (Berne, 1966), which has been useful in helping Tracey to cope with feeling like a very hurt little girl while at the same time being able to keep in touch with herself as a strong surviving adult. I felt it was important to attempt to empower Tracey by referring to the 'adult part' while also acknowledging the 'vulnerable hurt part'.

27 Co: *You've done the other route, you know where it'll lead, you can get pissed, go and express that pain on the street, cut yourself up, go to hospital, get treated*

by people who aren't equipped to deal with the emotional pain. As you say they'll send you on your way, it's more pain, more humiliation, more agony.

Here I was trying to encourage Tracey to think of the alternative strategies such as seeking help from an appropriate source and talking about how she was feeling, rather than acting on it.

27 T: *If I took the heroin and everything then they'd understand.*

Here Tracey is making it clear that she wants others to understand and that she feels she may have to take heroin to make them understand. This may also be an example of unconscious communication (Casement, 1992) because perhaps she has felt that I also have not understood her emotional pain, because I have not focused on it.

28 Co: *Yeah but that's (...) there are maybe other ways you could try. I know (...) I know you're feeling really hurt and that heroin is a pain killer.*

Following Tracey's comment, I acknowledge her emotional pain. I am also attempting to change the behaviour while validating her feelings and response as understandable.

This is an important process in DBT which Barlow (2001, p. 513) describes as a 'formidable challenge for the therapist, who must necessarily engage in a back-and-forth dance between validating the client's pain and pushing for behavioural change'.

28 T: *There's no other way to try because I've tried it all and there's nothing there*

29 Co: *Hey, hey, you've tried (...) you've tried the self harm yeah?*

29. T: (Tracey sobs and again shows me her self-inflicted cut on her arm.)

30. Co: *Yeah I can see. You've tried that, you've tried that, you've tried the self-harm, yeah? You've tried the overdosing, you've tried the getting pissed, all of those ways. You haven't tried finding something else (...) you're coming to see me which is (...) it's a start, it's a change isn't it? You were doing really well.*

30 T: *Yeah, but I've done something for you, like you told me to put my feelings down and I did and 'Claire' (...) sobs*

31 Co: *All right and it's (...) and it's terrible, because what's happened is I've asked you to do something and it's led to more abuse. Yeah? But I think what we have to see is that perhaps there has to be another way.*

Here I am again focusing on the theme that runs through all of Tracey's relationships, that relationships cause pain and that care is always linked to abuse. I am also trying to encourage a belief that there can be another way. However, I felt some responsibility for this latest experience of abuse because I had not raised the issue of how Tracey would maintain the security and confidentiality of her diary and other written information relating to our work. I had asked her to do something and this has led to her getting hurt.

31 T: *There ain't no other way (...) (shouting and crying)*

32 Co: *Okay, so perhaps what we have to do in future is that you have to keep that work – whatever you do – on you, in your pocket, sleep with it, bring it here and I'll look after it for you. Okay? Until you can find a real safe place for that stuff I'll look after it. But I want to see you being safe tonight.*

In this instance I suggest that an alternative strategy is for me to keep her diary safe. By talking about a strategy for keeping something safe, I felt I was communicating on two levels. Trying to communicate that there are other ways to do things and that I will keep part of her safe, if she will also try to keep herself safe. I think this was an effective intervention because in the following intervention Tracey referred to having no where to stay and then agreed to focus on finding somewhere safe to stay .

32 T: *I've got nowhere to stay or nothing.*

33 Co: *Okay, shall we try and sort that out?*

33 T: *Yeah.*

34 Co: *What about ... what about the idea that I ring the Samaritans and ask if there's somebody who would understand you? You know cos you've always said that you wanted a gay (...) a sort of gay person who understands you better. There's lots of people that understand gay young women. Perhaps you just met the wrong, one they change people all of the time. I could do that now, yeah? You could get yourself something to eat and actually start thinking this is a new way of coping with that pain.*

The reference to a 'gay person who would be able to understand her' referred to an earlier conversation in which Tracy said that this was what she needed. The suggestion that she gets something to eat is an attempt to focus her on self-care as part of an alternative approach to self-harm, to manage emotional pain. Tracey then re-focuses on her relationship with Claire who is one source of her emotional pain.

34 T: *But I want to be with Claire.*

35 Co: *Okay. At the moment Claire seems to be causing you a lot of pain.*

35 T: *Pain ! (Shouts, sobs)*

36 Co: *She's causing you a lot of pain. And perhaps a little time ...*

36 T: *She's breaking my heart (Sobs).*

37 C: *Yeah (...)*

37T: *But I'm frightened in case she shows the letter to all those c---s out there!*

38 Co: *Nobody out there is (...) nobody out there is going to let her do that. And yes it's your personal stuff.*

Here my tone changes from a calming, reassuring one to a stronger sounding voice because I needed to communicate that I was strong enough to prevent this further abuse of Tracey happening. I felt that it was crucial for Tracey to believe that no one was going to allow her to be abused and that the day centre remained a safe place for Tracey.

38 T: *That was for you that was, that was all my feelings what I done for you.*
(Sobs)

39 Co: *Yeah and it's all private and it is a real abuse and you ...*

39 T: *Some geezer can't read or write, he gave it to Claire. I put it away secretly at the bottom of the bag and he was emptying the bag sorting out the washing and he gave her the piece of paper and she read it.*

40 Co: *OK (...)*

I am not responding to Tracey's last comment, she had spoken about this earlier and going over the events in this way seemed like an unhelpful form of ruminating. It was also necessary to resolve the situation relating to her safety. This intervention worked because Tracey decided to focus on self-care and get something to eat.

40 T: *I'm going to get something to eat now.*

41 Co: *OK – that's a really good ...*

(Tracey walks to the door)

42 Co: *Do you want me to try and find out about the Samaritans?*

42 T: *Yeah. (Walking out)*

43 Co: *Yeah? Okay. Can I just say one thing?*

I follow Tracey out of the room and encourage her to try talking directly to others about how she feels. Tracey then goes out into the main part of the day centre.

Tracey was able to make a sandwich and to practise an alternative approach to managing her emotional distress. In this instance she was able to practise talking to others about how she was feeling. This was important because it was a new strategy for Tracey and she was able to practice it in the safe environment of the centre, with the opportunity to discuss it in the session immediately after trying it out.. Opportunities to practice are essential because as Linehan (1993a, p. 123) states, 'interpersonal skills can only be learned if they are practised, practised, practised'.

Tracey returns to the session after ten minutes. (Tape recorder still running.)

44 Co: *So you've got through it a bit.*

44 T: *Yeah I feel a bit (...) I talked to a worker and that, she said I was right to put things down on paper and that and Claire had no right to do it or anything.*

45 C: *That's right. But also can you see just by talking to people*

45 T: *Like I told my mate about it, she said it's not your fault, 'Trace'.*

46 Co: *No it's not.*

46 T: *Like Claire thinks it is my fault.*

47 Co: *But what's really important here is what you think, yeah, about being strong. It seems like you've shown me that you are really strong.*

Here I am reinforcing her behaviour and validating her strength; this was a successful intervention because it seemed to reconnect her to her own personal strength.

47 T: *I'm really strong but things just go (...) (gestures 'bam' with her hands)*

48 Co: *They do, but this time things went bam and rather than going out there and doing the same old thing ...*

48 T: *Yeah.*

49 Co: ... you've done it differently. You've talked to people, you've had some food.

49 T: Yeah.

50 Co: Because you seem like you've managed to comfort yourself.

50 T: Yeah.

51 Co: And is that not really important to you?

Tracey had managed to comfort herself without resorting to self-harm. I thought that this was a really important breakthrough and I was pleased that Tracey thought so too.

51 T: Yeah it is.

52 C: That you've managed to take control.

52 T: Yeah.

53 C: And that's really important isn't it? You've controlled the way you felt, you've asked for help, talked it through with people, you talked it through with your friends, you've taken care of yourself, that's brilliant!

2. Discussion

2.1 Summary

This case material presented an account of how an exploration of the functions of self-harm led to specific therapeutic interventions. This represents an alternative to the DBT focus on control and elimination of self-harm as a treatment priority. In this transcript Tracey referred to different functions of her self-harm. She talked about wanting to self-harm and to die. She also talked about the use of self-harm to manage and express her emotional pain. This transcript illuminates some important aspects of self-harm. For example, it shows the range of functions served by self-harm, and it also demonstrates how the meaning and purpose of the self-harm for the client can change even within one session.

Tracey referred to the changing functions of self-harm and the different functions required a different corresponding intervention. Examples included a focus on risk management when the self-harm was discussed with reference to suicide. When the function of self-harm was related to emotional expression, the therapeutic strategies included alternative methods of expression such as practising communication of feelings with others using language, rather than using action ..

2.2 Effectiveness of therapy

This case example provides evidence of effectiveness because it describes a process in which Tracey is initially very distressed and wants to self-harm. It ends with Tracey reporting back on how she has effectively implemented an alternative to self-harm that has worked for her. There was no pressure to stop self-harming and the transcript provides an account of Tracey's progress as she tries out an alternative to self-harm.. In addition to finding a new way of responding to emotional distress through communicating her feelings and accepting their emotional support and validation, Tracey experienced a sense of personal strength. At the end of the session she says: 'I am strong', a significant change from the feelings of despair she expressed at the beginning of the session. Tracey also experienced a sense of control over her emotions. This was important because her usual experience was that when 'things just go bam!' She has no control. This time 'things went bam' but she did not self-harm and found an alternative way to cope.

Tracey has not used self-harm in the past eleven months and was her own decision. She has incorporated a range of self-care routines into her daily life and has undergone reconstructive surgery to repair the damage to her body. This shift from self-destruction to self-reconstruction provided a 'concrete' indication of the effectiveness of this approach. Tracey has also found and maintained stable accommodation and recently decided that she no longer wanted to sell sex. This was particularly important because there was a strong relationship between Tracey's experiences of child sexual abuse and her painful re-enactments of this in her experiences of working as a prostitute.

2.3 The focus now

The focus of the work has now moved to Tracey's interpersonal relationships. This is one major area of Tracey's life that continues to cause her distress. Tracey ended her relationship with Claire, and has maintained a relationship with May, the non-abusive partner. However, Tracey continues to repeat the familiar pattern in which care becomes associated with abuse and this is re-enacted in her relationship with May. The pattern she repeats is that following a period of mutual care and closeness, Tracey reverts to being emotionally and physically abusive to May.

Both partners want to change and have just started coming to a weekly session together in an attempt to resolve this. This move from individual to couple counselling is unconventional but was the only option available to Tracey and May. Again this was mainly because they did not 'meet the criteria' for relationship therapy. At the time of referral, May was classified as a 'street drinker' and homeless and Tracey was labelled as having a border-line personality disorder and so both were regarded as 'unsuitable cases' by available services offering relationship therapy. This view of clients such as

Tracey as being 'unsuitable for therapeutic treatment' is challenged by the evidence presented in this case study. This view has also been challenged in an evaluation of the counselling service for the sex-workers using the drop-in centre. The provision of this counselling service for these clients has been controversial and many believed that it would not work. The clients were considered too chaotic to keep appointments, regarded as potentially too violent and unstable. In short, too dangerous, too damaged, too disordered or too drug addicted to 'do therapy'.

Other professionals offering more traditional services offered to sex workers such as sexual health advice, have expressed concern about the potential danger and damage of counselling for these clients. It has been suggested that the provision of therapy in this context for these clients is 'unsafe'. One of the questions posed was 'who is going to hold the client beyond the session?' The view expressed was that in order for the therapy to be 'safe', these 'victims' of extreme early abuse and neglect, would need to be supported, not sent back out to survive on the street, more vulnerable and 'un held'.

However, rather than deny these clients access to a counselling service, the alternative is to offer a tailored therapeutic approach that is appropriate, informed and empowering. The provision of a 'suitable treatment' for Tracey has offered her the chance to improve the quality of her life. It has helped her to see her own resilience and to consider the impact of her early experiences and the interaction of personal, socio-economic and political forces that have helped to shape her life. .

2.4 Concluding comments

In conclusion, there is a need to develop more effective counselling theory and practice to meet the needs of clients like Tracey, who are often regarded as 'unsuitable'. Clients like Tracey, who display 'border-line' behaviour, are frequently referred to in the clinical literature as 'unsuitable cases for treatment' and denied access to therapy. (Turp, 2003) The 'borderline client, as Yalom, describes, 'strikes terror in the heart of the middle-aged comfort-seeking psychiatrist', whose first impulse is often 'to get the hell away, far away ... use an excuse, any excuse' (Yalom, 1989, p. 214).

This negative, neglectful and often inaccurate view of therapy for clients like Tracey who display 'border-line' behaviour needs to be challenged and more effective approaches developed that can be modified to meet the needs of individual clients.

It is hoped that this case study presents an alternative more balanced and positive perspective on working therapeutically with clients like Tracey who are frequently regarded as unsuitable 'cases for treatment'.

SECTION D: Literature Review

Self-harming and self-soothing: A review of the literature on the use of self-harm as a self-soothing strategy

1.1. Introduction

This review explores the literature on the self-soothing function of self-harm. This includes a specific focus is on whether the self-soothing function of self-harm can be accounted for in terms of a developmental deficit in the capacity to self-soothe. The review also includes literature on the relationship between childhood abuse, developmental deficits and later self-harm. Accounts of developmental deficits and the connection with specific function/s of self-harm are also presented.

The rationale for this literature review is that self-soothing has been identified as an important function of self-harm and as Turp (2003, p.39) states: ‘the question of self-care is () inseparable from self harm.’

However, a preliminary review of the literature on self-soothing and self-harm found just one other piece of research specifically on this function (Gallop, 2002) and only a few very brief references.

