University of Newcastle

School of Education, Communication and Language Sciences

Doctorate in Educational Psychology

A CRITICAL 'INSIDER' STORY of SELF-HARM

John H Jamieson

2014

Declaration: This thesis is in part fulfilment of the requirements of the Doctorate in Educational Psychology, University of Newcastle. It is all my own work and has only been submitted for the DEdPsy and no other award bearing course.

Signed: …….John Jamieson ……

Student number: A8916648 Date: 01.12.14

22 Moorfield Avenue

Kilmarnock

KA1 1TS

e-mail: johnhjamieson@tiscali.co.uk

j.h.jamieson@newcastle.ac.uk

Acknowledgments

The help obtained for this thesis, and previous assignments, from my main supervisor, Prof. Liz Todd, is gratefully acknowledged. At times it was much needed and received with huge appreciation. In addition, the assistance provided by many other course tutors, including Wilma Barrow (secondary supervisor), during scheduled teaching days was extremely helpful. The careful marking of assignments, was very welcome indeed. I also wish to record my thanks to the two practitioner-consultants, Marie Natasha, an experienced worker with those who indulge in serious self-harming, and Lorna Canning, someone with substantial lived experience of self-harming. Lorna has been on the receiving end of services for many years. Marie and Lorna provided another level of supervision, a practical supervision, to add to the academic supervision I was already receiving. My thanks also go to Dr Ruth Gilbert, a clinical psychologist, and Ms Judith Jamieson, a clinical associate in applied psychology, who both agreed to their names and contact details going on the information and debriefing sheets and thus making themselves available to anyone who was inadvertently distressed by participating in the research. Finally, I will always be indebted to the numerous individuals who contributed their views on self-harming: pilot participants, main study research participants, current clients and former clients, and *insiders* who have shared their thoughts with other researchers whose work I have made use of.

Abstract

This thesis is a qualitative study of self-harm employing a theoretical framework somewhere between social constructionist and critical realist. For some time I had been of the view that not enough was being done to successfully support and intervene in the lives of those who engaged in self-harming. There seemed to be a gap in the research literature and clinical practice which could possibly be filled by seeking answers to research questions such as: What meanings can be extracted from data on self-harm provided by individuals who considered that they had never self-harmed, had mildly or moderately self-harmed, or, who had seriously self-harmed? What is self-harm from a phenomenological and functional point of view? Has the phenomenon of self-harm been appropriately named and defined? What implications might there be for support and intervention, and staff training?

The method of open, unstructured discussion rather than structured or semi-structured interviewing for collection of raw data was used, and the principal analytic tool was thematic analysis upon which were grafted parts of other qualitative methods such as narrative analysis and interpretative phenomenological analysis.

Findings and conclusions included the following:-

Piloting work produced 8 themes (addiction, control, coping, depression, emotion regulation, anti-suicide, suicide, and miscellaneous) and the main study added at least 11 more (purpose in life, pain, punishment, attention-seeking, unattractive/attractive, attacking to be attacked, communication, cry for help, dissociation/depersonalisation, someone to look after, and, manipulation). Four overarching themes were identified. First, what self-harm is – culturally unacceptable self-harming activities (CUSHAS) and culturally acceptable self-harming activities

(CASHAS); secondly, causes and functions; thirdly, support and intervention; and, fourthly, contradictions or dilemmas. From these overarching themes, and associated data extracts, synoptic stories on each of the six main study participants were assembled.

A new name for self-harm was produced, namely, *body self-harm* or *body self-harming* (BSH) and a new definition: *Body self-harming is behaviour which occurs when individuals, intentionally or unintentionally, give precedence to their mental health over their physical health by the process of damaging their own bodies.* And, the beginnings of a new conceptual framework were put forward. Conclusions were reached about support and intervention which, I argued, could usefully take a form that was not necessarily different from what might be required by anyone in need of psychological assistance, irrespective of the presenting issues. Finally, some suggestions were made about staff training which would consider culturally acceptable and unacceptable *Body* self-harming activities (CABSHAS and CUBSHAS) as essentially similar phenomena.

Contents

Page

Chapter 1

Introduction

Chapter 2

Method

Chapter 3

Analysis and Findings

Chapter 4

Discussion

Chapter 5

Conclusions, and implications for support, intervention and staff training

Appendices (1- 23)

Appendices A-B

Chapter 1

Introduction

1.1 Doctorate in Educational Psychology (DEdPsy) Assignments

It is not unusual for a DEdPsy student to stay on the same topic from the beginning to the end of the postgraduate doctorate. This is what I did.

My first assignment was called *'What is Self-harm?'* (Jamieson, 2009). I completed a selective review of the literature, and integrated this with my past experience in the area. Ultimately I found myself arguing that the term *self-harm* was a misnomer. Too much was included under the label. If the *self-harmed-the-self* in any way, it must surely be *self-harm*. Yet some researchers and clinicians excluded anorexia nervosa, bulimia, substance abuse, attempted suicide and suicide. As far as I was concerned these were very much self-harming.

High visibility activities such as cutting or burning raised many eyebrows while low visibility self-harming behaviour such as over-working or not exercising caused fewer

concerns. The latter were originally referred to by Favazza (1989), and later by Turp (2003), as CASHAS (Culturally Acceptable Self-Harming ActivitieS. The former, CUSHAS (Culturally Unacceptable Self-Harming ActivitieS), was a term I coined for my first DEdPsy assignment. Professionals, I thought, should be made more aware of both CASHAS and CUSHAS as they tried to help those with whom they were working. An attempt was therefore made to illuminate the multiple meanings of self-harm (McAllister, 2003), to examine various explanations, and to explore the definitional ambiguity surrounding the term with a view to ultimately improving intervention.

My second assignment involved comparison of published quantitative and qualitative papers on self-harm (Jamieson, 2010), a strategy I later discovered had been used by other teachers and researchers in order to explore the respective values of these approaches to a variety of topics in psychology (Braun & Clarke, 2013). One methodology I examined was almost exclusively quantitative and the other qualitative. I argued that methodologies do not have to be in competition with one another (Elichaoff, Rodriguez & Murphy, 2014). They may sometimes conflict, at other times co-exist, and sometimes even complement one another.

My third assignment (Jamieson, 2011a) was really part of the pilot study for this thesis. It looked at possible insights into self-harm which might be gleaned from thematic analysis of a selective literature review, 18 youtube video/slides on the topic, a discussion with an experienced self-harm worker, and a discussion with a person who seriously self-harmed. Comparisons were made of information obtained from all four sources. The themes which emerged were: a*ddiction, coping, control, depression, emotion regulation, anti-suicide, suicide, and miscellaneous*. I had discovered that there was considerable disagreement in the research community

about what self-harm should be called, and how it should be defined. There was no widely accepted theory that came anywhere near explaining all self-harm, though I thought that a few central features (e.g. experiential avoidance and emotion regulation) were beginning to emerge. Self-harm may in fact be a *normal* phenomenon engaged in by everyone. The difference between CUSHAS and CASHAS may be one of degree rather than quality.

This pilot work set the scene for assignment 4, the thesis proposal (Jamieson, 2011b), which was originally called *From Self-care to Self-harm, from Self-harm to Self-care: Crossing the bridges*, though that title was subsequently changed. Self-harm was a topic that had been well-researched over many years but I suspected that there may be a gap in the research literature and clinical practice. I was beginning to feel that *experiential avoidance* was a common, and perhaps universal, method of dealing (sometimes unsuccessfully) with all sorts of psychological distress, and self-harm was one way of coping. In addition, *emotion regulation* could be a priority for many, if not all, human beings. Some people are prepared to allow their bodies to experience dreadful hardship if it makes them *feel* better. They are ready to inflict terrible harm on their bodies (*self-harm*) if it means that their *minds* are soothed. *Normal* psychological processes and *ordinary* individuals could therefore hold the key to developing appropriate supports and interventions for those who engage in even the most serious types of *self-harm*. Abnormal psychology and psychopathology may have much to teach us, but so too may other areas of psychology and indeed other disciplines (Ceci, 2014; Barnes et al., 2014; Wickens, 2011).

My thesis would be an exploration of what 6 participants thought self-harm actually was from a phenomenological and functional point of view. It proposed to look at

what meanings were able to be extracted from data provided by individuals who considered that they had never ever engaged in self-harm, had mildly or moderately self-harmed, and those who had seriously self-harmed. What implications there might be for support, intervention and staff training would be considered. It was from this background of four DEdPsy university assignments that the scene was set to pursue answers to my research questions. However, my interest in the topic went back much further than this.

1.2 Background to my interest in self-harming

Someone described as a self-harmer is likely to be young, female and to cut herself (Hewitt, 2003). However, there are males involved too. In fact all ages, all social classes, and all ethnic groups are represented though not to the same extent (Nock, 2010; 2012). Some people will not cut themselves but will punch, burn, overdose, asphyxiate, swallow dangerous objects, go without food or damage themselves in other ways. It is a subject that has fascinated me from as far back as the 1980s (Jamieson, 1985) but caught my attention again more recently (Jamieson & Haggerty, 2010).

One reason for my resurgence of interest was an opportunity to attend a two day course run by sisters Clare and Terri Shaw (Shaw & Shaw, 2007a). Terri is the carer of her sister who has self-harmed for years. Clare said during the training that she might self-harm again. They reported that the preferred way to describe those who self-harmed was not *'self-harmers'* but people with *'lived experience of self-harm'* (or, *self-harm survivors*). I would later adapt this further to *'lived experience of self-harming'* in order to keep the emphasis off the entity 'self-harm' and on the process 'self-harming'.

Another reason for exploring self-harm was the lack of success I was having with a number of seemingly treatment-resistant people with *lived experience of self-harming*. One client swallowed a ballpoint pen which could not easily be removed, even by surgical operation. It had somehow managed to partially break inside her, resulting in two serrated edges which were in danger of puncturing her internal organs.

In an attempt to find out more about self-harming, participation in a second training course was arranged. It was run jointly by a children's charity, Barnados, and Penumbra, an organisation in Scotland specifically set up to work with young people who were self-harming. This course (Naranjo, 2008) involved half a dozen two hour sessions every fortnight over a three month period. A few of my clients continued self-harming. I felt a bit like Christopher Robin and Edward Bear in A. A. Milne's book *'Winnie-the-Pooh'* (see diagram 1 below):

Diagram 1: Winnie-The-Pooh

"Here is Edward Bear, coming downstairs now, bump, bump, bump, on the back of his head, behind Christopher Robin. It is, as far as he knows, the only way of coming downstairs, but sometimes he feels that there really is another way, if only he could stop bumping for a moment and think of it" (Milne, 1973).

There must be other ways of providing help for people who were self-harming. What is self-harm? Should a clear distinction be drawn between CASHAS (Favazza, 1996;Turp, 2003) and CUSHAS (Jamieson, 2009)?.

1.3 Explanations of the term self-harm

Some of us smoke and risk developing lung cancer. Others drink too much alcohol, eat too little or too much, over work, take insufficient exercise, and generally do not take good-enough care of themselves. I felt that this was an educational psychology issue overlapping considerably with clinical, forensic and health psychology, and other disciplines. The report Scotland's Future (2013) pointed out that *"…the best research operates across boundaries, be they disciplinary, institutional or nation state…"* (p.201). My intention therefore was not to ignore evidence wherever it was to be found. Literature reviews would be undertaken as the work progressed and would feature in several of the chapters.

Anonymous comments would be inserted throughout the work. These would be from clients with whom I had been in contact over the years (C1, C2, C3...etc.), from the literature (identified by author, date, page number), from pilot participants (Tommy, Sheena, Marie and Lorna) and from main study participants (Sharrie, Martha, Nancy, Mattie, Ellie and Kate).

I was concerned whether or not we actually knew what was being talked about when the term *self-harm* was used? Were explanations of self-harming so varied that there was no agreed definition? Could it be that everyone engages in self-harming of one sort or another?

1.31 What is self-harm?

The psychiatrist Armando Favazza (1996), who had a cross-cultural interest in self-harm, argued strongly against self-harm being trivialised by describing it as mere attention-seeking. He was equally critical of those who saw it as attempted suicide or as a symptom of mental illness such as borderline personality disorder (BPD). His preferred definition was: self-harm is *'a purposeful, if morbid, act of self-help'* (Favazza & Conterio, 1989, p.283). He preferred the term 'self-mutilation', defining it as *"...the deliberate destruction or alteration of one's body tissue without conscious suicidal intent"* (Favazza, 1996, p.*xviii*). However, those with lived experience of self-harming generally object to the descriptor *'self-mutilation'*. They view it as stigmatising, and, in the UK at least, are much more comfortable with the label *'self-harm'* or *'self-injury'.* Maggie Turp (2003), a psychotherapist, uses the expression *'self-harm'* as do most others in Western Europe. She wrote that *'...self-harm is an umbrella term for behaviour that results, whether by commission or omission, in unavoidable physical harm to the self; and that breaches the limits of acceptable behaviour…'* (p.36). And Walsh (2012), using the term *self-injury,* described it as *"…intentional, self-effected, low lethality bodily harm of a socially unacceptable nature, performed to reduce and/or communicate psychological distress"* (p.4).

The lack of agreement with respect to how self-harm should even be named permeates the diverse literature. It is sometimes called *'self-harm'* (Crouch & Wright,

2004; NICE, 2004, 2011), *'self-mutilation'* (Stanley, Gameroff, Michalsen, & Mann, 2001; Ross & McKay, 1979; Favazza, 1996; Chaney, 2013), *'self-injury'* (Crowe & Bunclark, 2000; Victor & Klonsky, 2014), *'self-destructive hehaviour'* (Firestone & Seiden, 1990), *'aggression against the self'* (Parfitt, 2005), *'self-inflicted trauma'* (Taylor & Cameron, 1998), *'self-abuse'* (Weber, 2002), and occasionally also *'attempted suicide'* (Shaw, 2002). Norman Kreitman, a psychiatrist and psychotherapist, was the first to use the term *'parasuicide'* (*The Psychologist*, 2013, p.171) to describe those who made non-fatal attempts to hurt themselves.

There have been systematic reviews on self-harm (Comtois, 2002; Hawton, Arensman, & Townsend, 1998; Klonsky, 2007; Webb, 2002), and both quantitative studies (Guthrie, Kapur, & Mackway-Jones, 2001; O'Connor et al., 2009a; 2009b) and qualitative studies (Josselin & Willig, 2014; Newton & Bale, 2012; Weber, 2002) in abundance. Yet, it seemed to me, that there was still something missing.

Oscar Wilde has acknowledged that *'the truth is rarely pure and never simple'*. The writer and satirist H. L. Menchen has wisely commented that *'to every complex problem there is a simple solution - and it is invariably wrong!'* The psychoanalyst Sigmund Freud wrote that *"...the easiest explanation is not always the right one; the truth is often not terribly simple"* (Freud, 1940/2003, p.34). I believe that self-harm is a complex issue, and it is not likely that there will be a simple way forward. However, I will comment on later, and generally support, the assumption of Occam's Razor that the simplest theory is usually the best.

It could be that self-harm is anything which people do to themselves which harms their bodies. I have intentionally written '*bodies'* because many people who self-harm appear to be hurting their bodies in order to assuage their minds:

"Cutting was my only release from the unbearable chaos inside me" (Arnold, 2007, p.7).

"I can cope with the physical pain I inflict on myself...It's the emotional agony that comes from who knows where...I can't put up with that" (C1).

"It [cutting]...distracted me from the awful pain and guilt and frustration inside. It gave me something real to focus on, an injury I could look after..." (Arnold, 2004, p.4).

"Self-harm used to be a way to get rid of the feelings inside of me, to get out all the hurt, anger and pain that I was feeling" (Truth Hurts, 2006, p.17).

"I need help. I am in terrible pain inside" (Talking Self-harm, 2012, p.4).

Most authors, but not all (e.g. Scanlon & Adlam, 2009), feel that the actual intention to self-harm and an awareness that the body will be damaged must be present for the behaviour to be classified as self-harm. However, while body-hurting is the general intention, so also is mind-soothing. A recent video on self-harm called *'Hurting to Heal'* (2013), the launch of which I was able to attend, was well named. Physical health and mental health sometimes appear to be in competition with one another. When people smoke tobacco they know that their physical health is being jeopordised, and yet they continue. Perhaps this should not be surprising. For example, a meta-review by Edward Chesney and colleagues at Oxford university (Chesney, Goodwin & Fazel, 2014) utilising data from 20 studies involving around 1.7 million people has shown that mental health problems produce a greater reduction in life expectancy than smoking 20 cigarettes a day. Would similar results be found in relation to excessive drinking, under/over-eating, or, taking too little or too much exercise? Underestimating the power of mental health factors may be

preventing a more accurate understanding of self-harm. Self-harming makes us feel better, and mental health benefits seem to take precedence over physical deficits.

Given the difficulties of finding a name for self-harm and a definition that clients, researchers and practitioners are satisfied with, perhaps it would be worth looking instead at 'what is NOT self- harm?'

1.32 What is not self-harm?

Could it be that what is NOT self-harm is anything which people do to themselves that is of benefit? Could self-care be described as the opposite of self-harm? Easy answers to such questions are not forthcoming because an act of self-care may be beneficial to physical health but not to mental health and vice versa. It would therefore be difficult to say whether or not such an act was actually *harming-the-self*.

Are self-harm and attempted suicide/suicide the same thing? In the 1930s the term *'wrist-cutting syndrome'* was first used by Karl Menninger, and somewhat later, in the 1950s, the words *'attempted suicide'* were introduced by Erwin Stengel as a label for a particular type of suicidal behaviour (Block & Singh, 1997). Self-harm was later used synonymously with 'suicide' (Shaw, 2002). In contrast, most definitions of self-harm exclude attempting to kill oneself. Warner & Spandler (2012) have identified one of the problems of research in self-harm as the lack of clarity about what is actually being researched. They specifically mention the intermingling of self-harm and attempted suicide / suicide as an issue.

Social constructionism has emphasised the importance of language and how meaning is created in the dialogue between individuals (Cooper & Roth, 2007). We are homonarrans, story-telling people, and the dramatist, Dennis Potter, put it well

when he said that *'the trouble with words is that you do not know whose mouth they have been in'* (cited in Maybin, 2001, p.68). Labelling theory (Becker, 1963; Lemert, 1951) has pointed out that labels can begin to develop so much power that there is a danger of the label becoming the thing itself. Social constructionists (Gergen, 1999; 2013) and labelling theorists have been saying for some time that it matters a great deal what something is called, and, the self-fulfilling prophecy, riding high in the 1960s, has by no means disappeared from sociological and psychological thinking. There is more than a ring of truth to the words of the American Fieffer cartoon character who was made to say (as cited in Jamieson, 1981, p.276):

> "I used to think I was POOR then they told me I wasn't poor, I was NEEDY. Then they told me it was self-defeating to think of myself as needy, I was DEPRIVED. Then they told me deprived was a bad image, I was UNDERPRIVILEGED. Then they told me that underprivileged was over-used, I was DISADVANTAGED. I still don't have a dime. But I have a great vocabulary."

In relation to self-harm, wrist-cutting syndrome, attempted suicide, suicide and so on, it seems to me that we still do not know what we mean, but we do *'have a great vocabulary'.*

I am leaning towards the importance of including the word 'body' in any acceptable label for self-harming behaviour because *body* self-harm is generally carried out in order to avoid *mental* harm. Caring for the mind, and coping with internal, emotional pain appears to be paramount. The new Diagnostic and Statistical Manual (DSM-5, 2013) contains the term *non-suicidal self-injury* (NSSI), but, partly as a result of resistance by UK psychologists and others (Caplan, 2013), DSM-5 did not make NSSI a full diagnosis. The most frequently used label on this side of the Atlantic is

still '*self-harm'*, and though I am not entirely dissatisfied with that name, I would like to look at why calling the phenomenon something else could be advantageous.

One implication for those who self-harm in culturally unacceptable ways as opposed to those who self-harm in culturally acceptable ways is the danger of stigmatisation. Believing that there is something seriously wrong or abnormal about oneself, that you are a *'self-mutilator'* or *'self-injurer'* or *'self-harmer'* may be damaging. The development of an identity based on such labels could promote resistance to change, not unlike what appears to have happened when the American Medical Association (in June 2013) formally accepted that *obesity* was a disease. According to recent early research (Hoyt, Burnette & Auster-Gussman, 2014), labelling obesity as a disease actually resulted in fat people eating more, choosing less healthy options, and harming their bodies even more. Over-eating is particularly interesting given that some psychologists have taken the view that *'an obesity crisis is surely self-harm on a massive scale'* (Rawlinson, 2013, p.470).

The medical model could be directing us towards physical treatments and associated explanations for self-harming when we might be better looking elsewhere. ICD-10 (International Classification of Diseases), a system used by the World Health Organisation, does not contain the label NSSI (ICD-10, 1992). However, it remains to be seen whether or not the next version of ICD due in around 2 years (ICD-11, 2017) will respond to the debate on self-harm in a similar way to DSM-5. A healthy exchange of information between normal and abnormal psychology and the linking of CASHAS and CUSHAS, I suspect, may be a useful way forward.