This review of the literature on self-soothing may also shed more light on the specific functions of self-harm and the underlying processes. It may also provide insight into the well documented relationship between childhood abuse and later self-harm (Mental Health Foundation & Camelot Foundation, 2006; Brenner, 1999; van der Kolk, 1991 Gallop & Everett, 2001).

There are also implications for counseling practice because an exploration of the self-soothing function of self-harm may help to identify factors that can produce and

maintain change. It may also provide indicators for the development of more effective therapeutic techniques, particularly, for working with clients who use self-harm as a self-soothing strategy

In order to set this review within a context, it begins with an outline of the literature on the aetiology of self-harm and its relationship with adverse early experience. (A more detailed review of the wider context of the self-harm research is provided in the literature review in Section B., of this portfolio)

A review of various accounts of the relationship between self-harm and adverse early experience will follow. Following on from this, literature on the different functions of self-harm and corresponding developmental deficits is reviewed. The focus then moves to research specifically on the self-soothing function of self-harm and explanatory accounts of this. The review concludes with a discussion of the value of this review in relation to theory and practice and recommendations for further research are outlined.

1.2. Theories on the aetiology of self-harm relating it to adverse early experience and abuse

Research into the origins of self-harming behaviour has consistently found that childhood sexual and physical abuse are common antecedents of self-harm. A great deal of this literature suggests that early adversity such as trauma, abuse and neglect are important factors in the later development of self-harming behaviour (van der Kolk, Perry and Herman, 1991; Gallop & Everett, 2001; Sansone, Sansone & Fine, 1995; Zweig-Frank, Paris & Guzder, 1994; Dohm et al., 2002; Levitt, Sansone & Cohn, 2004; Babiker & Arnold, 2001).

1.3 Attempts to explain the relationship between childhood sexual abuse and self-harm.

Research by Boudewyn & Liam (1995) focused on whether particular characteristics of childhood sexual abuse place individuals at greater risk of engaging in self-harm as adults. These findings confirmed that a more severe, more frequent or longer duration of sexual abuse was associated with an increased risk of later self-harm (Mental Health Foundation & Camelot Foundation, 2006, p. 23).

Romans et al. (1996) found 'a clear statistical association between sexual abuse in childhood and self-harm, and that this was particularly marked in women who had been subjected to more severe and more frequent abuse' (In Mental Health Foundation & Camelot Foundation, 2006, p. 23).

The relationship between childhood adversity and abuse and later self-harm was reviewed as part of a comprehensive two-year investigation inquiry into young people and self-harm. This also concluded that 'research indicates a clear link between self-harm and sexual abuse in childhood' (Mental Health Foundation & Camelot Foundation, 2006, p. 23.)

A great deal of the literature makes a connection between early adversity and abuse, but a problem with many of the studies is that they do not attempt to explain the link between childhood abuse and later self-harm. Further, much of the research attempts to establish causal connections, and does not account for the connection or take into account the range of mediating variables (Mental Health Foundation & Camelot Foundation, 1996).

However, there have been some attempts to account for the relationship between early abuse and later self-harm (Babiker & Arnold, 2001; Walsh & Rosen, 1988; van der Kolk, Perry and Herman, 1991), and this is now a growing area of research. One main area of recent research is exploring the way in which early adversity, abuse and trauma impact on development and result in the use of self-harm as an response (Yates, 2004).

1.4. An exploration of the relationship between the functions of self-harm, early adversity and specific areas of developmental deficit

Within the literature on self-harm, the functions of self-harm can be broadly located under four main headings: Emotional regulation, communication, dissociation and control. These four categories are outlined below.

1.5 The emotional regulation function of self-harm childhood adversity and development deficits

Linehan (1993) links a deficit in the ability to regulate emotions with later self-harm. She proposes that self-harm provides a way of regulating levels of arousal or of trying to bring the body back to equilibrium in the face of distressing feelings. She states that 'cutting and burning the body seem to have important affect regulating properties' (p. 60). Linehan goes on to suggest that a deficit in the ability to regulate emotions may be the result of an interaction between an individual's biological vulnerability and an 'invalidating environment' in which the individual does not learn to identify emotions. However, as Linehan points out 'the exact mechanism here is unclear, but it is common for individuals to report substantial relief from anxiety and a variety of other intense negative affective states following cutting themselves (p.60).

A range of recent research supports the view that self-harm provides a method of emotional regulation (Yaryura-Tobias, Neziroglu & Kaplan, 1995; Zila & Kiselica, 2001). Support for this self-regulatory hypothesis comes mainly from qualitative investigations in which people who self-harm have been asked about their reasons for self-harm. Many individuals have reported that self-harm provides a method of emotional regulation and that it offers subsequent relief from intense affect (Himber, 1994; Shearer, 1994; Strong, 1998).

Support for the emotional regulation function of self-harm can be found in research from diverse disciplines. For example, work reviewed by Gerhardt (2004) presents neuropsychological research that indicates that if the child is not taught to manage feelings there are corresponding effects on brain development. According to this view, 'the child is simply not being taught how to manage feelings and so may not develop the brain structures to calm himself and cope with distress' (p. 154). According to Gerhardt in order to learn to self-regulate emotion an infant needs to experience a regulatory relationship 'characterised by the presence of consistently responsive adult who can regulate the child's level of emotional arousal and stress and the corresponding level of cortisol (2004, p. 77).

1.6 A 'deficit model' and the function of self-harm as communication

A number of other authors have looked at the function of self-harm as communication (Gardener, 2001; Strong, 2003; Levenkron, 2000). The hypothesis that a deficit in the ability to communicate may lead to the later use of self-harm as a strategy for communication is supported by a range of research. For example, Levenkron describes one function of self-harm as being to compensate for a deficit in the ability of the individual to express experience through the use of language. The function of self-harm as communication is also accounted for by Miller (1994). She proposes that self-harm provides concrete expression for the pain an individual feels inside, but can not communicate using language.

Similarly, Strong (2003, p. 66) states that self-harmers can '... through this body language of blood and scars, communicate much more directly and forcefully than they can speak in words'.

The hypothesis that the use of self-harm as a method of communication is related a deficit in the ability to express internal experience using language, has been more recently explored by Bateman & Fonagy (2004). This research indicates that the deficit in the ability to express internal experience using language is caused by a disruption in the underlying capacity to 'mentalise'.

1.7 The control function of self-harm and development

Another way in which the connection between childhood abuse and later self-harm have been accounted for, is in terms of control. There are a number of references to the control function of self-harm (Berger, 2003; Strong, 2003; Potier, 1993). According to Strong (2003, p. 126), self-harm provides a sense of control. She states that, however self-destructive the act of cutting seems

... Cutters have moved from a place of passive helplessness to active control. Cutting is one thing they can control.

In earlier MSc research it was found that participants made a direct connection between their self-harm, experiences of early adversity and the use of self-harm to achieve a perception of 'control'. Participants described the perception of 'control' that self-harm provided for them in the face of abuse. In these circumstances this use of 'control' could be seen as resistance. The participants also explained how the use of self-harm provided a feeling of 'control' over them. In this way, the use of self-harm could be understood as an attempt to gain personal power (Williams, 2005). The experience of powerlessness is frequently described as a long-term effect of childhood abuse (Strong, 2003).

1.8 Early adversity, deficits in self-soothing and self-harm

The literature on self-soothing does not appear to offer a concise definition of self-soothing and it seems that knowledge of what constitutes self-soothing is regarded as a 'given', rather than defined. It is suggested that self-soothing in adulthood can be defined as a response that reduces emotional distress. Self comforting or uplifting activities may include a range of self-caring, self-nourishing activities and giving time, thought and focus on making ones self-feel better. Self-harm may be used as a method of self-soothing in the absence of an alternative strategy to reduce emotional distress and manage intense emotions .

The self-soothing function of self-harm has emerged in recent qualitative research (Williams, 2005; Arnold, 1995). In Arnold's study, 13% of respondents described the function of their self-harm directly as comfort and 57% reported that self-harm provided relief from feelings of distress (p.3).

1.9 Accounts of the development of the capacity for self-soothing and the concepts of 'internalization' and 'internalized representations'

There is some literature that accounts for how the capacity for self-soothing may be acquired. Winnicott (1958) initially developed the concept of 'internalization of the ego supportive mother' and 'transitional objects'. According to this theory, the child can use external objects to comfort the self.

For example the child's blanket, a tune, or the stroking of the arm ... can be used to recall the comfort of the mother when she is not there. As one matures, these self-soothing techniques are able to become more diffuse and more abstract ... one finds ways to comfort oneself (Winnicott, 1958. In Gallop, 2001, p. 22).

This concept of internalised representations was further developed within object relations theory (Mahler, 1979) . This provides an account of how failures in early care-taking may result in an inability to internalise soothing feelings. 'As an adult, the individual is unable to evoke comforting images or feelings of soothing and is unable to self-soothe' (Kreisman & Straus, 2004, p. 147). Object relations theory suggests that in order to develop a 'self-soothing capacity one must have first experienced it and internalised a caring figure or 'good object'. As Turp (2003) says:

The establishment of a good internal object is immediately relevant to self-care, for self care must surely be grounded in a sense of self-worth, in the understanding conscious and unconscious that, that one is deserving of self-care, that it is right that one should be treated with proper care and respect (p. 48).

Another rather controversial requirement in the development of a self-soothing capacity is suggested by Kystal (1988) who says that in order to self-soothe one must believe in the right to carry out this function, which is seen as a function belonging to the parental objects . So, according to Krystal self-soothing not only depends on the ability to implement self-soothing strategies, but also on a sense of entitlement with regard to the use of the self- caring functions.

According to Gallop & Everett (2001), the consequence of this failure to internalise adequate internal representations is a deficit in the capacity for self-soothing in adulthood. Gallop & Everett (2001, p. 20) also suggest that many individuals who have experienced childhood abuse and turn later to self-harm have not developed the capacity to self-soothe. They state:

... For many self-harmers a history of childhood trauma leaves them vulnerable to intense, overwhelming and painful affect. The internal capacity to comfort or self-soothe them when confronted by these feelings is often lacking.

Other research also makes the connection between childhood abuse, the failure to self-soothe and subsequent self-harm. For example, Strong (2003) suggests that abused and neglected children never learn from their parents how to soothe themselves and cannot trust others to help them do so and so later develop self-harming behaviour that can soothe and also be relied upon.

Arnold (1995, p. 3) also found that one of the important childhood experiences of the participants in her survey was a lack 'of appropriate nurture, support or guidance from the adults around her' and of opportunities in childhood to 'develop her own strategies for understanding and dealing with events, her experiences and her feelings'.

Research by Turp (2003) also indicates that inadequate early care is linked to an impaired capacity for self-soothing and the later use of self-harm. Likewise, Conterio, Lader and Kingston Bloom (1998, p. 139) state that 'the characteristics of self-injurers include parenting deficits which led to difficulties internalizing positive nurturing' self-injurers include parenting deficits which led to difficulties internalizing positive nurturing'.

Conterio, Lader and Kingston Bloom (ibid, p. 20) suggest that:

Having acquired no truly adaptive, internal abilities to soothe herself or control distress, the self-injurer comes to rely on action – not thoughts, fantasies or words – to gain relief. ... Strange as it may seem ... self-injury represents a frantic attempt by someone with low coping skills to mother her. Operating without a paradigm of maternal care, she feels alone, with no hope that a soothing presence will come make it all better.

Similarly, in their account of self-harm Levitt, Sansone & Cohn (2004, p. 78) also emphasize what they describe as ‘the ill-directed nurturing intentions of the self-injurer’:

Strange as it may seem to the uninitiated, self-injury represents a frantic attempt by someone with low coping skills to mother herself ... bodily care has been transformed into bodily harm ... the razor blade becomes the wounding caregiver ... a cold but available substitute for the embrace, kiss or loving touch she truly desires.

The self-soothing function of self-harm is also referred to by Babiker & Arnold (2001) and Gallop (2001), who offer a different account of how and why self-harm may function as a method of self-soothing. One explanation proposed by Babiker & Arnold (2001) is that self-harm provides an opportunity for self-nurture following self-harm. They suggest that :

The period following self-injury may, for some people, provide their only opportunity to experience physical caring and comfort. Whether or not there is physical pain, the person feels they have been through something and so now ‘deserve’ some special caring (p.78).

There is a range of recent neurobiological research that also provides support for the view that the capacity to self-soothe is acquired through interactions in infancy and that these interactions also influence the development of neurobiological structures and

processes related to the development of the self-soothing capacity (Gerhardt, 2004.; Schore, 1994)

1.10 Neurobiological research that links deficits in self-soothing, childhood abuse and later self-harm

Recent research from neurobiology suggests that the lack of the capacity to self-soothe in victims of abuse may be compounded by neurobiological disruptions. This provides support for the hypothesis that a deficit in the capacity to self-soothe is linked with early environmental adversity, abuse or trauma in childhood and later self-harm.

For example, Gallop et., al., (2001, p. 23) argues that in order to ‘fully understand the link between self-soothing behaviour and self-harming behaviour in abused women, it is important to understand that childhood trauma may result in permanent neurological changes’.

Gerhardt (2004) reviews recent neuroscience findings which suggest that the neural networks involved in self-soothing and self-comfort are initially dependent upon stimulation in the form of positive interactions from primary care givers. Gerhardt also discusses the impact on development of growing up in an adverse environment in which the carers have often not developed their own self-soothing capacities and so cannot help the child to manage emotions. Gerhardt (ibid, p. 151) suggests that ‘instead of responding accurately to the baby’s signal and soothing him ... she will increase his unpleasant arousal rather than regulating it back to a good state’. Further, Gerhardt suggests that the carers may not have developed a capacity to self-soothe and that ‘lacking self-soothing skills, such parents trying to cope with a baby will be highly stressed’ (ibid, p. 151).

According to Gerhardt (ibid, p. 147), the effects on the child’s brain of early abuse and neglect are like other forms of stress. She states that ‘the earlier a child experiences abuse or neglect, the smaller the brain volume, particularly of the prefrontal cortex’ and, further, that ‘with a weakly developed prefrontal cortex the capacity to soothe the self ... remains immature’.

An extensive search of the literature found no strong arguments which contradicted the hypothesis of a deficit in self-soothing as one factor in the later use of self-harm. In fact, the only argument found following an extensive review was that proposed by Krystal (1998) who rejected the concept of a deficit in the capacity for self-care/ self-soothing and stated that a 'capacity to self-care is a 'given'. The idea of a deficit in self-soothing is rejected by Krystal (1988) who suggests, that a failure to self-sooth is not related to a deficit in the capacity, but is the consequence of the belief that one does not have the right to implement self-care and self-soothing strategies. As Krystal states:

It is that he is unable to acknowledge, claim and exercise various parts and functions of himself; he experiences these as being part of the object-representation, not of the self-representation. Without being consciously aware of it, he experiences himself as unable to carry out these functions because he feels that they are prohibited to him, reserved for the parental objects (1998, p.174. In Turp, 2003 p.31).

However, it can be argued that if an individual feels that s/he cannot care for themselves or self-sooth (for whatever reason), then this amounts to a deficit in the capacity for self-care/self-soothing. Further as Turp, (2003, p.50), points out:

With recent neuroscience findings in mind. [] It seems unlikely that self-care is an emergent 'given', as Krystal suggests. The infant is ill equipped to manage biological functions on his or her own. [] There is little reason to suggest that a situation with regard to self-soothing and self comfort is different. Almost certainly, the neural networks involved in these functions, in common with other neural networks involved in physiological self-regulation, are dependent upon stimulation in the form of positive interactions with primary care-takers.

There is a substantial body of research that provides support for the theory that the capacity to self-soothe initially develops in interaction with environmental factors such as positive interaction with 'care givers' in infancy (Gerhart, 2003) . This view is

supported by recent neuropsychological research that indicates that the development of the brain and neuropsychological and physiological processes is shaped by environmental factors and in early interactions. This research indicates that adverse early socio-emotional experiences may result in developmental deficits and dysfunction. Further, research also suggests that developmental deficits and disruption of regulatory systems may result in the later use of self-harm as an adaptive response to dysregulation. In conclusion it is possible that the principle of self-regulation may provide one explanation of how self-harm functions as a method of self-soothing. It may also provide one account of the association between early adversity and later self-harm .

1.11 Implications for practice

There are clear implications for practice arising from an exploration of the functions of self-harm because the different theories which seek to explain the reasons why some individuals develop self-harming behaviour offer guidance on the approach to working

with individuals who self-harm. It is important to explore the functions of self-harm for the individual because once the functions have been identified it may be easier to generate alternatives and to develop more effective counselling strategies.

As Turp (2003, p. 39), Comments:

The idea of connection between the everyday vicissitudes of self care and behaviour typically described as self harm offers the possibility of a shared understanding between practitioners working with self-harm and the clients themselves.

In looking specifically at the implications for practice emerging from the research on the self-soothing function of self-harm, a main issue is the need to help the individual to develop the capacity to self-soothe. As Gallop et. al., (2001, p. 24) state:

Therapy for individuals who self-harm because of an impaired capacity for self-soothing must be directed at helping the woman to develop this capacity. This develops within a therapy relationship in which they experience safety, reliability

and non judgement. Work must be directed at managing emotion, developing less harmful methods of self soothing and dealing with the impact of trauma

Gallop & Everett (2001, p. 195) also refer to the importance of helping the client to develop 'their own repertoire of self-soothing strategies'. Ways in which this can be achieved may be to focus initially on self-care and, if necessary, the belief that the individual deserves care and comfort. Another issue that emerges from a review of the literature on self-harm as a method of self-soothing is whether it may be important for the client needs to internalise a positive image of the counsellor within a supportive relationship in which trust can be gradually developed.

Another related area includes the question of whether clients who have not experienced care, first need of an experience of care from the 'outside', before they can develop the capacity for self-soothing and self-care. If this is the case as (Gallop, et.,al., 2001) suggest, an important issue for the therapist is how to achieve this. The research

reviewed suggests that a balance is needed between the client's initial need for an experience of 'care' from the 'outside', while at the same time validating the client's ability to simultaneously develop self-care.

1.12 Implications for improving research

It seems that further research into deficits in the self-soothing capacity and the relationship to the later use of self-harm as a method of self-soothing is needed. When one considers that a lack of the capacity to self-soothe is regarded by Linehan, (1993) as a key factor in BPD, and given the strength of the association between BPD and self-harm, it seems that further investigation is crucial.

This review has also highlighted the need for further research into the requirements for developing self-soothing and mechanisms and processes underlying this capacity and the relationship with self-harm.

1.13 Conclusion

The review has explored the literature on the specific functions of self-harm and how they may be related to particular developmental deficits arising from experiences of early adversity such as abuse and neglect. The use of self-harm as a way of coping with deficits in self-soothing may lead to insights about the underlying processes or mechanisms. It has been suggested that the self-soothing function of self-harm may be related to disruption in the underlying regulatory systems and that self-harm can be viewed as a functional adaptation to this dysregulation. However, further research is needed to investigate the relationship between developmental deficits and dysregulation and the later use of self-harm as a method of self-soothing. Further research into the self-soothing function of self-harm seems essential for the development of the theoretical knowledge base and in order to inform the approach to working with clients who self-harm. As Gallop et., al. (2001, p. 25) conclude:

Those who understand the complexity and multiple meanings and purposes of self-harm are better positioned to provide clients with a supportive, growth-promoting therapeutic experience ... and to promote their internal capacity to soothe and comfort themselves.

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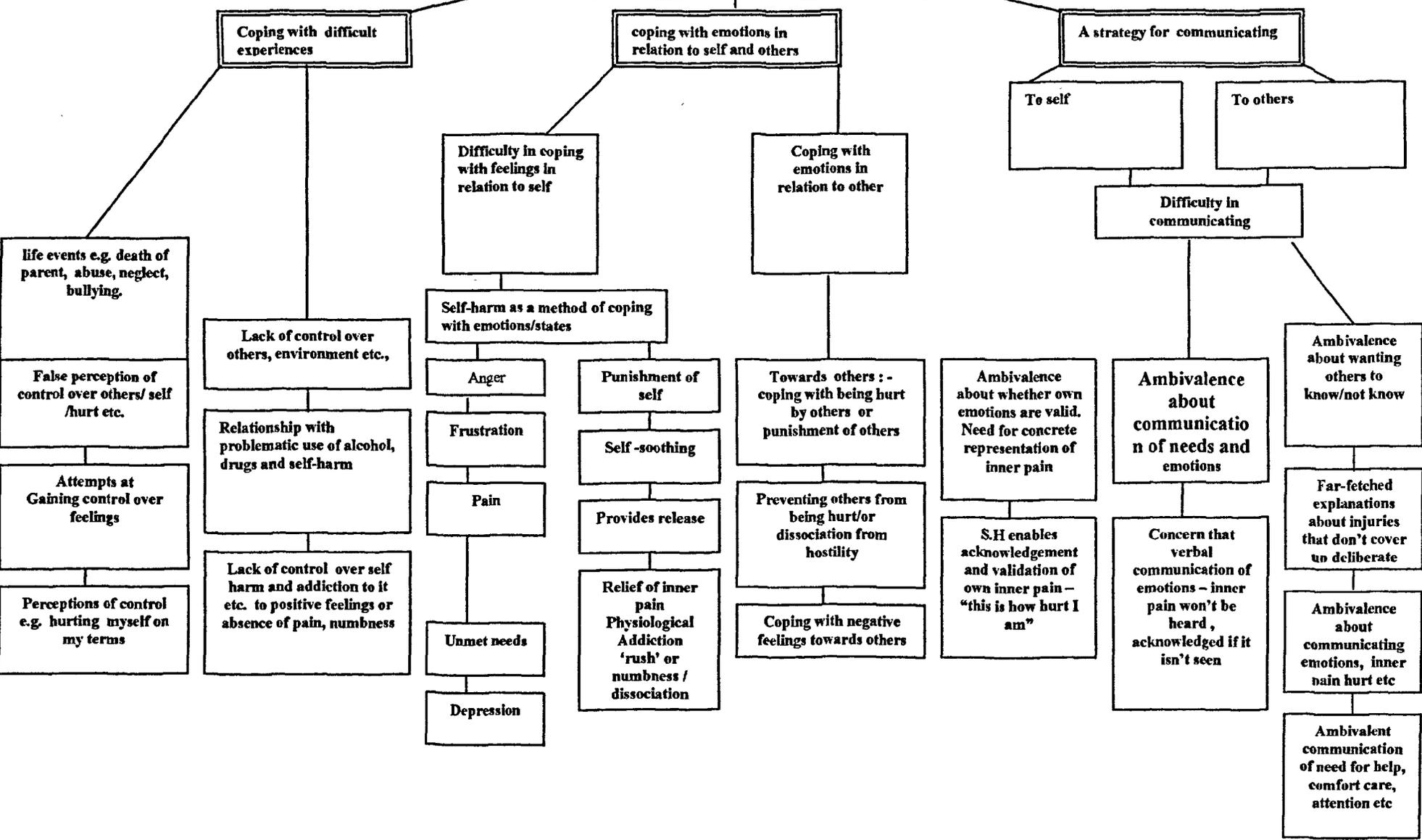
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Ways in which self-harm is used as a coping strategy



Appendix I: Chart of initial 'coping' model

Appendix 2 Recruitment Poster

Are you a young woman aged 16-25?

Are you self-harming?

I am interested in hearing about your experiences.

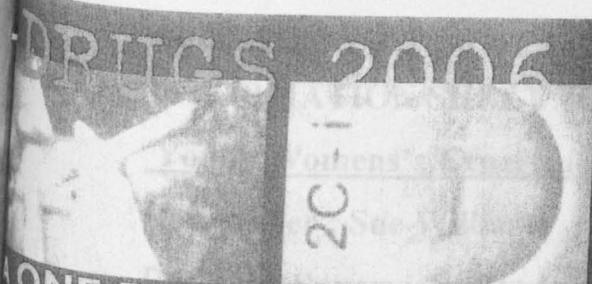
I am carrying out research as part of my

Doctorate at City University (London).

Research supervised by Dr. Jacqui Farrants

0207 040 0172

j.r.farrants@city.ac.uk



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GENERAL

Are you a young woman aged 16-25 years? Are you self-harming?

I am carrying out a research project and I am interested in hearing about your experiences. Please contact Sue, in confidence, about participating in this project.

07950367289

suwil99@yahoo.co.uk

Research supervised by Dr. J. Farrants (City University, London).

When responding to our adverts please mention that you saw it in **The Big Issue**

Appendix 4 Consent Form

Title of project : Young Women's Experiences of Self-harm

Researcher: Sue Williams
Counselling Psychologist in training
City University, London.

Research Supervisor : Dr. J. Farrants
City University, London.

I confirm that I have read and understood the attached information sheet .
I understand that my participation is voluntary and that I am free to not
answer any question, to take a break or to withdraw without giving any
reason.

I understand that any decision I make will not affect the service I receive in
any way.

I understand that confidentiality and anonymity will be maintained
throughout. However I am aware that if I disclose information that a child
or vulnerable individual is being seriously harmed, confidentiality and
anonymity cannot be guaranteed.

I confirm that I am not currently under the influence of drugs or alcohol
and that I am fully able to give my consent to take part in this project.

Participant Signature _____ Date _____

Researcher Signature _____ Date _____

Appendix 5: Sample of email contact with supervisor provided
another method of journaling and recording research process e.g.,
gradual development of model .

" Farrants, Jacqui " <J.Farrants@city.ac.uk> wrote:
Dear Sue,

This is all shaping up as very interesting - there i
very
intelligent thinking around your findings, and you w
and
persuasively. I think your polarisation idea is ver
and does
seem to fit your findings well, and also pulls toget
various
other research findings, which have been very bitty
different
functions of self-harm.