In relation to *'suicide'* and *'attempted suicide',* females are more likely to *attempt* suicide than males, but males are much more likely to succeed (Windfurh et al.,

2008). This could, of course, be related to males' preferred methods of attempting to take their own lives rather than to any other gender issue. Males are more likely to use extremely violent means of hurting themselves, such as shooting or hanging. Females tend to prefer overdosing on drugs from which there is a much greater chance of survival. However, there are variations in male/female comparison from country to country as shown in a recent publication by WHO (World Suicide Report, 2014).

Though suicide is undoubtedly *self-harm* in the extreme, when self-harm is discussed in the same breath as suicide or attempted suicide I believe that the waters are muddied considerably. Some people who self-harm say that they had no intention whatsoever of committing suicide:

"I'd never do suicide – that would just hurt other folk" (C2).

Some say that occasionally they are actually attempting suicide but more often they are not:

"Mostly I don't want to kill myself, but sometimes I do" (C3).

In fact for some people, self-harm appears to be a way of self-soothing, a way of preventing themselves becoming so low that they want to die:

"For me it's a relief. I can forget about my family problems for a while. For some people it's 'drink' or drugs to stop them worrying about things. I punch the wall sometimes, but that's not as good as cutting" (Tommy).

Tommy was a 16 year old young person *'in-care'* and my first pilot participant. In the case of looked-after and accommodated children and young people it is estimated that as many as 90% have mental health problems (Furnivall, Connelly, Hudson, &

McCann, 2008), though most have not been given a specific mental illness diagnosis.

1.33 Self-harm as a symptom of a specific mental disorder

People who self-harm have been diagnosed with anything from clinical depression to Munchausen syndrome (Van der Kolk, Perry, & Herman, 1991). The most common diagnosis is BPD / borderline personality disorder (Soloff, Lis, & Kelly, 1994), originally called *'borderline'* because it did not fit comfortably into either the *neuroses* or *psychoses*. BPD symptoms also include instability in relationships, self-image and moods, and impulsivity in various contexts (First, Pincus, Allen, & Widiger, 2000; DSM, 2013). Some textbooks use the term self-harm and BPD almost interchangeably (Townsend, 2000) when in fact self-harm is only one of 9 BPD criteria in DSM-IV (1994). Attention to all the criteria might lead to better treatment (Johnstone, 1997). It is not entirely clear whether BPD results in self-harm or self-harm causes BPD. Some researchers are critical of BPD to the point where they would prefer a separate, formal diagnostic label for self-harm (Crowe & Bunclark, 2000; Nock, 2010; Walsh, 2012). In DSM-5 (2013) there was a call for the term NSSI / non-suicidal self-injury to be researched further before being given the status of a diagnosis. The question remains, of course, whether an illness model is of much benefit anyway. A self-harm mental illness distinction between CUSHAS and CASHAS could mean someone being mentally ill in one culture and not in another. Anyway, it has been argued by some researchers that *"...globalising notions of psychiatric illness may cause more harm than good"* (White, 2013, p.182).

1.34 Limitations of mental illness models (and diagnostic labels)

The psychologist Dorothy Bishop (2014) has written about one of her many experiences of diagnosis. Parents had brought their 10 year old son for an opinion on his language difficulties. She thought he fitted the picture of someone with a developmental language disorder (Ricketts, 2011). However, in discussion with the parents, it transpired that the child had already been seen by a paediatrician who thought he was inattentive and impulsive and had diagnosed ADHD (Martin, 2014), an educational psychologist had suggested dyslexia (Elliott & Grigorenko, 2014), an occupational therapist had noted that he was a bit clumsy and had gone for developmental dyspraxia (Zwicker, Harris & Klassen, 2013), and, his teachers at school were wondering about the possibility of an autistic spectrum disorder owing to the triad of impairments and some obsessive behaviours (Wing, Gould & Gillberg, 2011). Maybe they were all right in some ways but wrong in others. No wonder some experts have suggested terms like ESSENCE (Early Symptomatic Syndromes Eliciting Neurodevelopmental Examinations) to cover a whole range of concerning behaviours (Pettersson, Anckarsäter, & Lichtenstein, 2013). Possibly the search for suitable words to describe self-harming in human beings will come up with something similar as a starting point. Afterall, the literature on intelligence appears to be comfortable with the ‘g’ factor to signify general intelligence along with more specific intelligences such as crystallised and fluid intelligence (Colom, Jung & Haier, 2006; Spearman, 1904); and, more recently, a ‘p’ (psychopathology) factor has been suggested as an appropriate term to encompass a range of psychopathological types of behaviour given that co-morbidity is so common among many problematical conditions (Caspi et al., 2014).

My concern is that over-emphasising the mental illness side of self-harming behaviour could result in pertinent psychological and sociological factors receiving

less attention than they deserve. Some researchers have argued strongly against using mental illness labels in relation to self-harming to avoid clinicians being channelled towards seeing disorders rather than people (Johnstone, 1997). Pathologising something like self-harm concentrates the mind principally on culturally unacceptable and often bizarre examples of self-harming thus skewing thinking away from the fact that self-harming is common human behaviour. Also, rather than being wedded to a diagnostic label, I am inclined to the position taken by Warner & Spandler (2012) that *"…mental distress (such as that associated with self-harm) is rooted in negative, oppressive or abusive experiences in the social world…Because people experience oppression and abuse differently, it follows that individual meanings are paramount…It is crucial to recognise the specific 'meaning' the person themselves attaches to their behaviour…"* (p.18).

Almost 150,000 people in the UK attend A&E annually as a result of self-harming. They are often seen as time-wasters and less deserving of staff attention than *'real'* patients (Mackay & Barrowclough, 2005), and there is very little evidence to show that keeping someone in hospital reduces future self-harming behaviour in any way (Van der Sande et al., 1997):

"I hate it when they make me stay in hospital. It's the last thing I want. It makes me worse" (C5).

I was totally stunned when I heard the news that my younger sister Clare had been admitted to hospital...I couldn't believe that things had got so bad...Florence Nightingale...said that a hospital shall do the patient no harm...It wasn't the safe environment I was hoping for...She was being given some pretty heavy medication... She was so doped up...Maybe that was the idea – to sedate Clare to the point where

she was incapable of harming herself...Yet...she not only continued harming herself, but the injuries she inflicted...were so much worse than those she had done when at home" (Shaw & Shaw, 2007b, p.26).

However, some self-harmers appear to welcome a break away from the stresses and strains of community living:

"I needed to get away from everything. The doctors and nurses were rotten to me but I was still glad to get looked after for a while" (C6).

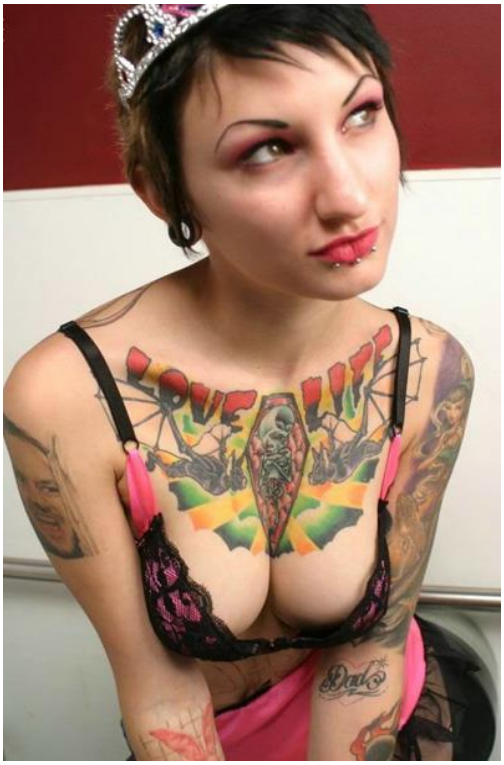
Attitudes, beliefs and behaviours of hospital staff need to be challenged. Professionals are employed to provide a service to people in need of care and attention as a result of injury no matter how that injury has been sustained. If staff were helped to see self-harm in a different way, perhaps on a continuum from self-care to CASHAS to CUSHAS, an improvement in understanding and an increase in empathy and more fruitful interventions could develop. Support and intervention for those in distress may lie in the direction of, at least initially, turning CUSHAS into CASHAS.

Self-harming is not easily explained as only some kind of pathology (Clarke & Whittaker, 1998). For example, consider tattooing and body piercing. These activities might at one time have seemed strange in the developed world. However, nowadays there are tattooing and body piercing shops on many high street towns and cities. Just over a decade ago Anderson & Sansone (2003) documented for the first time an example of tattooing which they considered to be self-harm. A 19 year old was voluntarily hospitalised with suicidal thoughts. He told staff that he would sometimes deal with emotional pain by paying for tattoos instead of cutting himself. He reported that people would see the cuts, and he would be embarrassed, but that *"…physical*

pain helps to take my mind off it" (Anderson & Sansone, 2003, p.317). Sometimes instead of cutting he would select parts of his body for tattooing. The more emotional pain he was experiencing, the more likely he was to choose a particularly sensitive area for a tattoo. The psychologists interpreted his behaviour as a case of mood regulation through tattooing instead of cutting, CASHAS taking the place of CUSHAS. Also, a study by Stirn and Hinz (2008) looked at subscribers to a body modification magazine in Germany. They recruited 432 volunteers who completed a detailed questionnaire about their activities and motives. 27% admitted to past self-harming by cutting. This was a large proportion compared to the percentage of the general population who admit cutting, and not far behind the huge percentage (30%) of prison inmates known to self-harm (Brooker, Repper, Beverley, Ferriter, & Brewer, 2002). Stirn and Hinz tentatively suggested that some people may have found culturally more acceptable ways of self-harming by body modifications (tattooings and piercings). See the photographs below:

Photograph 1: Tattoos – too many?

Photograph 2: Piercings – over-the-top?



Photograph 3: Tattoos and piercings – acceptable or unacceptable? In whose culture?

Some respondents stated that they had discontinued cutting after their first tattoo or body-piercing. Others said that they would sometimes decide to have a new tattoo or body-piercing after a negative experience, as a way of deliberately inflicting physical pain on the outside to counter what was happening on the inside. Such findings raise doubts about pathologising self-harm over seeing it as a more normal human activity.

Returning to A. A. Milne, a conversation between Rabbit and Winnie-the-pooh captured quite well something of the changes that were happening to me as my research progressed:

'I don't see much sense in that', said Rabbit.
'No', said Pooh humbly, there isn't. But there was going to be when I began. It's just that something happened to it along the way' (Milne, 1973).

A lot was happening to my thinking about the topic of self-harm *'along the way'.* Experts in the area of self-harm have developed a number of different explanations for what self-harm actually is. Some of these will be dealt with next.

1.35 Psychosexual explanations

Variations of a psychosexual theme occur in much of the psychoanalytic literature. Self-harm, particularly 'cutting', is linked to sexuality e.g. for sexual gratification or to punish oneself to establish control over sexual urges (Messer & Fremouw, 2008). It has even been suggested (Woods, 1988) that it could be a substitute for masturbation. Daldin (1990) has written that "*struggles against masturbation may result in aggressive and libidinal energies being damned up and displaced"* (p.281). Others like Zila & Kesiklica (2001) and Walsh (2012) viewed self-harm as related to

sexual confusion and body image: *"I've always hated my body. I've always felt it was dirty, disgusting...Anything to do with sex...It has to do with my father..."* (Walsh, 2012, p.215)…*"[I've had] 25 years of negative thoughts about being an ugly eyesore"* (Walsh, 2012, p.223). Evidence for the psychosexual nature of self-harm has come largely from anecdotal offerings of clinicians working with self-harming clients and individual case studies (Doctor, 1981; Parfitt, 2005), however, some descriptive surveys (Favazza & Conterio, 1989; Simpson & Porter, 1981) have been carried out by those with leanings towards psychosexual explanations. Weaknesses in these studies include the fact that comparisons with individuals who say that they do not self-harm have rarely been attempted (Messer & Fremouw, 2008); the theoretical orientation of clinicians may have had a bearing on interpretations; the participants tended to be people who had already been at A & E; and, rarely was the psychosexual model fully supported by self-harm survivors.

"My psychiatrist was no use. I only went to see him once. All he wanted to talk about was my sex life and I didn't like that" (C7).

1.36 Depersonalisation / dissociation explanations

Depersonalisation or dissociation refers to an experience of separation of mind and body (Miller & Bashkin, 1974). Self-harm results in a reconnection. Dissociation is also a psychological state experienced by those who take hallucinogens (Blackmore, 2014). It is repeatedly referred to by many people who self-harm (Suyemoto & MacDonald, 1995).

"When I feel numb and...I don't really exist, I cause myself harm and it brings this rush that brings you back to earth" (Truth Hurts, 2006, p.25).

“It’s like pinching myself awake...I self-harm in order to feel real when I feel dead” (Babiker & Arnold, 1997, p.78).

Surveys, longitudinal studies, and correlational research have all been used in support of this explanation of self-harm. A clinician survey carried out by Suyemoto & Macdonald (1995) revealed that, irrespective of a therapist’s orientation, dissociation was a major factor. Longitudinal studies too have found that people who self-harm confirm the prevalence of dissociating experiences (Van der Kolk et al., 1991). Correlation research (Brodsky, Cloitre, & Dulit, 1995) also has shown, particularly in females diagnosed with borderline personality disorder (BPD), that there is a high correlation between dissociation and self-harm, even when such things as depression and early childhood abuse are controlled for . However, each of these types of study has some weaknesses. Surveys like that of Suyemoto and Macdonald canvassed the views of 500 randomly selected therapists but less than half responded. Of the respondents, even fewer (44) provided usable information. Longitudinal work like that of Van der Kolk limited themselves to participants who already had a psychiatric diagnosis such as bipolar disorder or BPD and to those in the age range 18-39. This has obvious implications for generalising findings to younger people and those over 40. As for those without psychiatric illness or who do not take hallucinogens, there is less evidence that they dissociate to the same extent. Finally, correlational studies like that of Brodsky and colleagues clearly demonstrate a link between self-harm and dissociation but leave some doubt as to the direction of causation. Does dissociation cause self-harm or does self-harm cause dissociation or does a third factor result in both?

1.37 Psychosocial / interpersonal explanations

Case studies have a lot to say about interpersonal explanations of self harm (Bennum, 1984; Suyemoto, 1998). The emphasis in psychosocial explanations moves away from *'the individual'* and on to *'relationships between individuals'*. Some case studies (Crouch & Wright, 2004; Hartman, 1996) have acknowledged that too firm a focus on the *person* has sometimes resulted in the *inter-personal* being ignored. For example, Hartman (1996) described an adolescent female in a psychiatric unit cutting herself and deduced that it was mainly because of the adulation she got from peers. It was her badge of honour, something she was really good at. As the author put it, this was a *'uniquely dramatic act that often provoke[d] dramatic responses in the surrounding system'* (p.15). Similarly, Crouch & Wright (2004) using interpretative phenomenological analysis (IPA) coded interview transcripts from 4 adolescent females and 2 adolescent males in a residential setting, and found dominant themes such as the importance of being accepted into a group. Producing a reaction in others appears to be paramount for some people who self-harm:

"I mostly did it in secret but in some ways I wanted to be found out. I needed someone to know what was going on inside me" (C9).

"I couldn't tell anyone what was happening to me in words, so I tried to show it by my wounds. I couldn't cry, so the blood was like the tears..." (Arnold, 2004, p.6).

"There is a special bond among people who cut themselves...It really freaks out my parents when we do this" (Walsh, 2012, p.300).

Problems with case studies include how small and select the groups are, (sometimes only 2 as in the Hartman study), and the possibility that the individuals chosen already matched authors' pre-conceived notions of self-harm. Also, very little

account tends to be taken of culturally acceptable versus culturally unacceptable self-harming. In addition, work like that of Crouch and Wright has resulted in critics like Kazdin (2003) commenting adversely on validity and reliability due to the use of what he described as a *'semi-projective'* tool for data analysis.

The interpersonal model is also suggesting that self-harming behaviour is engaged in by people who are part of a dysfunctional system such as a family, children's home, school, hospital or community. It may be carried out to gain attention, or to deflect attention from a malfunctioning system, or, simply as a form of communication between one part of the system and another. However, if self-harm is mainly a method of interpersonal communication, what sense can be made of the ultimate communication, suicide?

1.38 Attempted suicide / suicide explanations

Some experts specifically exclude attempted suicide/suicide in their definitions of self-harming (NICE, 2011). However, others clearly include it. For example, in a National Children's Bureau Highlight on young people who self-harm, Hewitt (2003) wrote that *'the term self harm refers to a wide range of behaviours with motives ranging from coping and survival to attempts to seriously injure oneself or even kill oneself'.* Indeed the National Institute of Health and Clinical Excellence guidelines (NICE, 2004; 2011) have pointed out that those who are treated for self-harm at hospital A&E departments in the UK are 100 times more likely than others to eventually kill themselves. However, Ryan and colleagues reported the figures as only 18 times more likely (Ryan, Clemmett, & Snelson, 1997). Such a huge discrepancy may, of course, be to do with how self-harm is named and defined. These statistics point to suicidality and self-harm co-existing (Vivekanada, 2000). To

say that those who self-harm are *never ever* trying to commit suicide is clearly wrong. Yet, clinicians and researchers repeatedly report that self-harming is soothing, and is a powerful strategy to reduce the likelihood of suicide (Firestone & Seiden, 1990; Naranjo, 2008; Shaw & Shaw, 2007a & 2007b):

"When you put pressure on me to stop self-harming, that's when I feel really bad…I get tense. I could explode. If folk stop me for too long, that's when, maybe, I could kill myself" (C10).

"It's a solution that means I'm not going to completely flip out or kill myself" (Arnold, 2007, p.4).

"Burning myself with caustic soda has a survival purpose for me. It stops me killing myself and enables me to cope with the pain and torment I sometimes feel" (Babiker & Arnold, 1997, p.73).

Like Walsh (2012), and a number of others working in this field, it would appear to me that self-harm and attempted suicide / suicide are not quite the same. However, there are similarities. Self-harm may be a risk factor for suicide. It may be that we should treat self-harm and attempted suicide *independently,* but monitor and assess them *inter-dependently*. Interestingly, Suyemoto and MacDonald (1995) in their survey of therapists found that, irrespective of theoretical orientation, the suicide / attempted suicide hypothesis was the second least likely explanation (psychosexual being the least likely).

1.39 Biological explanations

Prominence has rarely been given to physiological or biological explanations for self-harm, except in so far as it is thought to be a symptom of a mental illness like bipolar

disorder or BPD. Usually psychological factors are to the fore. However, there is some evidence to suggest that there might be a biological predisposition in some people to behave in self-harming ways. A few studies have implicated problematic neurotransmitter activity in the central nervous system, or unusual physiological responses to self-harming in relation to how tension is reduced (Haines, Williams, Brain, & Wilson, 1995; Stanley et al., 2001; Winchel & Stanley, 1991). Also, individuals with personality disorders who self-harm have been compared on a number of biological measures with similarly diagnosed people who were considered not to self-harm (Simeon et al., 1992). While most of the measures did not indicate any significant differences between the groups, a few differences with respect to what was going on at platelet imipramine binding receptor sites have been noted (Messer & Fremouw, 2008).

The weaknesses of biological studies are that most have been carried out with adults only; have tended to involve only serious CUSHAS; participants usually already have a psychiatric label; and, the direction of causation is uncertain.

1.310 Behavioural / environmental explanations

While environmental factors are not ignored in other explanations of self-harm, they are given prominence in behavioural models where the role played by learning takes centre stage. Factors such as: the link between abuse in early childhood and self-harm; self-harming behaviour possibly serving as a powerful re-enforcer / reward; the desire to belong to a particular group requiring self-harm as an initiation rite; and, observing and imitating self-harming behaviour, have all figured in behavioural / environmental models. Some quite sophisticated explanations can be found in the work of Nock and Prinstein (Nock & Prinstein, 2005; Nock, 2012) which has looked

at functional approaches to self-harm and how antecedents and consequences have played their part in maintaining self-harming behaviours. In one study they interviewed 108 self-harmers between the ages of 12 and 17. These young people responded in ways which largely supported the predictions made by learning theory (Nock & Prinstein, 2004). Most frequently they said that individual reinforcement was what was important to them. Social reinforcement was also endorsed as one of the main motivators. Self-harming was rewarding. They felt so much better while doing it, lending some credence to the mood regulation explanation to follow.

1.311 Mood regulation explanations

Mood regulation can be found under a number of different names (Klonsky, 2007). It has been called the affect regulation model, the expression model, or the emotion model. There is usually an increase in tension in people who are about to self-harm. Some dissociation and identity confusion may also occur as in the 'depersonalisation' explanation. There may be a feeling of anger towards oneself or others. The experience of emotional pain is common-place (Suyemoto, 1998):

"I became trapped in a world of my own, suffering the hurts and pains in silence. Cutting was my only release..." (Arnold, 1995, p.13).

Mood regulation turned out to be the most frequent explanation given by therapists in the survey by Suyemoto and MacDonald (1995). Self-harming apparently makes clients feel so much better:

"Cutting isn't the problem for me – it's the solution. If I don't cut myself I can't cope. I feel I'm going to go crazy" (Turp, 2003, p.35).