Some thoughts:

Ensure you reference everything - eg the various p
list.
In answer to your question - no need to include al
that
relate to a theme - just give a selection (3 or 4)
that
illustrate your theme the best. It is your job to
to the
reader that what you are saying you have found (ie
are
valid and grounded in the data.

http://uk.f531.mail.yahoo.com/ym/ShowLetter?box=Inbox&MsgId=381_19082053_3... 26/07/2007

Appendix 6 Summary Chart for transcript

THEME	SUB-THEME	<i>Notes and Quotes</i>	Page Number	Line Number
Coping mechanism				
Coping with difficult life events				
	Coping with stressful events			
	Coping with feelings of powerlessness and lack of control over events			
	Control over hurt			
	Family adversity			
	Family relationships Revenge Self-punishment			
Coping with experiences of powerlessness and lack of control	Coping with feelings of powerlessness and lack of control over events			
	Abuse- bullying and feeling of powerlessness			

	Neglect			
	Taking back control			
	Coping with emotions in relation to self			
Coping with difficulty/ inability to communicate experience	<p>Issues of addiction and lack of control over self-harm</p> <p>Communicating I tried to explain to her but she didn't seem to understand too much. And . She didn't want other people to see them. 17 819- 820- I tried to explain to her but she didn't seem to understand too much</p> <p>R She never talks about them. 17/799-803</p> <p>feelings/emotional states to self</p>			
Coping with ambivalence about communicating	Communicating feelings/emotional states to others	Or I'll say a cat scratched me. My dad actually saw a scar ... when I was still living at		

<p>experience</p>	<p>Ambivalent communication of need for care, comfort, help etc.</p> <p>Ambivalent communication of Inner state/emotional pain</p>	<p>home I'd actually got a pair of scissors, I was up in my bedroom and I'd cut my wrist. My dad said 'What's that?' and I was like 'Oh a cat scratched me'. And he bought it. You know he just ... 18 841-847</p> <p>it didn't look anything like a cat scratch.</p> <p>he didn't say anything else after that.</p> <p>They didn't ask anything else after that. They were like 'Oh okay'. And it's like ... it's almost like if people can't handle it ... mm. 18/863-864</p>		
<p>Coping with</p>	<p>Coping with distress-</p>			

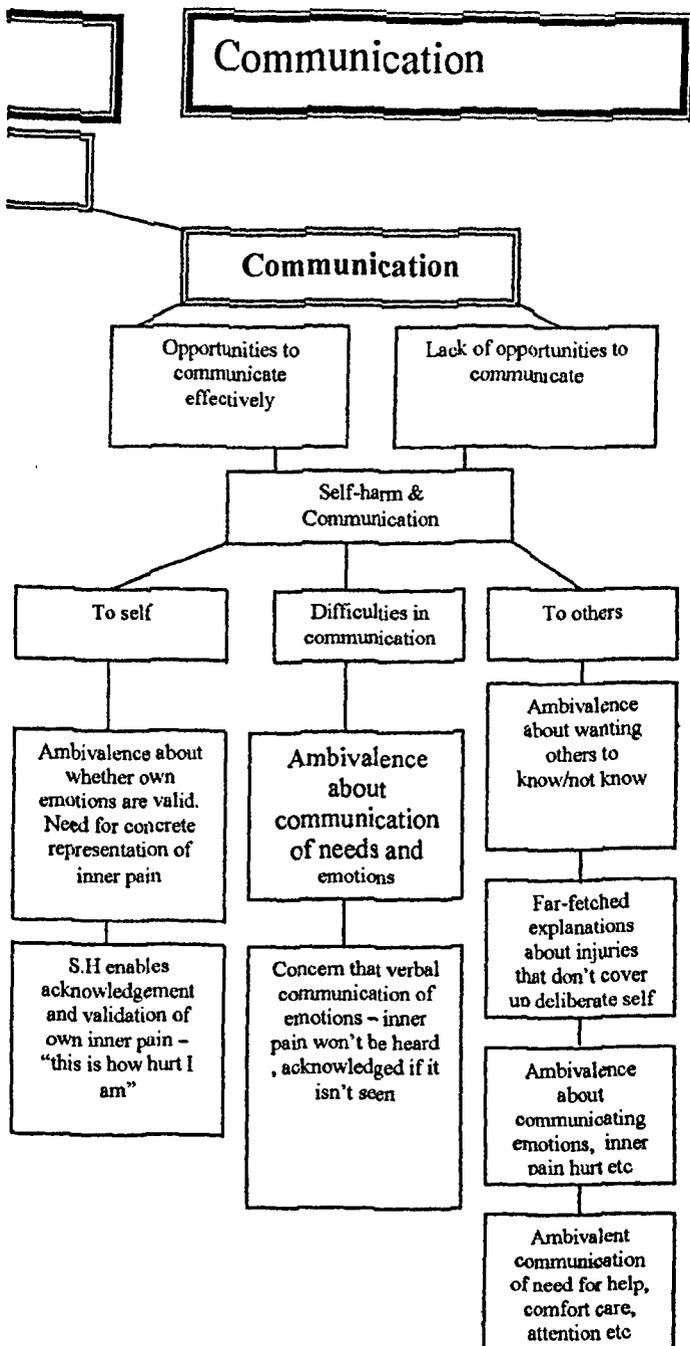
emotions in self	self-soothing			
	Anger			
	Frustration			
	Pain	Yeah I think so, yeah yeah. I just feel like my head's going to explode and the only way to get rid of it is to bash my head on a wall or try 11/516-518		
	Unmet needs			
	Depression			
	Coping with anxiety and tension-provides relief/release			
Coping with emotions in relation to others				
Professional Responses (Nurse,	I think because they don't understand, they don't comprehend why people do these things to themselves. 20/941-942			

PAGE

NUMBERING

AS ORIGINAL

Appendix: 7 Diagram of stage in analysis



Appendix 8: Ethics release form

Ethics Release Form

All students planning to undertake research in the Department of Psychology for degree or other purposes are required to complete this Ethics Release Form and have it signed by their supervisor and one other member of staff prior to commencing the investigation. Please note the following:

- An understanding of ethical considerations is central to planning and conducting research.
- The published Code of Ethics of the British Psychological Society (1997) Code of Conduct, Ethical Principles and Guidelines. BPS. Leicester and American Psychological Society (1992) Ethical Principles of Psychologists and Code of Conduct. American Psychologist, 47, no 12, 1597-1611 should be referred to when planning your research.
- Approval to carry out research does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, eg: Hospitals, NHS Trusts, HM Prisons Service, etc.
- Completed and signed ethics release forms must be submitted as an appendix in the final dissertation

Please answer all of the following questions:

Has a research proposal been completed and submitted to the supervisor?

Yes No

Will the research involve either or both of the following:

2.1 A survey of human subjects/participants

Yes No

2.2 An intervention with a cohort of human subjects/ participants, and/or an evaluation of outcome of an intervention?

Yes No

Is there any risk of physical or psychological harm to participants (in either a control or experimental group)?

Yes No

Will all participants receive an information sheet describing the aims, procedure and possible risks involved, in easily understood language? (Attach a copy of the participants information sheet)

Yes No

Will any person's treatment or care be in any way prejudiced if they choose not to participate in the study?

Yes No

Will all participants be required to sign a consent form, stating that they understand the purpose of the study and possible risks ie will informed consent be given?

Yes No

Can participants freely withdraw from the study at any stage without risk of harm or prejudice?

Yes No

Will the study involve working with or studying minors (ie <16 years)?

Yes No

If yes, will signed parental consent be obtained?

N/A

Yes No

9. Are any questions or procedures likely to be considered in any way offensive or indecent?

Yes No

10. Will all necessary steps be taken to protect the privacy of participants and the need for anonymity?

Yes No

Is there provision for the safe-keeping of video/audio recordings of participants?

Yes No

11. If applicable, is there provision for de-briefing participants after the intervention or study?

Yes No

12. If any psychometric instruments are to be employed, will their use be controlled and supervised by a qualified psychologist?

N/A

Yes No

If you have placed an X in any of the double boxes further information below:

, please provide

Appendix 9: Interview schedule

Sue Williams

Research on Self-harm October 05

'An exploration of the use of self-harm as a coping strategy in relation to self and others.'

Thank you very much for agreeing to take part in this study.

1) What does the term 'self-harm' mean to you?

2) Can you tell me about the first time you self harmed?

Prompts

What did you do?

What did you feel?

What did you think?

What did it do for you?

3) What does self-harm do for you now?

Prompts

What do you do?

What do you feel?

What do you think?

What does it do for you now?

4) Have your self harm changed in the time you have been doing it?

Prompts

Has what you do changed?

Has the way you feel about self-harm changed?

Has the way you think about self-harm changed?

Has what it does for you changed?

5) What happens after you self harm?

Prompts

What do you do?

What do you feel?

What do you think?

What does it do for you?

6) Is there anything else that you want to tell me about self harm?

Appendix 10: Example of transcript

INTERVIEW: 'ELIZABETH'

I: interviewer, R: respondent

p.1

I So are you all right? Are you sure you don't want a coffee? Yeah?

R Um ...No

I Thanks ever so much for coming, I really do appreciate it.

IE.1.13 So ... I can see you've got a bandage on your arm now.

R 15Ice skating.

I Really?

R Yeah.

I Do you want to talk about it?

R Um... maybe.

I How did you ... ?

R Don't know, just fell over.

I Fell over?

R Yeah. But um ...its tubi-grip.

I Yeah. Does it hurt?

R Um...

I Okay... I mean if you don't want to answer a question that's fine you just say 'No, shut up! Don't want to answer that one, that's absolutely fine... No pressure ...I promise. If you feel that then just tell me to shut-up! I can take it (laughs).

R47 It's a self harm attempt (laughs).

I Yeah, well I can understand something about that.

I Can you say anymore about what it does for you?

R52 ... helps me feel able to get on with the day (inaudible)

I Right, yeah that's very interesting. Can you say more about how it helps?

R Um ... alcohol being another one.

I Yeah what's the alcohol ... How does that help you get through the day?

R When I'm sober I see things in a different light and I can't handle that so I have to be drunk.

I And can you say anything about how the self-harm helps you get through the day?

R 66 -68It's just a way of expressing how I'm feeling to myself and a release ... just a release mechanism. When I get really pent up and angry I just end up hurting myself.

I And when you say expressing the way you're feeling to yourself, can you say a little bit more about that?

Eliz 2/R

72 -74I can't

deal with the emotional pain that's going on. So I have to make it physical, then I can comprehend the pain. See the scars and the cuts and stuff or the burns.

I And do those scars speak to you in a way then?

R Yeah just ... in a sense just ... makes it reality.

I RELIZ 2 80 -83 can't sort of express myself when ... you know all the emotional crap that goes on. And I end up ... I have to hurt myself physically by cutting, scalding or whatever. Just to ... for me to see the pain.

I Yeah, well I can understand that.

I I don't know I can't really explain it.

I That's a brilliant explanation.

R Is it?

I Yeah it's a very interesting explanation of ...

I Right.

R I've been trying to cut it down and stuff and whatever, and then there's been a lot of crap happening in the past week or so and my drinking's really gone up. I'm trying to cut it down but I'm finding it hard at the moment.

I And does your self harming increase when you're drinking?

R Yeah. In the past few weeks because of things that have been going on. I just want to take it out on myself.

I Can you remember the first time that you self harmed?

R Not exactly. But I was living at home with my parents. I was about 12 or 13. I used to ... when my parents were out doing the weekly shop and that I used to throw

myself on the floor to hit my wrist. And then after that I started putting bleach on my arm.

I Right.

R Or boiling the kettle and pouring boiling water over my arm.

I What were you sort of thinking about though? Do you remember ...

R I don't remember exactly, I just did it and then like hid it. I didn't tell ... you know my parents didn't even know I was doing it. And I used to tie elastic bands round my fingers and sleep with it all night really tight till my fingers were ... I mean this finger, that little finger, I lost feeling because I'd left the band on.

I And that just ... did you say 12 or 13?

R About that age yeah. 13, 14 ... 12, 13, 14, round those years.

I Right. And can you say anything else ... I mean if you don't want to answer a question that's o.k.

R3 13 I don't know exactly what started it off, but my mum's schizophrenic.

I Right okay.

R And has been since just before my brother was born. And there's 5 ½ years between us. He's 5 ½ years younger than me. And it started just before she had him. Her cousin who she was very close with, they used to do everything together, she died of cancer. 138

I Right.

R And her cousin Carol she had two boys, William, same age as me, there's a couple of months between us, and then she had Neil. And that's round about the time

my mum had my brother. And then just after Neil was born Carol died of cancer. And that set off her schizophrenia and stuff. And then like ... so I've grown up with ... I knew my mum before the schizophrenia started but I've only got vague memories of that. 3 143-144 And so most of my life, well the rest of my life I've known mum being ill. And I think that's possibly to do with the way I behave and the way I do things.

I So very very difficult, very difficult.

R It has been. But I mean we're talking and you know we're getting on all right now, but there's been times when I left home and came to London, my mum didn't speak to me for months, she didn't want to talk to me at all.

I Why was that?

R She got arse-ache (?) about me getting up and leaving.

I Right.

R Just disappearing.

I I was still in contact with my grandparents and tried to speak to my dad whenever, but my dad couldn't speak to me all the time because you know being at home with my mum, and things were difficult. And then it was ... I mean I started originally self harming when I was still living at home. And then I didn't do anything for a number of years until after I left and came to London. And then I started cutting.

R Right. And was there something then that ...

I It was just the situation with my mum, between me and my mum, that she didn't want to know me because I'd moved away. And she had arse-ache(?) with me, I had arse-ache with her.

I Things were really difficult.

R Yeah, so you know I just spent a lot of time just cutting my arms and then gradually over the time, over the years it progressed. Started cutting my legs, cutting my body, cutting my face. Mainly just cut my arms, but it did go on to cutting other parts of my body.

I Right. So it's changed over time as well?

R Yeah oh yeah, yeah.

I From putting elastic bands on to sort of cutting.

R Or just going round and ... I went through a phase ... I was living in a hostel in Stoke Newington and I kept going down to the basement to the art room and just bashing my head on a brick wall. I've got photos of me with a cut here, and I just always kept head butting.

I And has what self harm does for you changed? Because you said at the beginning that what it does for you now is it gives you a way of communicating emotional pain to yourself.

R Mm.

I Expressing that pain to yourself and also acting as a release? ...is that what you said ...?

R Yeah, it's always been that way but in recent years I've been trying to stop doing it.

I Right.

R I think the alcohol has taken over a bit. I use the alcohol sprees to get a different feeling, and maybe on occasions some other drugs and a bit of puff or ... I mean I went through a phase where I was taking speed a lot and acid. And then I stopped all that.

I When you were doing the speed and the acid were you self harming?

R On and off. Yeah.

I Or was it like you were substituting one for the other?

R Yeah, I think so yeah, more substituting. I was still self harming because I was in and out of hospital a lot then. You know suicidal attempts things like that. Yeah it has changed over the years, but in one way or another I still self harm. Whether it's through the alcohol, cutting... drugs ...

I Yeah.

R Or something else.

I What happens after you self harm? Can you sort of explain after you've cut yourself or ... what happens after you ...

R I feel calmer.

I Right.

Re 5 237-242 It starts off I feel really pent up and angry or upset or whatever, or a mixture of those emotions ... and then I self harm. And I keep self harming until those feelings have subsided. It might just be a few minutes, 5 minutes. It might be half an hour. You know might just do two or three cuts, but I might cut all the way up both arms and just carry on until there's no room left to cut.