Psycho-physiological tests involving skin conductance, heart beat monitoring, and, blood pressure recordings have all been used in experimental studies which have lent some support to this model. For example, self-harming and non-self-harming controls have been compared with respect to how they responded to imagined self-harming scripts (Haines et al., 1995). One finding was that only those who regularly self-harmed experienced increased tension on the approach to self-harming, followed by a marked reduction in tension during and after self-harming. There were no differences between the groups when neutral imagery scripts were used. However, criticisms of such studies can, of course, be made on the grounds of poor ecological validity and their limited selection of types of self-harming. Nevertheless, researchers using different methods have provided support to the mood regulation idea. Groups of people who self-harmed, depressed individuals and controls were interviewed about self-harming, as well as having their case notes carefully scrutinised, and, Bennum & Phil (1983) concluded that *"self-mutilation can be seen as a method of reducing and controlling arousal…"* (p.79). Ross and Heath (2002; 2003), using questionnaires and semi-structured interviews, in their study of 61 adolescents who claimed to self-harm compared to a matched control group, reported greater levels of affective states in the former. These mood states were regulated by self-harming. Also, the women in the Bristol survey (Arnold, 1995) gave *"relief of feelings"* as the number one reason for CUSHAS. The three top *'feelings'* identified as precipitating self-harm were: "*overwhelming emotional pain", "self-hatred", and "anger".* The emotion regulation model has accumulated substantial support from a variety of types of research over the years. No other model, it seems to me, has the potential to fit as neatly into the CUSHAS / CASHAS idea as this one.

Perhaps the greatest weakness in the model is the tendency to assume that if CUSHAS are not engaged in, self-harming is not happening. People can drink themselves to death, or smoke their lives away as more than 650,000 people in Europe do every year (Stihler, 2013), and not be thought to be self-harming. Studies which try to compare people who self-harm with so-called controls may not actually be looking at different samples.

1.312 A merging of models?

In this complex area some theories have less relevance than others to frontline workers and clients. For example, the theory of secondary gain implying that a self-harming person is only seeking attention or affection does not have much of value to say to those who largely carry out CUSHAS in secret (Feldman, 1988). Psychiatric labelling hardly seems appropriate for minor acts of self-harming, or for CASHAS, or for young children (Walsh & Rosen, 1988; Walsh, 2012). The perverse pleasure that some people are thought to get from self-harming is certainly not true for everyone (Welldon, 1988). And, while self-harm can sometimes be linked to sexual abuse in childhood (Wise, 1989), and to adult trauma such as rape (Greenspan & Samuel, 1989), these experiences do not happen to everyone.

What seems obvious to me is that no one model of self-harm is yet able to explain every case. Existing theories of self-harm are only supported by some of the data some of the time, not surprising given the definitional ambiguity referred to by Mangnall & Yurkovich (2008), McAllister (2003) and Warner & Spandler (2012). Self-harm has been thought to be attempted suicide at one extreme, and used to avoid killing oneself at the other. It can take on the mantle of CASHAS (tattooing, smoking, excessive drinking, over-eating, nail-biting) at one end, and CUSHAS

(cutting, burning, overdosing, severing limbs) at the other. Looking at the phenomena in relation to culture, and on a continuum, may be one way forward.

1.313 Cultural theories of self harm

'Culture' usually refers to a tradition of ideas, values, beliefs, knowledge and activities passed from individual to individual and group to group down the generations, a kind of corporate memory transmitted over decades (Handy, 1985). Kirmayer (2006) has described culture as *'formal and informal practices, explicit and tacit rules, ways of making sense and presenting one's experiences in forms that will influence others'* (p.133). It must surely be worthwhile being aware of different cultures and sub-cultures to help avoid misinterpreting behaviour.

In biblical times eunuchs in the imperial court voluntarily underwent castration. More recently, in the 16th and 17th centuries, young boys were castrated to retain their soprano voices. In the 19th century, some Christian sects in Russia were known to practise castration. Amazon females sometimes had a breast removed by others or by self-surgery (Ross & McKay, 1979). The word *'amazon'* literally means *'without breasts'*. Religious literature is replete with examples of self-harm as purification or atonement for sins. There are sayings in the New Testament attributed to Jesus like *'…if thy right hand offend thee, cut it off…and if thine eye offend thee, pluck it out…"* (Mark chapter 9 verses 43-48), words taken literally by some believers (Carson & Lewis, 1971). *"Even if I do get certified [as legally insane] and in the eyes of the world I am mad, it is far better for me to have cleansed myself"* (Favazza, 1996, p.27).

A modern religious and cultural context has been provided by Favazza who described self-harm as a rite of passage to wisdom, self-coping and power. In some

cultures self-harm does not signal psychopathology but has social purpose and meaning. Favazza's perspective was a bio-psycho-social one operating within a religious and cultural context (McAllister, 2003). People who self-harm have ascribed to themselves, or have been ascribed, supernatural powers (Asch, 1971).

A few studies have shown self-harm to be more common among whites (Bhugra, Singh, Fellow-Smith & Bayliss, 2002). Others have found it more prevalent in minority groups (Marshall & Yasdani, 1999; Whitlock, Eckenrode & Silverman, 2006). Having a sexual orientation other than typical heterosexuality seems to predispose some people to self-harm. Identifying oneself as bisexual is a risk factor (Whitlock, Powers & Eckenrode, 2006; Whitlock et al., 2011). However, unless one includes eating disorders, there is very little support in the literature for a higher rate in middle and upper socioeconomic groups (Strong, 1999). In fact, one might have expected it to be more prevalent among lower socioeconomic groups due to a link between adversities and self-harm. There are around 13.5 million people in the UK alone considered to be in poverty (defined as having a household income below 60% of median income; Haddad, 2012). Stresses imposed by poverty have long been assumed to increase the risk of self-harm (Favazza & Conterio, 1989), and there is evidence that social disadvantage correlates highly with numerous behaviour problems and ill-health (Metzer, Fryers & Jenkins, 2004; Wilkinson & Pickett, 2009). The Department of Health (DoH, 2011) has come to the startling conclusion that mental health issues have resulted in more disability than either heart disease or cancer.

"I'm nearly 28...[an] English teacher...from a very loving middle class family...The media...believe that people who self-injure are all silly attention-seeking teenage girls, or emos, or people unable to function normally. Not so…I've been relying on

self-injury to get me through certain days since the age of 13...There isn't really a typical profile... " (Lifesigns, 2013, p.1).

The search for a distinct self-harmer profile within cultures, or between cultures, has so far been somewhat elusive (Brodsky, Cloitre & Dulit, 1995). Self-harm can, and perhaps should, be understood as a cultural phenomenon. There is, in my view, likely to be an interplay between cultures and self-harm. In cultural terms, self-harm is more than a problem *within* an individual. Cultural theories generally recognise factors like injustice, power, poverty and marginalisation. The body can be viewed as a communicating text. In a sense the skin is like a wall on which to inscribe graffiti. It is the border between what is outside and inside the body. Maggie Turp (2003; 2007) wrote about *'psychic'* skin. She described the body as *'a barometer of psychological change'* (Turp, 2001). Similarly, Keleman (1985) called it *'the somatic architecture of feeling'*, and Armando Favazza described the skin as a *'message centre or billboard'* (Favazza, 1996), illustrating his point by referring to blushing, turning pale, tattooing and piercing as well as cutting or burning the skin as ways in which humans transmit important information. In addition to being the site for cultural experiences to be displayed, Favazza was convinced that self-harming was a way of communicating internal pain.

It may be that we are all somewhere on a self-harm continuum. There may be no such thing as non-self-harmers as opposed to self-harmers. Turp (2003) was one of the first to use the terms *'high'* and *'low visibility'* self-harm. A self-harm continuum could look something like this:

adequate self-care	compromised self-care	hidden self-harm	low visibility self-harm	high visibility self-harm

CASHAS	mild self-harm	moderate self-harm	severe self-harm	CUSHAS

Diagram 2 Self-Harm Continuum

Turp promoted the notion of a continuum rather than the more commonly held dichotomous view of what she called the *'Qualitative Leap'* model of self-harm. In this model most of us are in the *'good-enough'* self-care category and a small minority in the more serious self-harm category.

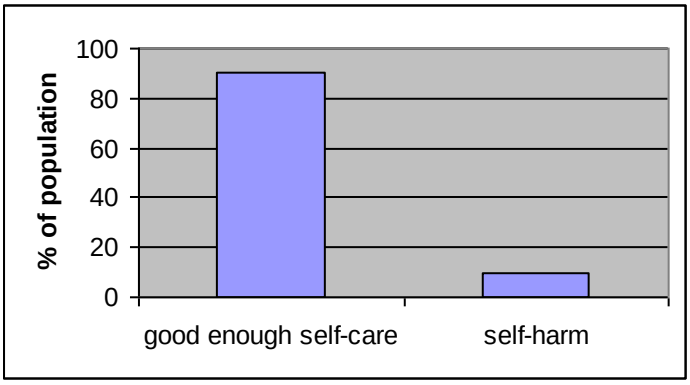


Diagram 3: *'Qualitative Leap'* Model of Self-harm

1.314 Implications for psychologists and others

The complexities surrounding the issue of self-harm, the explanations for it, and its multiple names and definitions, suggest that psychologists (and others) should be more aware of the need to scrutinise the conventional discourses on self-harm and the often unsatisfactory outcomes in relation to support and intervention. McAllister (2003) put it well when she concluded that *"…opening up self-harm to multiple readings offers hope that individualised, effective responses for clients may be possible" (*p.184). However, our present state of knowledge suggests to me that currently we can do little more than follow the exhortations of the French writer and philosopher, Albert Camus, who wrote: *"Don't walk in front of me, I may not follow.*

Don't walk behind me, I may not lead. Walk beside me and just be my friend". We may have to walk beside those who engage in CUSHAS (and CASHAS) for some time to come before we can offer much in the way of effective intervention.

1.4 Reflexive analysis

Reflection, reflective practice or reflexive analysis is an important element in any research, but particularly in a qualitative study. Mediocre reflection consists of listing experiences of a personal nature and perhaps making the odd critical comment on the research process (Patent, 2010). However, reflexivity in social research should be more than self-contemplation and introspection (Bourdieu, 1992; Shaw, 2010). It should be to help us understand our learning and facilitate others understanding. Reflective practice involves the application of knowledge, skills and reflection on outcomes (Schon, 1983). It is linked to what Kolb (1984) considered learning to be. He saw it as experiential, going from the first stage of *'concrete experience'* to *'reflective observation'* to *'abstract conceptualisation',* and then to *'active experimentation'* in a cyclical fashion (Kolb & Fry, 1975).