I I can see you've got lots and lots of scars on your arms.

R Mm. They go all the way up.

I And then do you have to wash them all off or ...

RE 6 250-252 Yeah I just ... I leave it a little while, wrap it in a towel. Like I've got my self harm bag.

I What's that? What's your self harm bag?

R255 It's got bandages, tubi-grips, a little tin with all the blades, and a towel. And I've been trying to throw it all away but I can't. So I keep it in a cupboard, or you know carrier bag. It's just been there all the time, for a long time now.257

I Have you had any help that you feel has been helpful with the self harm at all? Have you wanted any help with it?

R262 Well I went ... I did psychotherapy. It was a trial period for 6 weeks, one to one. But half way through that I ended up being admitted to the hospital. But I still carried on as an inpatient going to the psychotherapy because it was all based at the same site in the hospital at (-) And the (-)... you know it was in the sense ... it was a trial period for the psychotherapist to decide was I suitable for cognitive therapy.

I Right.

R6/271--274 She turned round basically at the end of it and said no I wasn't suitable because of my personality. I couldn't do cognitive, you know ... But I'm still waiting for ... that was some years ago now, that was 3 or 4 years ago. And I'm still waiting for something to happen. And I started art therapy, I was in hospital last July trying to do a detox and then from then a couple of months after that I started art therapy. But ...

(interruption someone comes in briefly)

R You don't mind me locking the door? Sorry, sorry about that.

I You were saying you started ...

R Yeah I started art therapy but then because of various things that have been going on recently my drinking's gone up and everything so I've not made it to a few ... just before Christmas and just after Christmas there were a lot of things going on, so I didn't go to a few of the groups. And then I spoke with the art therapist and I've got to go this Wednesday tomorrow just to say goodbye. I'm not going to continue for now, but I can be re-referred to the group at a later date.

I Why was that? Was that your decision?

R My decision

I Yeah.

I Right. I'm finding it difficult to get to the group, because also on a Wednesday afternoon and a Friday afternoon I do voluntary work at a drop in project. So on a Wednesday ... cos the art therapy group's on a Wednesday morning and it's just too much for me on one day. I'm going there then I have to rush over to where I do the voluntary work. And ... um ...

I What's the voluntary work in? Do you mind saying?

R Well it's (-) it's a drop in project for homeless and unemployed people, people with mental health issues and stuff. And I just help out in the kitchen.

I So in spite of your own struggles if you're able to do that, that's ...

R Trying to, in the sense that hopefully I can progress and maybe get a part time job initially and then lead on to a full time job working with homeless people or people with mental health issues or stuff like that.

I That would be really good.

R Yeah. Cos I did nurse training.

I Right.

R When I left from college I dropped out of art college to go and do nurse training. But I only got half way through that, there was a few incidents that happened then. And um ... so I dropped out of that. And that's when I ...

I Did you drop out or did they ...

R E 7 321-322 No I dropped out. I couldn't handle things cos ... basically um ... I was raped by someone in the group below me, in the nurse accommodation. I moved into nurse accommodation and things happened. That's what led me to leave nursing and come to London.

I That's terrible.

R Just kind of run away basically. And that's what my mum couldn't handle.

I Right. That is really awful. Now I'm just thinking about the sort of help that you would find helpful. You've had this one very very brief trial with psychotherapy.

R Mm.

I And ... a couple of art therapy. Is there anything else that's been helpful to you in helping you with the self harming?

R Being occupied and doing art. I mean there's ... when I lived in a hostel ... well it'll be 8 years this May since I've lived in my flat and I lived in a hostel, () for 2 years before I moved to the flat.

I What was the hostel...?

R It's people ... it's the () Hostel ... well the hostel's still there but it's not () any more I don't think, it's all changed over. That unit was ... there was 12 residents, all vulnerable young people, quite a few of us had self harm issues, eating disorder

issues. You know various mental health issues in general. And it helped me quite a bit because I got involved, I was doing a lot of the food ordering, filing cabinets, sorting them out. I did quite a bit with ... met Princess Diana and all those sort of things.

I Who also self harmed.

R Yeah. I wrote a letter to her, I've got a copy of it. But that was in the December before she died.

I Right.

R Uh ... so she never got round to replying.

I That's sad.

R But she had actually visited the hostel a few years before I moved in there. Cos there's like ... there was a photo on the wall.

I So it was an issue that was important to her?

R Yeah yeah.

I Can you think (-) of any of the ... of anything that would be helpful to you in terms of sort of help with self harm. You said about being busy and actually using your skills.

R Mm.

I But in terms of a therapy, regardless of what other people say about you know maybe you're not dead suited to cognitive therapy or whatever, what do you think would be helpful to you? If you could magic up help ... is there anything that you think would be really helpful?

R I really don't know. But I think being able to get involved with a project ... for me personally, something to do with art. Uh ... or a drop in centre project. I do find that really kind of rewarding. And it makes me see a different point of view.

I Can you say more about that? When you say a different point of view.

R Just talking with other clients that use that sort of project, like at (), I see ... it kind of makes me feel all my crap ain't that bad.

I Why?

R There's other people worse off than me. At least I've got a roof over my head, I've got two cats, I've got a doctor that I see regularly, a social worker and stuff like that. Um ... whereas some people haven't got any of that sort of stuff you know in place.

I Do you find seeing the social worker useful, helpful to you?

R Yeah. I do yeah.

I Can you say in what way that's helpful?

R Well the social worker I've got at the moment I mean it's only a locum. But the social workers I've had in the past they've always been there to do things. Practical things like sorting out housing. I mean I got a bit behind in my rent at one point because I was ill, I was in hospital and forgot to take a letter down to the housing office about my rent, you know going up or whatever. So they kind of ... they're good for doing those sort of things, and just being there for someone to talk to.

I Right, I was going to say because if ... this is ... some of the self harm is about expressing your feelings to yourself and then ... having somebody to talk to.

R Yeah no ... uh, I find it helpful the fact that they're there and I can ring up any time. You know if they're in the office they'll talk to me. If they're busy then okay

fair enough I'll contact them later. Or they'll get back to me later. But it's knowing that there's someone there I can just talk to and say 'Look I'm feeling shit because this has happened, that's happened, so and so's pissed me off, what do I do?' I mean with my present situation at the moment my social worker knows this person that's been difficult. We've actually both got the same psychiatrist. And they were concerned because I let her stay at my place for a while. She's now back in hospital but she keeps texting me all the time. And so my social worker and my psychiatrist and her social worker all ... they're all aware of the situation.

I Right.

R And they know that she's doing my head in. And they're all kind of watching out for me because at this time of year there's like a pattern where I end up going down the hill at the start of the year.

I What do you think that's about?

R I don't know. I thought last week that maybe I'd conquered it and I was going to get through it without any hitches this year. But things are starting to go downhill and I'm finding things difficult at the moment. I'm trying not to let it get ... you know everything get on top of it. But within the next few weeks if I don't try and sort things out I am going to end up in hospital.

I449 Right. When you say you'll end up in hospital how would that work? How will you end up in hospital?

R452 Either by ... end up overdosing or just drinking, getting totally out of control and then collapsing in the middle of the street somewhere.

I And then people would take you to ... would they take you an A&E department ?

R Um, I don't know, it would depend.

I Okay. So is that your way of coping when things get ... when you get to the end of your tether?

R Yeah. The next step after physically self harming, cutting. That's been on my mind for the past couple of weeks, three weeks.

I10 e 466-476 What about your psychiatrist then? Does he or she ...

R Yeah, he totally knows everything.

I Right. What sort of help do you get from him?

R Well he listens when I see him and that, he listens to what ... you know he leaves it kind of in my hands as to what I want to do. If I want to go into hospital for some support he's willing to admit me. He won't admit me unnecessarily. I've been sectioned in the past but the psychiatrist I've got now, he won't do that unless it's really drastically necessary.

I Is there ... you were saying that in order to get into hospital you would take the overdose or harm ...

R No not to get in hospital ...

I Right...sorry...

R ... I would take myself before I did any of that.

I Right okay, that's important.

R Yeah no I'd take myself if I was thinking along those lines, or it would be the next stage where I'd just be so pissed off and I'd end up doing something sort of detrimental ...

I Is it important for you to take yourself ...?

R Mm, I'd rather take myself voluntary rather than end up on a section and doing something drastic and being sectioned. I would only go to that step of maybe an overdose or jumping off a building as a last resort if I was totally off my head.

I Right.

R Cos it has happened in the past and now I've got to that stage where I didn't know what I was doing at the time, it just happened and I ended up being sectioned and ...

I Was that because ... cos you come across as a highly intelligent young woman ...

R Okay.

I ... is there ... when you say you didn't know what you were doing ...were completely off your head...? is that through drink or drugs?

R Not necessarily. Sometimes yes, it has been the situation because of drink and drugs, both whatever. But there has been occasions where I've not been on anything and I've just totally lost the plot and ended up ...

I Do you know what causes that loss, losing the plot? Is it something like emotional pain? Just gets too intense?

R Yeah I think so, yeah yeah. I just feel like my head's going to explode and the only way to get rid of it is to bash my head on a wall.. . Um ... something like that ... whatever.

I From what you've said you don't seem to be getting a lot help geared towards the self harming... Are you ?

R I'm on Prozac.

I Right. How has that been for you?

R It has been pretty good.

I How long have you been on Prozac?

R Well I've been back on it now since July.

I Right okay.

R I've been on and off it over years and ... but I stopped taking it for a few years, refused to take anything. And then I agreed to start taking it again in July, that was during the detox.

I Do you find it hard taking Prozac... and drinking? Doesn't it ...

R Well initially because I wasn't really drinking, but the drinking's gone up more in recent months, in the past two or three months. Um ... so yeah I am feeling the effect, the fact that Prozac's not working properly because I'm drinking too much.

I Right.

R And that's why I know I've got to sort out the drinking.

I Or possibly the underlying issues?... because ... if you're not drinking, you're self harming by cutting or ... um ...

R It's just kind of a vicious circle all the time.

I Yeah...it is ...it is ...it's really really hard...isn't it...?... Is there anything else you want to say about self harm? Anything that you think would be important for people to know about self harm?

R Don't know really.

I You've said a lot of really interesting insightful things about self harm, and I think it's really important that people start to understand more about it, and how it's used.

R Mm.

I Because ... how would you ... I mean from what you've said it sounds like you use it to stay alive, to cope.

R 12 E 574-577 Yeah yeah. It's a coping mechanism, definitely yeah. I'd rather cut my arms or hurt myself in some way as opposed to punching someone's lights out. You know, I'd rather hurt myself than hurt the other person. I turn everything in on myself.

I Yeah.

R If I feel upset or bad about a situation, the way I've handled situations and stuff ... and I've taken it out on myself.

I You started at a very young age to self harm.

R Yeah I suppose so yeah.

I 589-591 It's sometimes those first initial attempts at self harm can sometimes tell you a lot about your reasons for doing it. I mean you've spoken really articulately about your reasons ... that it's about communicating that pain to yourself?

R Yeah.

I That suggests to me that in some way ... well in fact you've said it ... that if you can't see it it doesn't seem real. I think you've said that...did you?

R Yeah yeah.

I And I can see you're covered in scars.

R That's just ...(laughs)... yeah.

I And it's ... that's an awful lot of pain.

R It's over many years though.

IE 13 607-631 Have you been able to get into discussions with your psychiatrist about what the self harm means to you?

R No.

I What ... what does he ...

R He knows I self harm but he don't ...

I Does he see the scars?

R Yeah. Yeah, no he's seen them. He sees them when they're fresh cuts.

I And what does he say about the cuts?

R He doesn't say anything. I suppose he just dismisses.

I He dismisses. Why do you think he dismisses?

R I mean he knows I do it ... he knows it happens. But he never confronts me over it.

I He never talks to you about it?

R No.

I How does that ... you are an intelligent woman ... how does that ... if you think about it for a minute ... what sort of sense does that make to you?

RE637 That he's not doing his job properly, I don't know.

I What would you say in your capacity as a support worker to young vulnerable homeless people if a girl came in with the sort of scars you've got with fresh cuts? Would you ... what do you think you would ... what would you do to help that person? I know I'm putting you on the spot and you don't have to come up with any answers.

Re645-648I don't know. You know what, I really don't know. Um ... I suppose if that person wanted to talk about it, I would say 'it's ok to talk to me about it'. If that person felt comfortable about talking about it then I'd get into a discussion about it.

I But you feel your psychiatrist doesn't want to do that with you?

RE652 No I don't think so.

I What about your social worker? Is that a man or a woman?

R E14 655-666It's a man at the moment. It's just ... I've had so many ... I've had more bloody social workers than I've had hot dinners.

I Okay. Have any of these social workers talked to you about self harm, about what it means for you?

R I think one or two have mentioned and enquired.

I About?

R About the self harm. Specially on occasions when I've done it round about on those occasions and stuff. Um ... no, they've not gone in depth about anything. They've not said anything, questioned anything.

I Have you had any contact with any of the self harm ... or groups for people who self harm?

R I tried getting in touch with um ... what is it, the self harm network or ...

I Yeah. Is that based in Bristol, is that?

R I think so. I tried ringing the number once but I couldn't get through to anyone. It was like an answering machine.

I Right.

R And I left a message but I never really got any response back.

I Nobody responded to it.

R No.

I

R (Mistake in transcription epeated bit – taken out – could confuse R.No's)

I Cos that's something that I could ... I could certainly give you some information on that.

R Mm. I have tried in the past to access some phone numbers, you know different places, but it's just a case of leave your message, leave your number, we'll get back to you.

I Well I can definitely get you together a resource pack to give to you.

R Yeah?

I Yeah.

R That'd be good yeah.

I I'm aware that's it's coming up to half past 2 and I don't want to over stress you. Let me see, this is ... Is there anything else you'd like to say about self harm?

R No.

I Something that has really struck me is that ... it's obviously a really serious problem for you.

R Mm.

I And yet your psychiatrist doesn't mention it. How often do you see your psychiatrist?

R It varies. Um ... I'm due to see him 20th February, and I last saw him before Christmas.

I Right.

R It's usually about every 6 weeks, 3 months. Sometimes it's more often depending on how I've been. But I can phone him up and speak to him. Like I speak to him on the phone quite often anyway.

I Right that's good, so you feel able to do ...

R Yeah yeah, I can ring up and get ... you know if he's around. Or he'll call me back, I leave a message say can he call me. And he calls me back, we have a chat or whatever. And if need be I will ... you know I'm able to see him more often if I need to. Um ... yeah no I do feel comfortable with my doctor.

I That sounds like a good relationship.. is it?.

R15 E 747-758 But he never really goes ... says much about the self harm issues. You know it's the depression, or like personality disorder, all those ...

I Have you had that diagnosis?

R Yeah yeah.

I When did you get that diagnosis?

R Years ago. Um ... few years ago.

I Right. And is that something that you understand and accept?

RE16/ 760-764 Well it's just a kind of label, isn't it? No I've read a bit about it in books and stuff and I can see the pattern. And that yeah possibly there is a personality disorder somewhere. Um ... I don't know it's just one of those things basically, that's what's wrong with me isn't it? Don't like the name, I don't like the title.

I What does it conjure up for you?

R I'm a nutter, but then I am. So ...

I I wouldn't describe you as a nutter, I would describe you as somebody who's experiencing an awful lot of emotional pain and finding it very difficult to have that heard. Can you remember when you were younger what your mother's response or your father's response or any adult's response to your emotional pain, distress, crying was...did anyone respond to that...to you?

R E16/776-779 When I was very young I fell off my horse and broke my arm, when I was 4. And my mum was very kind and loving to me. But that's before she got ill. And then since she became ill it was all a case of well start bottling things up, get on with it, and deal with it like attitude.

I Right.

Re 16/783-785 There was love there, parental love and all that, but um ... there was love there, but yeah ... but not in the way ... uh how can I put it? ... you would expect from a parent.

I Right. Okay, do you want to say a bit more about that?

R You see my dad was kind of ... and still is ... he goes along with whatever my mum says, just to keep the peace. And my mum ... okay she shows love and affection in her own way.

I What's her own way?

R More-so in recent years when I go round there or whatever or they come to visit me, you know my mum'll give me a hug and say oh I've missed you and everything. Then she phones me every bloody day.

I Right.

R Uh, checking up on me probably. And um ...

I What to checkyou?

R No to check up my drinking.

I Right. Which in a sense is another way of dealing with these feelings that ...

R Yeah. But um ...

I So she phones you every day?

R Mm.

I What do you think she makes of your scars?

R She never talks about them.

I She never mentions them?

R She did ... one time probably ... my parents still lived in (-). I'd gone ... it was one day in the summer and we had a barbecue in the garden. A few members of the family and friends were there and that. I was sitting down the end of the garden on the grass with my mum and dad chatting and I had these loose trousers on and she saw the scars on my leg and some of the cuts were quite fresh, probably about a week old. And she said 'What's that?' And that's the first time she knew about the self harm. Cos I always kept my arms and legs covered up. And she said 'What did you do that for?' and I said 'Well sort of self release'. I tried to explain to her but she didn't seem to understand too much. And that was the only time it's ever been talked about. Apart from there was other occasions when I went home maybe to go to help out at the church fete or different places and my mum always used to ... because it was in the middle of the summer or beginning of summer or something, the weather was warm, she'd always tell me to cover up my arms, hide those scars. She didn't want other people to see them.

I How did that make you feel?

R Um ... (pause) I felt guilty a bit I suppose. Um ... felt uncomfortable that she'd said that 'Cover your arms' and stuff. I found it quite difficult and I got quite upset about it.

I Mm, must have been... been very very hard thing to hear.

R Mm, her not wanting other people to know. Mm. I generally just say something stupid about the scars. I mean a lot of them are faded, they're not as bad...

R 18E 850- 856I'll say a cat scratched me. My dad actually saw a scar ... when I was still living at home I'd actually got a pair of scissors, I was up in my bedroom and I'd cut my wrist. That was the first time I ever cut. And um ... must have been about ... I had long sleeves on. I'd covered it up but like the sleeve sort of ravelled up or

whatever. My dad said 'What's that?' and I was like 'Oh a cat scratched me'. And he bought it. You know he just ...

IE18 858and it didn't look anything like a cat scratch?

R I don't know, maybe it did, maybe it didn't. But he just thought 'Okay' and he didn't say anything else after that.

I Is that what you wanted?.

E 18 865RI don't know... it's a way of them not having to take it on. You give an explanation. And even though the explanation doesn't match the pattern of scarring at all ... the person ...buys it and they don't ask anything else after that. They were like 'Oh okay'. And it's like ... it's almost like if people 869can't handle it ... mm.

I And that's why I think it's so important for people to know more about how ... the sort of help that would be good for people who self harm.

R Mm, yeah.

I And that's why your contribution is so important to help them with that.

RE 18 878Well I find like if my cuts have been quite deep and I've needed stitches, going up to A&E, some of the staff are very good and deal with it, you know without judgement and stuff. Then there's other staff that are just 'What are you doing that for to yourself?' You know they're questioning all the time 'Why have you done that?'

I And what are you ... I can see from the way you're looking, your facial expressions, that's not a kind enquiry. How did you feel when they were talking to you in that way? What message were you getting from them?

R EThat they were 18/888-893... it was kind of like I'm a bad person for doing it. And I have actually responded to some of their comments and said 'Well, what, should I have bloody punched someone in the face then?'

I And what have they said when you said that?

RE 18-894-896 Nothing. Just shut up. I said well you know if someone upset me I either punch them in the face or I took it out on myself. Only went a bit too far and it went too deep.

I So like you haven't always been responded to with kindness, understanding and care.

R Very few occasions I have. But I think at ...l, that's my local, local hospital, they're a bit more understanding. But it just depends what staff's on duty.

I And have you noticed a change more recently?

R Yeah.

I Have they become more understanding?

R Yeah.

I Right. And that may be because more work is being done now.

R Possibly. Also at (-)l they've got um ... the psychiatric unit's got a brand new building and there's EPS.

I EPS?

R Emergency Psychiatric Service.

I Right.

R E913 And they liaise with A&E. So like Monday to Friday 9 till 5 you can go round to EPS.

I Right.

R Unless you actually need medical attention for a deep cut, then you just go to A&E. But then they'll liaise with the EPS team. Then after hours you have to go to A&E, but they'll contact whoever's on duty from the EPS department.

I So does that mean you get somebody to talk to who could talk to you about the emotional pain?

R Depending on where that ... you know say it was me for instance anyway turning up in A&E ... if I just needed someone to talk to they'd be there just to talk to. If I needed being admitted they would admit me. If I needed medication they'd give me medication and then discuss that through the chap that we have in the department. So they've got a pretty good understanding but there's still the general staff in A&E that get a bit funny with you if you've self harmed.

I Mm, it's because ... why do you think that is? Why do you think?

RE 20/946-951 I think because they don't understand, they don't comprehend why people do these things to themselves.

I That's right. I think you've captured it. (?48.45)

R951 And I think um ... they're just not that educated I suppose.

I Absolutely right. That's one of the reasons why it's so important to do this sort of research.

R Yeah.

I And you've been really really helpful. I really appreciate that. Is there anything else you'd like to say about self harm to sort of finish off this interview?

R Um, no not really.

I You feel you've said everything you wanted to say?

R Yeah I think so yeah.

I Let me just ... I'll turn this off now.

(tape turned off – Participant started talking again -turned back on!)

I So that's another reason, another starting ... point where you started that you were being bullied.

R Yeah.

I Could you tell me a little bit about that?

R Uh well I was in my first year at secondary school and we lived backing onto the school fields, our garden fence adjoined the field. And we had a situation in Science using battery acid, writing your initials on the paper with glass rods with battery acid. And our teacher said something about don't get it on you, it'll burn your skin. And then one of the boys thought he'd got it on his jumper and then there was all this big fuss, the teacher dragged him to the sink and was washing his jumper under the tap, trying to wash off if there was any acid on there. And then that night I went home and I physically shook all night long. I felt cold, I felt clammy and I just shook, I just was just shaking all night. And then after that every time I went to a Science lesson I wouldn't touch the door handle to get in. I was constantly washing my hands. I had a separate school bag for the days where I had Science lesson.

I Why was that?

R Cos I thought I'd got acid on me. This incident with the guy, the kid in my class. And I just went home and I thought well I had acid on me I was going to die.

I Right. So that was a real trauma?

R Yeah. I just thought I weren't going to wake up in the morning. I thought was going to be dead. And then after that when I realised you know I'm still alive I ended up ... I had a separate certain school uniform just for when I went to Science. I only wore those things. And because I'd actually walked in the house and walked on my bedroom carpet with my school shoes on I wouldn't ... I couldn't touch the carpet with my bare feet. I had to always have slippers on. I wouldn't sit on the carpet, I wouldn't touch the carpet.

I I'm getting lost here (laugh) Cos you were saying you were bullied...then?

R Well because of all this stuff that's why I got bullied.

I Because of ...

R I got so ... must have been so traumatised I just didn't want to go to those science lessons. I wouldn't even go to the science block. And then other kids in my class, and then it went round ... cos there was someone's cousin or brother or someone in another class and they all got to know about it. So they all started picking on me, bullying me and stuff. And then I went to the teacher about it. These kids got put on report, and then they got their cousins and whoever else to bully me more because they'd been put on report.

I Oh that's terrible isn't it?

R And then there was one incident ... I was on my way home and I was cutting through the field to climb over the fence to home and it was near the PE block and this girl, I think she was a cousin of one of the kids in my class and she was with a couple of friends and she was saying to her friends 'Oh hold my bag, I'm going to beat her up.' You know saying that to me that she was going to beat me up. And then luckily my PE teacher came round the corner and said 'No I'll hold your bag for you' and they all got sorted out and that. But the teacher witnessed it.

I Right, which was lucky for you.

R Yeah. Else I'd have been beaten up.

I God that's terrible isn't it?

R And um ...

I Cos you know this is actually something else that's quite a common thing, it's important to you know record that, is that a lot of people who go to self harm have experienced bullying. That's sort of seen as a sort of trigger.

R Yeah.

I Well I really hope that you get to resolve this.

R Yeah.

I I really think it's ...

R I mean everything improved after that, because thankfully my parents were moving house, we moved to the other side of town, so I started in my second year at a new school.

I Oh that's great.

R Yeah, it was a bit dodgy to start with, but eventually it improved and I did really well, came out with some good grades for my GCSEs and stuff.

I Yeah. So you now need to get back on track again..Yeah?.

R Yeah yeah.

I And you've got the ability to do that.

R Try. (laughs)

I Well I will definitely remember you ... um, it's just very interesting talking to you, I could go on forever ...

R (laughs) Yeah... Yeah?

(End of interview)

Appendix 11: Self-checking form for analysis of sections of transcripts used to illustrate themes

CHECKING ; Impact of my questioning / question technique etc. /on participant response –

Maybe need to put in interviewer questions/comments/ response as well as participant's response –

R *But within the next few weeks if I don't try and sort things out I am going to end up in hospital.*

I *Right. When you say you'll end up in hospital how would that work? How will you end up in hospital?*

R *Either by ... end up overdosing or just drinking, getting totally out of control and then collapsing in the middle of the street somewhere.*

I *Okay. So is that your way of coping when things get ... when you get to the end of your tether?*

R *Yeah. The next step after physically self harming, cutting. That's been on my mind for the past couple of weeks, three weeks.*

Yeah yeah. It's a coping mechanism, definitely yeah. I'd rather cut my arms or hurt myself in some way as opposed to punching someone's lights out. You know, I'd rather hurt myself than hurt the other person. I turn everything in on myself.

I *You've spoken really articulately about your reasons ... that it's about communicating that pain to yourself?*

R *Yeah.*

I *That suggests to me that in some way ... well in fact you've said it ... that if you can't see it, it doesn't seem real. I think you've said that...did you?*

R *Yeah yeah.*

I *And I can see you're covered in scars.*

R *That's just ... (laughs) ... yeah.*

I *And it's ... that's an awful lot of pain.*

R *It's over many years though.*

I *Have you been able to get into discussions with your psychiatrist about what the self harm means to you?*

R *No.*

I *What's his ... what does he ...*

R *He knows I self harm but he don't ...*

I *Does he see the scars?*

R *Yeah. Yeah, no he's seen them. He sees them when they're fresh cuts.*

I *And what does he say about the cuts?*

R *He doesn't say anything. I suppose he just dismisses.*

I *He dismisses. Why do you think he dismisses?*

R *I mean he knows I do it ... he knows it happens. But he never confronts me over it.*

I *He never talks to you about it?*

R *No.*

I How does that ... you are an intelligent woman ... how does that ... if you think about it for a minute ... what sort of sense does that make to you?

R That he's not doing his job properly, I don't know.

Unless you actually need medical attention for a deep cut, then you just go to A&E. But then they'll liaise with the EPS team. Then after hours you have to go to A&E, but they'll contact whoever's on duty from the EPS department.

I So does that mean you get somebody to talk to who could talk to you about the emotional pain? P. 261

R Depending on where that ... you know say it was me for instance anyway turning up in A&E ... if I just needed someone to talk to they'd be there just to talk to. If I needed being admitted they would admit me. If I needed medication they'd give me medication and then discuss that through the chap that we have in the department.