Some authors have divided reflexivity into two types, personal reflexivity and functional reflexivity (Goodley, Lawthom, Tindall, Tobbell & Wetherell, 2003; Wilkinson, 1988). The former refers to personal life experiences of the researcher which may have influenced the work. The latter is more to do with the research processes themselves. Some qualitative researchers like Carla Willig (2008) prefer the term epistemological reflexivity, however, it seems to me that it could just as easily be called methodological reflexivity, or, analytical reflexivity.

When I reflect on my own life and activities which might be described as self-harming, I am more than a little surprised. Though I did not recognise what was

happening at the time, I now suspect that my attempts, as an adolescent, to attract girls by having well sun-tanned skin may have been self-harm. In those days (1960s) there was not quite as much information in the public domain about the dangers of cancer. I would spend hours half-naked in the fields as a farm labourer during school and university holidays. I have subsequently had cryotherapy and several operations to remove rodent ulcers, basal cell carcinoma, essentially skin cancer.

As a young man I played professional football for Motherwell FC, currently one of the 12 clubs in the Scottish Premier League. Players would compete with one another not only to be the best footballer but to have the best suntan. Ultraviolet lights were used to supplement natural sunlight. However, players would also sustain injuries which I now think may sometimes have been self-harming. The physical injuries I got playing for Motherwell FC, and later for a smaller, semi-professional team, Troon Juniors FC, may not always have been a consequence of unavoidable accidents. In retrospect, I wonder if some of the injuries were due to deliberately putting my body in harm's way. Paradoxically, some injuries resulted in anxiety-reduction. They took my mind away from more worrying aspects of the game. They provided me with an explanation for not playing well, and, they were an excuse for not being good enough to be selected to play in the first place. Some top professional football players today appear to be extremely injury-prone. I wonder if self-harm plays a role?

It was a cold February evening in 2013 when I was driving my youngest son, Rory, and his friend to a football match in Prestwick. We overtook a motorcyclist. He looked distinctly uncomfortable even though he seemed to be wearing all the correct clothes. He was hunched over his bike trying to make himself as small as possible in the biting wind. It reminded me of *my* motorcycling days. I had left psychology for a short period in the 1980s to take up the position of Head of Education in a residential

school for some of the most troubled and troublesome young people in Scotland. It was a stressful job. Occasionally I would travel to work on a motorcycle and arrive at the school during the winter months hardly able to speak, my face and lips numb with cold. Though it did not occur to me at the time, I now wonder if there was an element of self-harm in my behaviour. The extremely cold journey could have been a distraction from the stresses of having to manage a team of around 15 teachers, and 100 difficult young people some of whom had committed murder. I remember thinking that having a motorcycle helped my street credibility, but was it possible that these cold, unpleasant journeys served another purpose? Could the hardship I imposed on my *body* have been a coping mechanism for dealing with some of the anxieties of the job?

Another example of what may have been self-harm, though I am only now becoming aware of the possibility, was a tendency I had to make sure that I would completely empty my plate at breakfast, lunch and dinner. I never liked to leave uneaten food. Ostensibly the rationale was that a large proportion of the world's population had barely enough to eat and therefore I should not be contributing to unnecessary waste. In order to leave a clean plate I would end-up overeating and have a sore stomach and flatulence. I wanted to avoid guilt over waste. Was this another example of hurting my body (self-harm) in order to cope with other issues?

Moving from personal reflexivity to functional reflexivity (Goodley et al., 2003), I recognise that the published literature on self-harm emanates from many disciplines. I am therefore unlikely to do justice to the enormous volume of research work. The literature review will be developed further as I proceed. It was almost inevitable that I would become biased by the literature swoop covered in assignments 1, 2, 3 and 4 (Jamieson, 2009; 2010; 2011a, and 2011b). I may therefore have had thoughts

about themes pre-determined by earlier reading. For example, in assignment 3, the 18 www.youtube.com video/slides that were selected for study were only a tiny fraction of those that could have been looked at. I had no rational basis for taking the first 18 as opposed to, say, the last 18 in the collection of many thousands of contributions. Perhaps the last 18 video/slides would have resulted in different pilot themes. I also now wonder how typical the views of the experienced worker with self-harm actually were, and why she chose to introduce me to one particular self-harmer as opposed to someone else. Why did I allow her to select that person in the first place? Would my main study research questions have been the same if I had interviewed some other worker, or some other person who self-harmed, in this pilot?

The pilot research was qualitative in nature and my interest has been mainly in the hermeneutic rather than the scientific tradition. Tesch (1990) has described 26 essentially qualitative procedures that social scientists can employ. That was almost 25 years ago. There are now many more qualitative methods / types of analyses (Braun & Clarke, 2013; Harper & Thompson, 2011; Willig, 2008). The kinds of research questions towards which I was leaning did not easily lend themselves to being translated into testable hypotheses derived from theory. I wanted to find out what people were saying about self-harm and my quest was to explore subjectivity rather than to seek objectivity. My data would be largely *'inner experience'* and *'symbolic'* rather than '*material'* and '*behavioural'* (Phoenix & Thomas, 2007).

1.5 Summary

This introductory chapter has attempted to place my current research in the context of all the assessable work carried out for the DEdPsy. It has reviewed the background to my interest in the area, has offered a number of explanations for self-

harm, and has given some insight by means of reflexive analysis into personal past experiences which may have affected the work. Answers to the question *'what is self-harm?'* were not easy to come by. While both quantitative and qualitative approaches have useful contributions to make, the stage my thinking was at on the topic of self-harm meant that it would be a qualitative approach which I would privilege.

Chapter 2

Method

2.1 Introduction

Research findings are undoubtedly affected by methodology. It is not unusual for researchers to seek to compare quantitative and qualitative papers on the same subject. The advantages and disadvantages of each can be outlined and more logical and rational decisions made regarding which methodology is likely to be most appropriate for the research questions envisaged. Braun & Clarke (2013) did this for the topic of sexual risk-taking by comparing the qualitative work of Christianson, Lalos, Westman & Johansson (2007) with the quantitative work of Herlitz & Ramstedt (2005). I surveyed some of the quantitative and qualitative literature on self-harm as part of assignment 2 of the DEdPsy (Jamieson, 2010), and examined two published papers, one qualitative (Oldershaw et al., 2008) and the other quantitative (Nock & Prinstein, 2004), in order to help me choose a methodology for my research. Their ontologies, epistemologies and methodologies were carefully scrutinised.

The Oldershaw et al. (2008) and Nock & Prinstein (2004) papers emanated from the hermeneutic and scientific traditions respectively (DSE212 Course-team, 2007). I argued that methodologies do not always have to be seen to be in competition. They

may sometimes conflict, co-exist, or complement one another. Assignment 3 of the DEdPsy (Jamieson, 2011a) provided another opportunity to do some pilot work, fine-tune my thoughts, deal with teething problems, and explore difficult methods issues that only become evident in the actual practice of research. When '*all is said and done',* it is sometimes the case that *'much more is said than done'.* It was now time to actively engage in *'doing'* some self-harm research myself.

At this stage I still had not settled on a research question for my main study. However, the one for this pilot was: *'What are the differences and similarities in the insights provided by (a) a selective review of the literature on self-harm, (b) a selection of video/slide presentations of self-harm appearing on www.youtube.com (c) a discussion with an experienced worker with self-harm (Marie), and (d) a person known to seriously self-harm (Lorna)?'* It was anticipated that themes would be identified from all four sources.

Having considered ontology, epistemology and methodology and examined the strengths and weaknesses of quantitative and qualitative approaches, I decided to experiment with a particular qualitative method of analysis known as thematic analysis. A search was made for a widely accepted theory of self-harm to explain all or most self-harming behaviour. If an all-encompassing theory did not already exist, perhaps there were central features around which a new theory could be built. On the other hand, maybe the best way of viewing self-harm was to consider it to be a normal phenomenon engaged in by everyone. The terms CASHAS (Culturally Acceptable Self-Harming Activities) and CUSHAS (Culturally Unacceptable Self-Harming Activities) seemed to me to be reasonable ones while exploring the argument for a continuum of self-harming activities. There does appear to be a trend towards more dimensional approaches to many psychological issues. For example,

Professor Francesca Happé, who was on one of the working groups for DSM-5 (2013), in an interview for *The Psychologist* commented: *"…We were told that for the whole of DSM-5 we should recognise that things are typically dimensional and that there should be more…description of the individual…Things like adverse living circumstances and additional mental health difficulties should be specified and considered, all of which I think is really positive...*" (Happé, 2014, p.762). Also, like Ceci (2014), a professor of developmental psychology at Cornell University, I was keen not to restrict myself to one discipline in my search for information. He wrote: *"We ignore the other social sciences at our peril, as they are making very important contributions to the very same topics we are addressing…Our insularity prevents us from answering some very important research and policy questions"* (p.296).

Another look at a selection of the relevant literature, in particular at multiple labels, meanings, causes, theories and solutions for self-harm was carried out during this preliminary work. The pilot explored the reasons for adopting the method of open, unstructured discussions rather than the more common semi-structured interviews. It also gave invaluable experience of thematic analysis of 18 self-harm videos/slides (Appendix 4), and thematic analysis of a discussion with the experienced self-harm worker (Marie; Appendices 5&6), and with one of her former clients (Lorna; Appendices 7&8). Why thematic analysis should be the preferred analytic method was considered. And finally, ethical issues with respect to the various procedures were examined (BPS, 2006, 2009; HCPC, 2008; and APA, 2010).

During piloting work, recent theorising applicable in the area of self-harm (e.g. *experiential avoidance/replacement* and *emotion regulation*) were seen to be emerging as having implications for how knowledge about problem behaviour in general, and self-harming in particular, could be taken forward (Clarke et al., 2012;

Kingston, Clarke & Remington, 2010). Comparisons were made of data gleaned from all four sources (the literature, youtube videos/slides, experienced worker, and serious self-harmer). The themes which emerged were *addiction, coping, control, depression, emotion regulation, anti-suicide, suicide,* and *miscellaneous*. While these themes provided considerable food for thought, it was interesting to me that some other themes had not been picked up. For example, Sutton (2007) had listed what he called the *eight Cs of self-injury*: coping and crisis intervention; calming and comforting; control; cleansing; confirmation of existing; creating comfortable numbness; chastisement; and, communication (see NICE, 2011).

The considerable disagreement in the research community about how self-harm should be defined, and what it should even be called, came to the fore in the pilot. The best ways of viewing self-harming may indeed be to consider it to be a *typical* phenomenon engaged in by everyone. The difference between severe and mild self-harm as well as between CUSHAS and CASHAS may be one of degree and not quality, and related to the sub-culture or culture within which the behaviour is occurring.