So they've (EP 's) got a pretty good understanding but there's still the general staff in A&E that get a bit funny with you if you've self harmed. 262

I Mm, it's because ... why do you think that is? Why do you think?

RE 20/946-9511 think because they don't understand, they don't comprehend why people do these things to themselves.

I That's right. I think you've captured it. (?48.45)

R951 And I think um ... they're just not that educated I suppose.

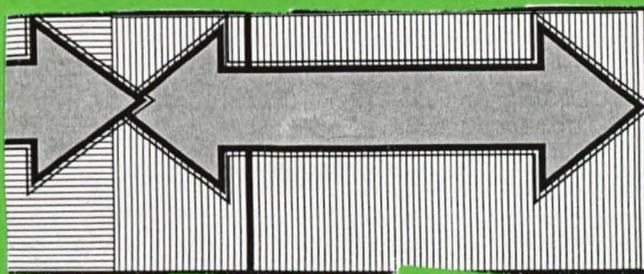
I Absolutely right. That's one of the reasons why it's so important to do this sort of research.

R Yeah.

A
Self-Harm
Resource Pack

Compiled by

SUE WILLIAMS



What this Pack Contains:

- **Information on self-harm**
- **Information about self - help groups and services.**
- **Self - harm treatment checklist.**
- **Treatment incident report.**
- **Useful publications.**

What is Self-Injury?

Self-injury is any form of self-harm which involves causing injuries or pain to your own body. It can take many forms.

The most common form of self-injury is probably cutting. Some young people may also burn themselves, punch themselves or hit their bodies against something. Some young people pick their skin or pull out hair.

How common is Self-Injury?

Self-injury is far more common than most people think. All sorts of young people self-injure and often there is little outward sign that there is anything wrong. A lot of young people that self-injure find it very difficult to talk about it. They may feel that no-one understands or that people will be angry.

It seems that more girls self-injure than boys. This may be because boys are able to express strong emotions like anger more easily.

Many young people that self-injure believe they are the only person that does this. Fear and shame may force them to keep it secret for many years. This means that no one knows how big the problem really is.

Why do Young People Self-injure?

There are always powerful reasons why someone self-injures. For most it is a way of coping with great emotional pain.

Many people cope with their problems in ways that are risky and harmful to themselves. Some drink or eat too much, smoke, drive too fast, gamble or make themselves ill through overwork or worry. They might do this to numb or distract themselves from problems or feelings they cannot bear to face (like 'drowning your sorrows').

Young people may have a number of different things going on in their lives. Growing up may already be a very difficult time, but a lot of young people have additional problems with other issues such as bullying, sexuality, problems with friends, bereavement, pressures at school, abuse, pressures to fit in, race, culture, religion or money.

Some young people may also care for relatives that are unwell and may not have had a chance to be 'young'. Some young people may live in households where there are abusive or violent relationships. They may come from families where expectations to do well at school or college are very high and feel under pressure to succeed.

Some young people may also come from families where talking about how they feel is very difficult and a lot of emotions are left unexpressed.

Any of these factors may be very distressing for young people and could be reasons for their self-injury.

Some of the Myths about Young People and Self-Injury

It's only a teenage thing, she'll grow out of it.

If a young person is hurting themselves it is a sign that something is bothering them, that they need help. If not, over time the self-injury can become more severe and more of a problem.

He's only doing it to be cool

Whilst one-off cutting may be part of being accepted by the group, if someone repeatedly feels the need to hurt themselves, there are very likely to be underlying problems that need sorting out.

She's just copying her mates at school

Young people who self-injure find that it helps them to cope. The only reason why somebody would continue to hurt themselves, is because they find it helps them to cope with emotional pain they feel or with the problems they have in their life.

Myths & Common sense

<i>Current treatment of people who self-harm is based on inaccurate stereotypes</i>	<i>The responses below are based on the real experiences of self-harmers</i>
"It's attention seeking"	If attention was the motivation, it's not an efficient way of getting it. There are many easier, less painful and less degrading ways of attracting it.
"It's a Borderline Personality Disorder"	Self-harm is not a diagnosis. Because you engage in self-harming behaviours does not make you Borderline. However, <u>most</u> individuals with BPD do engage in these behaviours.
"They're manipulative"	Self-harm is frequently a secret activity. A&E departments will only see a very small number of self-harm incidents. It's not about its effect on others.
"Self-harmers are usually hysterical women under 30 who grow out of it"	Recent research shows the difference in rate of self-harm between men and women is less marked. There is no evidence to show that people 'grow out of it'. It is not a behaviour or development 'disorder'
"It's self-inflicted so it's not serious"	How severe the wound is won't tell anybody how bad the person feels. Individuals have many ways of expressing their distress, often substituting one for another. Your perception of the seriousness of the injury may not indicate the extreme distress that injury represents.
"If you won't see a psychiatrist, you can't want to get better"	Psychiatry has had little success in helping individuals who self-harm. Neither drugs nor behavioural treatments can address the issue of self-worth.
"either they enjoy pain or they can't feel it"	Each person has a different pain threshold. Commonly the loss of sensation some people experience during injuring returns soon after. By the time the person is receiving treatment, it is common for the sense of pain to be amplified.
"Don't waste your time with her, we've been treating her for years"	A long history of injury often results in being considered 'a hopeless case'. No attempt is made to offer support as it's assumed you're 'incurable'.
"It's tension relieving"	Tension is rarely the sole pressure on an individual to harm themselves. Each person has their own pressures and triggers.

UK-WIDE ORGANISATIONS

Bristol Crisis Service for Women

Set up in 1986 to respond to the needs of women in emotional distress. We have a focus on self-injury and have carried out extensive research. We provide information and publications, also training for professionals.

Leaflets, publications & training: 0117 927 9600 during office hrs.

Address: PO Box 654 Bristol BS99 1XH

Website: www.users.zetnet.co.uk/bcsw

Helpline: 0117 925 1119 Friday & Saturday nights 9pm – 12.30 am and Sundays 6-9pm

National Self-Harm Network

Acute medical and psychiatric service provision is lacking in understanding and treatment of self-harm. Survivor-led organisation, founded in 1994, aims to bridge the huge gulf in understanding, and to campaign for the rights of those who live with self-harm. Leaflets and publications have been produced for individuals who self-injure and health care professionals. Contact NSHN for more details.

Address: PO Box 7264 Nottingham NG1 6WJ

Email: info@nshn.co.uk

Website: www.nshn.co.uk

SASH (Survivors of Abuse and Self-Harm)

Penfriend network. We offer support, friendship and most of all understanding. To stop the loneliness for you the survivor, also to feel part of society again. To allow you to communicate your feelings and thoughts on a one to one basis in writing. £5.00 annual fee for half yearly newsletter. Send SAE for enquiries.

Address: 20 Lackmore Road, Enfield, Middlesex, EN1 4PB

Email: sashpen@aol.com

Breaking Free

Primarily supports women survivors of childhood sexual abuse. Offering a telephone helpline, individual and group sessions, support by letter and act as an information and sign-post agency for male and female survivors, families and friends of survivors and professional bodies. Telephone hours updated weekly.

Contact name: Maddie Paul

Address: Breaking Free, Marshall House, 124 Middleton Road, Morden, Surrey SM4 6RW

Email: breakingfreecharity@hotmail.com

Helpline: 0208 648 3500 – updated weekly

Self Harm Alliance

National survivor-led voluntary group which supports any person affected by self-harm. We provide monthly newsletters, postal and email support, produce publications and have a telephone helpline.

Telephone: 01242 578820

Helpline hours: 6pm-7pm Tuesdays and Sundays, 11am-1pm Thursdays

Address: PO Box 61, Cheltenham, Gloucestershire, GL51 8YB

Website: www.selfharmalliance.org

Email: For support: support@selfharmalliance.org
For administration: admin@selfharmalliance.org

WALES

Cardiff

The Amber Project

For young people who self-harm (16-25 years old)

Contact name: Caryl Stock

Address: The Amber Project, Danescourt Young Homeless Project 62
Plasturton Avenue, Pontcanna, Cardiff, CF11 9HH

Telephone: 029 2034 4776

07905 905 437

South Wales

The Basement Project

Provides publications. Our work is founded on respect for individuals and their rights to determine their own needs and make choices for themselves. Supply free self harm fact sheets in English, Welsh or Urdu.

Contact name: Lois Arnold / Anne Magill

Telephone: 01873 856524

Address: PO Box 5 Abergavenny NP7 5XW

Website: freespace.virgin.net/basement.project

West Wales

Llanelli Self-Harm Support Group

Currently on hold. Contact for further information, as the group may start up again in the future.

Contact name: Wendy King

Telephone: 01554 752 751

Address: 46 Thomas Street, Llanelli, Carmarthenshire SA15 3JF

SCOTLAND

Scottish Self-Harm Forum

A multi-agency group which exists to raise awareness of the issues relating to self-harm.

Contact: Pat Little

Address: Penumbra, Norton Park, 57 Albion Rd, Edinburgh, EH7 5YQ

Telephone number: 0131 475 2380

Email: patrick.little@penumbra.org.uk

Edinburgh & Lothians

Wounded Wings

We provide a facilitated self-help support group for women aged sixteen plus in a safe, secure and confidential environment which runs for fifteen weeks at a time. We can provide various resources regarding self harm & surrounding issues. We also offer limited onezone support.

Contact name: Fiona Downie

Telephone number: 07730 872784

Address: 32 Craighall Road, Edinburgh, EH6 4SA

Website: Woundedwings.org.uk

Email: Woundedwings@talk21.com

Glasgow

Reach Out Project

A project for young people aged 16-25 who are or have been homeless in Glasgow and for whom self-injury is an issue. We offer a safe and confidential space to talk, information on self-harm and help with accessing other services. We also offer self harm training for agencies, along with information and support for workers.

Telephone and Fax: 0141 579 0017 Mon-Fri 9am – 5pm

Address: The Reach Out Project, Quarriers, 934 Dumbarton Rd, Whiteinch Glasgow G14 9UQ

Email: reachout.quarriers@totalise.co.uk

Lanarkshire

GASH – Group Around Self-Harm

An established, facilitated group open to women and girls aged 14 + who self-harm in some way. Meets first Thursday of every month in Wishaw. There is also a group for men which meets on the third Thursday of every month at Bellshill. These groups offer confidentiality and anonymity. Also training for professionals.

Telephone: Sandra 01698 323 566 (evenings)

Irene 01698 355 179 (evenings)

NORTHERN ENGLAND

Berwick-upon-Tweed

Berwick Youth Project

We offer information and support services to young people (under 25).
Have a leaflet on self-harm and alternative strategies.

Contact name: Debra Jerdan

Address: Berwick Youth Project, 10 Golden Square, Berwick-upon-Tweed,
Northumberland, TD15 1BG

Email: info@berwickyouthproject.co.uk

Birkenhead

SH Support Group

Confidential self-harm support group.

Contact name: Nicola Riley

Address: c/o Wirral MIND Fountain Project, 90 Chester Street, Birkenhead,
L41 9EA

Blackpool

SHUSH (Self Harm Group Uniting Self Harmers)

Meetings take place on the second Tuesday of each month, between
7.00pm – 9.00pm. We provide a safe, confidential user led group for
women to discuss any issues around self harm. Meetings are light and
informal.

Address: MIND Social Centre, North Shore Methodist Church, Dickson Rd,
Blackpool, FY1 2AP

Telephone: 01253 626997 (Monday-Friday 9.00am – 5.00pm)

Email: shushuk_@hotmail.co.uk

Bolton

Support for Self-Harm

Small, friendly support group for people in the Bolton area.

Telephone: 01204 527 200

Address: Deajon House, c/o MHIST, 30 Chorley New Road, Bolton, BL1 4AP

Carlisle

SIS (Self-Injury Support in North Cumbria)

SIS offers support to people who self-injure and to those people who support them. SIS provides information and advice, counselling, facilitated group support, telephone (9am to 5pm weekdays) and email support, website, library loan service and workshops/training for local organisations. Open group meets fortnightly.

Contact name: *Jill Eastham*

Telephone: 01228 515 500 (9am-5pm weekdays)

Address: *Riverside House, Warwick Road, Carlisle, Cumbria CA1 2BS*

Email: jill@sis-cumbria.co.uk

Website: www.sis-cumbria.co.uk

Leeds

Trust – support for people who self-harm

A self-help group where people can meet and talk on the same level. You will be taken notice of, nobody will put you down, you stay in control of what happens to you. Open to women and men aged 16 or over.

Contact name: Diane

Telephone: (Self-Help Initiative) 0113 245 5151

Address: c/o Self-Help Initiative Project, Third Floor, 6-8 The Headrow, Leeds, LS1 6PT

Supported Housing Project

Leeds Mind Supporting Housing Project provides support to single people who are experiencing mental health problems, as well as supporting people who use self harm as a way of coping. Support is available in shared accommodation and single tenancies. Therapeutic emphasis is aimed at looking at other ways of coping. The focus has tended to be around issues which impact on the individual. We also access other services and support groups.

Contact name: Linda Felix, Project Manager

Telephone number: 0113 230 7670

Address: Supported Housing Project, Leeds MIND, 26 St Michael's Road, Headingley, Leeds, LS6 3AW

Email: housing@leedsmind.org.uk

Manchester

PUSH - People Understanding Self Harm

A non-judgemental support group for people with issues around self harming. Open to anyone, regardless of age, gender or circumstance. Run by and for people with personal experience of self harm.

Contact name: Ask for Nicky or Marcus who will put you in touch with us.

Telephone: Zion Community Resource Centre 0161 226 5412

Address: 339 Stretford Rd, Hulme, Manchester, M15 4ZY

Website: www.selfservices.org.uk

Email: selfhelpservices@yahoo.co.uk

42nd Street

We offer one to one support, counselling and group work to young people aged 14-25 who are under stress or are having mental health difficulties. We work in Manchester, Salford and Trafford. We offer specialist services to young people who are lesbian, gay, bisexual, questioning, men and black young people. We offer training and advice on suicide and self harm issues.