After the pilot study, and in the form of assignment 4 of the DEdPsy (Jamieson, 2011b), a detailed research proposal was put together in order to demonstrate that: a) my research questions were appropriate, viable and ethically sound; b) suitable methodologies/methods had been considered; c) data collection and analyses had been properly thought through and were likely to yield results that would enable me to answer the research questions; d) the findings of the research would make an original contribution to knowledge; e) consideration had been given to implications of the findings; and, f) all ethical issues had been addressed with due regard to the guidelines of the BPS, the HCPC, and the APA. The research would try to be of

sufficient quality to be worthy of publication, be intellectually creative, and make a substantive input to knowledge in the field of self-harm. I would be attempting to review, analyse, evaluate and synthesise relevant research from a wide variety of research traditions, and draw out significant threads (Todd, 2011).

The literature review in the research proposal pointed towards identification of a *'gap'* in the literature. The research questions, which were originally not even questions, continued to evolve until the thesis write-up stage, eventually becoming:

1. *What meanings can be extracted from data on self-harm provided by individuals (a) who consider that they have never self-harmed; (b) who have mildly or moderately self-harmed; and, (c) who have seriously self-harmed?*
2. *Can personal and epistemological reflexive analysis add value to a qualitative study of self-harm?*
3. *Do reflections on the processes involved in being a student on a taught professional doctorate contribute to the overall credibility of this type of study?*
4. *What is self-harm from a phenomenological and functional point of view, and has the phenomenon of self-harm been appropriately named and defined?*
5. *What implications might there be for support, intervention, and, staff training?*

The conceptual contribution the thesis was likely to make to knowledge in this area would be partly identified by exploring a) *experiential avoidance* (the process of dealing with unwanted private experiences, memories, thoughts and feelings), though I preferred to call it *experiential replacement* since experiences were often not simply *avoided* but *replaced* by other more tolerable ones; b) *emotion regulation* (the altering of undesired feelings by taking some action to manage them better);

and, (c) other ideas such as *the stimulus struggle* (Morris, 1967)*, top-down and bottom-up processing* (Niesser, 1976; Gibson, 1950; Gregory, 1966)*, perceptual control theory* (Powers, 1973); *equilibrium and homeostasis* (Cannon, 1932)*,* the interrelationship between *bodies and minds* (Toates, 2007)*, mindfulness* (Bennett, 2014)*, acceptance and commitment therapy* (Hayes et al.*,* 2003), *psychological well-being* (Joseph et al., 2012)*,* and, *the therapeutic alliance* (Antoniou & Cooper, 2013)*.*

While some animals will self-harm from time to time, evidence for species outwith human beings actually committing suicide is very limited. Desmond Morris (1967; 1969) has pointed out that a few animals kept in unnatural conditions in zoos will self-harm. However, provide most animals with food, drink, company, play, stimulation, shelter, warmth and a modicum of good physical health, and they will thrive. This does not seem to be the case with humans. Many of us can have all the creature comforts, and more, and still engage in self-harming activities. Some of us will even be suicidal. It was Albert Camus who once wrote: *"There is but one truly serious philosophical problem, and that is suicide"* (Anderson, 2008). Humans are indeed somewhat confusing, complex and profound.

2.2 Participants/co-researchers

I gave considerable thought as to where, and how, I would recruit participants for this project. I looked at various ways of putting together a sample, from random sampling to quota sampling to convenience sampling (Cochran, 2007). *Convenience* sampling is quite common in both quantitative and qualitative work. Essentially what researchers do is select people who happen to be available. Convenience sampling has been described by Sandelowski (1995) as possibly the least justifiable and rigorous of all the methods, though, as the name suggests, it is the easiest and most

convenient to arrange. There is also *snowballing or friendship pyramiding* which is a way of sampling that comes about as a consequence of a particular researcher's networks, and those of the first participant(s) recruited. This is really just a variation of convenience sampling (Braun & Clarke, 2013). There is *stratified sampling* or *stratification* or *quota sampling* which involves ensuring that a broad enough range of different types of individuals are selected for the sample e.g. a mixture of genders, age ranges, and ethnicity that roughly correspond to what might be found in the population. There is *theoretical sampling* in which, as data analysis proceeds, participants are chosen in order to pursue particular theory development. This is similar to what Patton (2002) called *criterion sampling* which emphasises the desire to sample specific issues, or, *purposive sampling* whose primary *purpose* is to produce *"insight and in-depth understanding"* (p.230).

In my research work, I finally concluded that the only essential criteria were (a) a genuine interest in the subject of self-harm, and, (b) a willingness to be involved. The participants turned out to be mothers and daughters, teachers and pupils, waged and unwaged, and resistant to being seen as self-harmers or non-self-harmers. Those who engaged in CUSHAS wished to be known as individuals with *'lived experience of self-harm',* or, as indicated by Spandler & Warner (2007), *'self-harm survivors'.* Given that I was interested in exploring what all sorts of people considered self-harm to be, it hardly mattered who came forward. This was supported by my second supervision session, though the first to be recorded and transcribed:

JJ: …Could I be legitimately using participants who are more of an opportunity sample?
LT: I thought we talked about this?
JJ: Did we?
LT: Yeh, I thought we had a conversation about this?

JJ: What did we decide?
LT: I thought we decided that you could use anybody you want to...[lines 190-194, Appendix 20].

It was originally anticipated that I would be seeking 15 participants for the main study. There was no shortage of volunteers. However, each discussion lasted anything from 52 to 79 minutes and I was taking at least an hour to transcribe every 5 minutes of audio/video recording, not too dissimilar to other researchers (Arksey & Knight, 1999; Braun & Clarke, 2013). I therefore settled on recruiting only six participants. This small number initially caused me to wonder if I might end up failing to collect enough useable data, especially when it transpired that all six participants were female. However, there are no hard and fast rules in qualitative research about numbers of participants (Patton, 2002). Morse & Field (2002) stressed the importance of having sufficient data to be able to complete a full analysis which answers the research questions while Braun & Clarke (2013) have pointed out that qualitative work tends, on the whole, to have smaller samples than quantitative. Smith, Flowers & Larkin (2009) suggested that work of a qualitative nature can be successfully carried out with anything from three to six participants, and Clarke & Walker (2013) using IPA, a technique not too dissimilar to my own brand of thematic analsis, had only one participant. Crossley (2009) wrote that it is not exceptional to have a single text or a single participant analysed in-depth, and Hefferon & Gil-Rodriquez (2011) have advised supervisors and research students that sometimes *"...less is more...",* and continued, *"… include fewer participants in the sample, fewer questions... fewer... themes in the analysis*…[By] *observing these simple guidelines researchers…achieve more depth..."* (p.758).

The concept of *saturation* refers to the point at which more data does not necessarily add more knowledge (Bowen, 2008). I felt that I had to have enough participants to

ensure data were in-depth rather than shallow. I wanted to tell a rich story with thick description but not be overwhelmed with data (Onwuegbuzie & Leech, 2005). Though two of my six participants had histories of serious self-harming (CUSHAS), it proved difficult to separate the other four into any category other than CASHAS.

I was looking for individuals who were prepared to be more than mere participants. The role of collaborator/co-researcher was outlined in the Information Sheet for the main study (see Appendix 10) and verbally explained to them.

Sharrie (see Appendix 14 for transcript) was recruited from an Open University (OU) psychology tutorial group. A group of about 10 students attended a brief talk on self-harm which I gave as part of a general tutorial on psychology related to the second level OU module, DSE212, Exploring Psychology. I invited all students to consider becoming involved. Two agreed. One left the OU and did not respond to an e-mail when I tried to make contact with her. This left only Sharrie, a female in her early 30s who did not consider herself to be a person who self-harmed. She and her partner had two young children. Sharrie stayed behind after one of the tutorials at the University of the West of Scotland, Hamilton. The open, unstructured discussion took place in the same teaching room in which the tutorial was held. The video/audio recording lasted 63 minutes.

Martha (see Appendix 15) was recruited from a workshop on self-harm which was convened as part of a major conference I attended in Glasgow. By chance we found ourselves in the same workshop. The workshop leader asked all members of the group of about 25 people to introduce themselves. At the end of the event, Martha approached me to say that she stayed about three miles from where I lived and would be pleased to be part of my research. She was a female in her mid 50s, had 4

grown-up children, was wheel-chair bound, and lived with a male platonic friend whom she described as her *driver*. She was a person who had seriously self-harmed for much of her life. She eventually contacted me by e-mail to ask why I had not yet been in touch. I replied immediately, making an arrangement to meet her. After a failed attempt to see her at my home due to difficulties with wheel-chair access, the open, unstructured discussion took place at her home in Ayrshire. The video/audio recording lasted 74 minutes.

Nancy (see Appendix 16) was also recruited from the same workshop on self-harm as Martha. Nancy later indicated an interest in my research and I agreed to get in touch with her via a mutual acquaintance. She was female, age 32, had no children, and lived with her partner in Scotland's capital city. She had previously been someone who seriously self-harmed but was now working as an advocate for clients with mental health difficulties. She was one of the keynote speakers to the main conference. For the duration of the workshop she held a stress-ball in her hand. Some months later I contacted her. The open, unstructured discussion took place in her office. The video/audio recording lasted 78 minutes.

Mattie (see Appendix 17) was recruited from a group of students and tutors on a residential week run by the OU. DXR222, Exploring Psychology Project, is a compulsory module if students want their degrees to be recognised by the BPS. Tutors were expected to teach and supervise module activities in the mornings and afternoons. The evenings were set aside for voluntary lectures on topics which tutors were currently researching themselves. Of around 100 students and 10 tutors, about 50 students plus 3 tutors attended a talk I gave on self-harm. One tutor asked to become part of my research. Mattie was in her early 50s. She was an experienced secondary school teacher and the mother of two grown-up daughters, one of whom

seriously self-harmed. The open, unstructured discussion took place in one of the tutorial rooms set aside for students working on their projects at the University of Sussex. The video/audio recording lasted 54 minutes.

Ellie (see Appendix 18) was recruited from the same source as Mattie. She was a 26 year old OU student and a qualified primary school teacher. She did not consider herself to be someone who self-harmed. The open, unstructured discussion again took place at the University of Sussex in one of the tutorial rooms. The video/audio recording lasted 52 minutes.

Kate (see Appendix 19) was also recruited from the same group as Mattie and Ellie. She was an OU student, aged 22, and worked one day per week for a data processing company. Though she was someone who bit her finger nails severely, she had never really considered herself to be someone who self-harmed. The open, unstructured discussion again took place at the University of Sussex in one of the tutorial rooms. The video/audio recording lasted 58 minutes.