Contact name: Maryam Arbabi

Telephone: 0161 832 0169

Helpline: 9.30am-5pm Mon-Fri 0161 832 0170

Address: 2nd floor, Swan Buildings, 20 Swan Street, Manchester M4 5JW

Merseyside

Daily afternoon drop-in

Used to run a support group for women aged 14-25 who self-harm. Now have a daily afternoon drop-in for women facing a variety of issues, including self-harm. Women can gain information and peer support. Women with children under 4 can be allocated a key worker to give additional support, friendship, a listening ear and information.

Contact name: Lorraine Webb

Telephone: 0151 474 4744

Address: c/o Venus Resource Centre, 592-596 Hawthorne Road, Bootle, Merseyside, L20 6LA

Drop in opening times: Monday to Friday 1.30pm to 4.00pm

Nottingham

Cutting Back

Weekly group every Saturday 1.30pm – 3.30pm, held in a central location. A safe, non-judgemental, supportive space run by and for women who self-injure. See self-harm as coping, and part of the philosophy of the group is working on self esteem.

Contact name: Angie Smith

Address: c/o Self-Help Nottingham, Ormiston House, 32-36 Pelham Street, Nottingham, NG1 2EG

Email: a.smith433@ntlworld.com

Salford

Salford Women's Centre

Drop-in Women's Centre, crèche facilities, community café, one-to-one counselling service, support groups, etc.

Contact name: Joanne Drinkwater

Telephone: 0161 736 3844

Address: Halton Bank, Langworthy Rd, Salford, M6 7AB

Email: jo.drink@ntlworld.com

Website: www.poptel.org.uk/biz/salwomen.html

Stockport

Self-Injury Support Group

Support group for men and women who self-injure facilitated by two counsellors. Every week, Wednesday evenings 7.00-8.30pm. Not drop-in (ring first).

Contact Name: Sheila Webster or Vicky Taylor

Telephone: 0161 480 7393

Address: Stockport Mind, Dove House, 65 Union St, Stockport SK1 3NP

Stoke-on-Trent

Echo Group

Echo Group is a social group for self-harmers, provided in a safe environment. Open to men and women aged 18 and over. We meet twice a week on Monday afternoon's 1.00pm-4.00pm (to look at feelings behind self harm) and Wednesday mornings 10.00am - 1.00pm (provides social support) at the American Clubhouse, Waterloo Rd, Burslem, Stoke on Trent.

Contact Name: Judith Shaw, Co-ordinator

Telephone: 07876 161356 or 07876 161 356

Address: 27 Brunswick Place, Hanley, Stoke-on-Trent, ST1 3DD

SOUTHERN ENGLAND

Brighton

Threshold

A Women's Mental Health Initiative offering drop-in facilities, Friday day service, counselling, information and a newsletter. Free self-harm factsheet for mental health service users.

Local Counselling Enquiries: 01273 622 886

Drop-in Enquiries: 01273 628309

UK Women and Mental Health Information Line: Freephone 0808 808 6000
(for users and professionals)

Monday and Wednesday 10am –12pm and 2pm to 4.30pm
Tuesday and Thursday 2pm to 4.30pm
(24 answerphone outside of these open hours)

Contact Name: Kat Williams

Address: 14 St George's Place Brighton BN1 4GB

Website: www.thresholdwomen.org.uk

Email: infoline@thresholdwomen.org.uk

Bristol

SISH (Self-Injury Self Help) Group

An open facilitated support group for women for whom self-injury is an issue. We meet on Thursdays, alternate mornings and evenings, in central Bristol.

Telephone: 07788 142 999 (mobile)

Address: c/o Box 73, 82 Colston Street Bristol BS1 5BB

Devon (South)

Self-Harm Support Group

(Not currently running. Hoping to start up again soon.)

A support group for people who self-harm. A place for people to share their experiences in a safe, confidential and understanding environment. Somewhere for people to explore different coping strategies.

Contact Name: Crystel

Telephone number: 07811 559 620

Address: The Studio, Bramley Cottage, 28 Fore Street, Kingsbridge, Devon TQ7 1NY

Email: crystel@smileyface.com

Essex (North East Essex & Tending)

Supportline

Telephone helpline providing confidential emotional support for children, young adults and adults on any issue. Particularly aimed at those who are isolated, vulnerable, at risk groups and victims of any form of abuse. Includes support for depression, self harm, eating disorders and survivors of abuse.

Contact name: Geri Burnikell

Telephone number: 020 8554 9006

Address: PO Box 1596, Ilford, Essex, IG1 3FW

Website: www.supportline.org.uk

Email: info@supportline.org.uk

Helpline: 020 8554 9004 Flexible hours; next opening time will be announced on the answer machine.

Gloucestershire

Self Harm Alliance – see National Organisations, page 4

Herfordshire

Inside Out

A social/ support group run at Cheere House, near Hemel Hempstead Hospital. We run weekly, please call evenings for information.

Contact name: Simon Simmonds

Telephone: 07793 371513

Website: www.iout.org

Email: info@iout.org

Support Group for those who Self Injure

A support groups for those that self injure. Male and female; aged 16+ years. Recognising self harming behaviour as a coping strategy and providing a safe, confidential space in which to explore feelings and thoughts, in order to minimise harm. Facilitated by two trained and accredited counsellors. Access by self referral or through other professionals. Please call for times/dates/location.

Contact Name: Tina Rawlings/ Mike Stillwell

Telephone: 01438 841241

Address: HAPAS (Hertfordshire Alcohol Problems Advisory Service), 22 Prospect Place, Welwyn, Hertfordshire, AL6 9EN.

Email: admin.hapas@btconnect.com

London

HUSH (Hidden Universe of Self Harm)

We are a mixed, user led self-help group meeting weekly on Wednesday afternoons. We are working to promote understanding around self harm.

Contact name: Dave Verran

Address: Julia Kipps or Dave Verran c/o Prichards Road Day Centre, Marion Place, Prichards Road, Bethnal Green, London E2 9AX

Telephone: 07799 681 740

Email: jpua42@hotmail.com

Self-Harm Support Group

Currently not running, but may be re-started if a lot of interest is shown. Information when running: *The support group provides a safe and confidential environment for individuals to share experiences. We do not judge or have expectations of individuals' self-harm. Meet once a week.*

Contact name: Peter or Lorna

Telephone: 0207 272 6936

Address: Islington MIND, 35 Ashley Road, London N19 3AG

Zindaagi

Work with young Asian women vulnerable to suicide and self-harm. Have a 'Guide to East London Support Services for Young Asian Women'. Also provide training on working with young Asian women who self-harm. *'Silent Scream – young Asian women and self-harm – a handbook for professionals'* training manual available.

Telephone: 020 8472 0528

Address: 661 Barking Road, London E13 9EX

Email: zindaagi@nawp.org

Website: www.nawp.org

Suffolk

(No name)

A self-help group based in the Suffolk area, for people who self-injure. Safe, supportive and confidential, it is enabling people to explore their feelings, share experiences and discuss coping strategies.

Contact name: Stephanie or Pauline

Telephone: 01473 329671

Address: c/o ESANetwork, St Clements Hospital, Foxhall Road, Ipswich, Suffolk, IP3 8LS

Surrey

Breaking Free – see National Organisations, page 4

Swindon

SPEAR - Self Preservation Encouraging Active Response

To relieve the illness of individuals that take the action of deliberate self-harm. Free information on website, free postal support service and direct support for individuals living in Swindon. Training provided for agencies.

Contact name: Sue Ozolins

Telephone: Mon-Thurs 9am-2pm 01793 520111

Address: Project SPEAR, First Floor, 1 Milton Road, Swindon, SN15JE

Email: info@Projectspear.com

Website: www.Projectspear.com & www.yme-uk.com

Helpline: 10am-12pm Mon – Thurs

Self injury treatment checklist

what you need to know to make my treatment as effective as possible:

I need you to examine my injury in a private room.	
I am distressed	
I need to sit alone	
I need someone to sit with me	
I am happy to sit in the main waiting area	
I need to wait somewhere quiet	

I am happy for students to observe or treat me.	
I am able to discuss what has happened	
I prefer to be treated by a female doctor	
I prefer to be treated by a male doctor	
I would like to see a social worker	
I would like to see a psychiatric liaison nurse	
I would like to see a psychiatrist	

Any other information:

To The Triage Nurse.

National Self-Harm Network.

Incident Report: *refusal of treatment.*

Self-injury in Accident and emergency departments.

The National self-harm network is a survivor-led organisation working for a better understanding of self-harm and entitlement of our rights. We oppose the refusal of treatment for self-inflicted injuries on moral grounds. We believe that everyone has the right to medical treatment for their injuries, regardless of the cause, and based only on clinical need.

This leaflet is to enable you to report when you are refused treatment. The report is anonymous and you can photocopy this leaflet for further use. Just fill it in and send it back to us. This leaflet will be available to anyone in the UK who wishes to inform us of their refusal of treatment.

The National self-harm network has initiated this national reporting system in response to the increasing evidence from men and women of being refused treatment for their injuries in Accident & Emergency departments. (refusal is also being reported in other settings, GPs, prisons, psychiatric hospitals).

We will use the data we receive to compile statistics to present to purchasers, trusts and the Department of Health. Please send this back to us every time you are refused treatment. Help us to make a difference, so that treatment for self-inflicted injuries will become an automatic right. Thank you. *Continued overleaf.*



Please tick;

I have been refused treatment;

Plainly

Constructively

Did you question or complain about the treatment you received?

Yes

NO

What was the outcome?

Tell us briefly and concisely about the refusal.

Refusal of treatment is plain or constructive. Here are some examples;

Plain, being told directly, 'you shouldn't have these cuts stitched any more, it's not worth it, you will only do it again'.

Being told by an Accident & Emergency doctor that you will not receive treatment for the current injury, or, for future injuries because it is self-inflicted.

Receiving written notification from a department, or, manager stating that you can no longer receive treatment for self-inflicted injuries or only for certain kinds of self-harm i.e. overdose but not cuts.

Constructive. Being offered treatment which is inconsistent with previous treatment received for a comparable injury; i.e. dressing applied to an injury which would usually be treated surgically.

Being offered different treatment plans for an injury (with no clinical explanation) i.e. one doctor, hospital wanting to leave an injury whilst another wants to stitch, repair.

Constructive refusal as a form of deterrence. (poor treatment deters you from seeking treatment).

Inappropriate dressings applied, less than due care and attention paid to wound cleaning or pain relief. Being stitched without a local anaesthetic. Being treated in an insensitive, degrading, patronising, hostile or negative manner which results in you feeling afraid to remain, afraid of what will happen, or afraid to return. Being threatened i.e. 'if you don't find alternatives, the staff will see no point'.

National Self-harm Network
Campaigning for rights & understanding of self-harm

NSHN
PO Box 16190
LONDON NW1 3WW



Did anyone accompany you to the hospital?	Yes	<input type="checkbox"/>	NO	<input type="checkbox"/>
---	-----	--------------------------	----	--------------------------

Which hospital- did you attend (or are already resident in)
Name of hospital

Address or area

Did you seek and receive treatment else where for your injuries?	Yes	<input type="checkbox"/>	NO	<input type="checkbox"/>
--	-----	--------------------------	----	--------------------------

Tell us what happened briefly and concisely;

NB if you want to make a formal complaint about your treatment, contact your local Community Health Council for details and advice. If you decide to make a complaint, you will need a lot of support. Let us know the outcome.

Please send back to the National self-harm network

The

Basement Project

82 Colston Street Bristol BS1 5BB 0117 922 58

"THE SELF-HARM HELP BOOK"

A BOOK FOR PEOPLE WHO SELF-HARM

FULL OF PRACTICAL IDEAS BASED ON THE EXPERIENCE OF PEOPLE WHO SELF-HARM. THIS BOOK AIMS TO HELP INDIVIDUALS:

- UNDERSTAND THEMSELVES AND THEIR SELF-HARM
- DEVELOP WAYS OF DEALING WITH THEIR EXPERIENCES AND FEELINGS
- BUILD UP THEIR SELF-ESTEEM AND INNER RESOURCES
- HAVE MORE CHOICES ABOUT SELF-HARM

THIS BOOK WILL ALSO BE A VALUABLE RESOURCE FOR WORKERS AND SUPPORTERS WHO WANT TO HELP INDIVIDUALS IN A RESPECTFUL AND EMPOWERING WAY

Written by Lois Arnold and Anne Magill. Available January 1998

The Basement Project is a community resource providing support groups for individuals who were abused in childhood. Our educational programme includes training, supervision, consultation, research and publications. The income from this work helps finance our direct work with individuals.

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- copies of Strength in Numbers Group support for women abused in childhood £5

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Publications



Women and self-injury booklet series

1 Understanding self-injury

For those who self-injure, professionals and anyone else who wants to understand self-injury. This booklet explains what self-injury is and why someone might feel driven to hurt her own body. There are ideas for help and lists of resources and further reading. Explanations are illustrated with quotes from women with personal experience of self-injury.

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This booklet is for any woman who is struggling with self-injury. It is also of value to professionals wishing to help someone overcome self-injury. It aims to help an individual understand and tackle what causes her to want to hurt herself. Again, women's own words help explain the ideas discussed.

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3 For friends and family

The aim of this booklet is to help those who want to understand and support a woman or young person who struggles with self-injury. An important focus is the feelings and experience of supporters. There are quotes from partners, family and friends, and ideas to help supporters cope with their own feelings and needs.

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4 Self-injury support and self-help groups

This booklet is for anyone interested in setting up or being involved in a self-help group. It examines the practical concerns as well as some of the particular issues that may arise in a group supporting people who self-injure.

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