While 31 individuals from this residential week volunteered to be participants, I was only able to record individual discussions with three of them. I provided a verbal explanation and apology to the others during a final plenary session convened as part of the scheduled OU module. However, since the volunteers provided me with telephone numbers, home addresses, and e-mail addresses, I also contacted each one personally and sent them the thesis proposal, the information sheet (Appendix 10), the consent form (Appendix 11) and the Debriefing Sheet (Appendix 12). All were invited to remain in contact and to share their thoughts about self-harm. I promised to make use of their contributions in the thesis write-up. These students were so geographically spread that it would have been difficult to follow-up and

arrange face-to-face meetings anyway. The locations were: London, Newark (Nottinghamshire), Eddington (Middlesex), Ely (Cambridgeshire), Great Saxham (Suffolk), Langford (Bedfordshire), Cambridge, Fakenham (Norfolk), Watford (Hertfordshire), Birmingham, Newcastle, Bedford, Thornton (Lancashire), Benfleet (Essex), Liverpool, Sleaford (Lincolnshire), Glasgow, St. Leonards-On-Sea (East Sussex), Mansfield (Nottinghamshire), Mitchelstown (County Cork, Ireland), Petersfield (Hampshire), Edinburgh, and Aberdeen. The three participants with whom I did meet were simply the first three to approach me to negotiate an appointment time.

2.3 Procedure (and what was learned from pilot studies)

Pilot work has already been referred to. I initially put together a semi-structured interview from material culled from (a) the self-harm work of Ross & McKay (1979), Sinclair & Green (2005), Nock & Prinstein (2004), and, Oldershaw et al., (2008); and, (b) general advice provided in the research literature on semi-structured interviewing (e.g. Smith, 1995; Smith, Flowers & Larkin, 2009). After interviewing Tommy (an adolescent boy in a Children's Home) and Sheena (an adult female patient) in a low secure mental hospital, I became less convinced of the advantages of using semi-structured interviewing and more aware of the disadvantages. When it came to commencing further piloting, I decided to entirely ditch semi-structured interviewing in favour of an unstructured, open interviewing style, more akin to a discussion or conversation. Knowing that a research interview has been defined as *'a conversation with a purpose'* (Bingham & Moore, 1959), or, *'purposeful, directed conversation'* (Jamieson, 1978), gave me confidence that this was the direction in which I wanted to go.

The next stage of the piloting involved an open, unstructured discussion with Marie (an experienced self-harm worker) and then with Lorna (one of her former clients). Marie chose to meet me in a hotel in Edinburgh where we had an evening meal together. Lorna was offered the opportunity to be in the company of Marie or on her own, and to choose a venue. We met in her home and she decided to have Marie *and* a friend present. The friend said nothing for the entire length of the *'purposeful conversation'*. However, Marie, in addition to carrying out brief introductions at the outset, did make an occasional contribution. Both sessions, with the agreement of the pilot participants, were video recorded and later transcribed (see Appendices 5 & 7).

At this stage I felt that I still had much to learn about video and/or audio recording, as well as transcribing, and therefore extra piloting took place in relation to these activities. For example, my main DEdPsy supervisor, Professor Liz Todd, agreed to the audio / video recording of our supervision sessions. This provided invaluable practice at knowing how to set up the equipment unobtrusively. Video recording supervision sessions also proved helpful in promoting reflective practice, a way of working known as VERP (Video Enhanced Reflective Practice; Landor, 2014a; 2014b). VERP has developed from VIG (Video Interaction Guidance), used for many years in psychological services in Britain and Sweden (Kennedy, Landor & Todd, 2011). Transcribing supervision sessions highlighted the importance of personally carrying out this task. I was able to become much more intimately engaged with the data.

As well as benefiting from her expert academic supervision, I was able to use my supervisor as almost another pilot participant. Given that I was interested in what anyone thought self-harm was, no-one was excluded from becoming a participant.

After recording and transcribing three of the supervision sessions, I carried out thematic analysis on each one.

In summary, the changes made from piloting to main study included the following: (i) shifting from semi-structured interviewing to open, unstructured discussion; (ii) changing the research questions e.g. making them into proper questions and re-arranging the order; (iii) going from simply writing down what I could remember after the event, as in my interviews of Tommy and Sheena, to video recording of Marie and Lorna, to audio/video recording meetings with my academic supervisor, to audio/video recording individual discussions with all six main study participants; (iv) revising the information sheet used in the piloting to include an offer to main study participants of a copy of their written transcript, a copy of the thematic analysis, an assurance that the recordings and transcriptions would be kept under secure conditions and destroyed when the research was completed, and, an invitation to interview me and to have the recording sent to them (Appendix 1 and Appendix 10); (v) revising the consent form used in the piloting to include not only a participant's right to withdraw data in the main study but to withdraw data without giving a reason (Appendix 2 and Appendix 11); (vi) extending verbal debriefing in the pilots to include detailed, written debriefing in the main study which highlighted the help which was available if a participant was distressed by being part of the research (Appendix 12); and, (vii) continuing to be flexible regarding venues for meeting participants e.g. for pilots the venues were a Children's Unit, a low secure mental hospital, an hotel/restaurant and a participant's home, and, for the main study the venues were a teaching room in the University of the West of Scotland (Sharrie), a participant's home in Ayrshire (Martha), a participant's work place in Edinburgh (Nancy), and, a project room set aside at Sussex University (Mattie, Ellie & Kate).

I introduced another level of supervision to complement the academic supervision. I invited Marie and Lorna to be my *practitioner-consultants*. We had regular meetings to discuss aspects of the self-harm research which were less academic and more practical in nature. For example the practitioner-consultants encouraged me not to use the term '*self-harmer'* when referring to people with *'lived experience of self-harm'*. However, I eventually decided to go one step further and to re-designate people with *'lived experience of self-harm'* as those with *'lived experience of self-harming'.* Cullen (2013) has pointed out that: *"...as long ago as 1921 R. S. Woodworth was warning against 'menacing psychological nouns', where we transform verbs such as remembering into memory, seeing and hearing into sensation, and thinking into thought. Then we go hunting for the things we have just invented, instead of studying the activity denoted by the verb we started with"* (p. 776). Perhaps my research questions had already fallen into this trap by use of the term *'self-harm'.*

Similar ethical procedures were followed for the main study as for the pilot exercises but with a small number of modifications requested by the ethics committee in the School of Education, Communication and Language Sciences (ECLS) of the University of Newcastle.

2.4 Further ethical considerations

In addition to the BPS (2006; 2009), HCPC (2008) and APA (2010) guidelines there are other moral codes which indicate how difficult it can be to make correct ethical decisions. Joseph Fletcher (1966), for example, has illustrated how complicated matters can be. He rejected *legalism* (following the rules and regulations to the letter of the law) and *antinomianism* (no guidelines at all and simply a free-for-all) in favour

of *situation ethics* i.e. taking moral actions on the basis of context. Ethics-in-practice should go beyond non-maleficence (first, do no harm) to beneficence (do some good), and should include consideration of autonomy, justice, fairness, fidelity, truthfulness and keeping promises. (Sutton, 2013). Transpersonal psychologists like Cohen (2013) have for some time been encouraging a move away from the more negative stance of the BPS Code of Ethics and Conduct (2009) with its injunction to *'avoid harming clients'* (p.18) to the more positive requirement *'to be compassionate [and] to sympathetically resonate and empathise with one's participants'* (Braud & Anderson, 1998, p.73; Anderson & Braud, 2011).

The piloting work and scrutiny by the Newcastle University ethics panel resulted in further adjustments to my main study. First a preliminary ethical assessment form was completed. Then a full ethical assessment was carried out owing to the sensitivity of the topic. Alterations were subsequently made to procedures and documentation initially used in the pilots. Thankfully the days are long gone where riské studies like those of Henry Murray at Harvard on stress in the late 50s (Chase, 2003), or the classic work in the mid 1960s of Milgram (1974) at Yale on obedience to authority, or the mock prison experiments in the 1970s of Zimbardo and his colleagues at Stanford (Zimbardo et al.1995) can be carried out with impunity.

Though some academic centres of excellence have been criticised for not placing the teaching of ethics at the heart of their work (James, 2013a), in recent times entire conference workshops have been given over to considering the development of ethical approaches to research. Matters are rarely as simple as they might first appear. It is not only about protecting supposedly vulnerable people from potential harm by excluding them from projects. For example, who decides whether or not participants are vulnerable, especially if they express a wish to be involved (James,

2013b)? Being denied opportunities to participate may prevent people from reaping rich rewards like being listened to non-judgmentally, having their views recorded and disseminated in a way that could mean services being improved, and, feeling empowered that someone is genuinely interested in what they have to say. While significant harm should, of course, be minimised in all research, the benefits of participation should not be ignored. A balance should be struck between the need to protect participants from harm and participants' desire to be contributors to advancing knowledge (Lumsden, 2013). Qualitative research has highlighted *'ethically important moments'* where greater flexibility and reflexivity are required in dealing with *'ethics-in-practice'* (Guillemin & Gillam, 2004).

Open, unstructured discussion is not without its ethical problems. While structured and semi-structured interviews could be accused of forcing participants to respond to particular issues at least the questions are laid out in advance for all to see. Questions raised by a researcher using an unstructured format may lead participants down unexpected roads on which they would rather not be travelling.

2.5 Reflexive, reflective and procedural log (research journal)

From the time DEdPsy tutors assessed the research proposal (Jamieson, 2011b) as *"...logically well presented [and] written...in an appropriate, scholarly manner..."* I not only began to seek the necessary approval from various ethical committees, I also started keeping a research journal which I called my *Reflexive, reflective and procedural log* (Jamieson, 2014a). This journal was used for recording thoughts, feelings and experiences as the work took shape. It was meant to encourage reflective practice. I was hoping to gradually move from descriptive comment to more evaluative, interpretative, and, eventually, inferential writing. Ideas and concepts

would be recorded in the log as soon as possible to prevent loss to the thesis (Braun & Clarke, 2013; Clarke & Walker, 2013; Willig, 2008). Afterall, "*the palest ink is considered to be better than the best memory"* (Chinese proverb quoted in The Week, 2014a, p.25).

The *log* was intended to be a note of excitements, frustrations, clarities and confusions. It served as a kind of audit trail for what I was doing, why I was doing it, and how it should be done. It helped me to remain in touch with the trials and tribulations met on my research journey, and to track developments in my thinking. I wrote in the journal, sometimes on a daily basis, what I had already done by way of researching self-harm (past), what I was currently doing (present), and, what I planned to do (future).

The first entries were in November 2011 and the last ones in November 2014. I had started by recording the titles, section headings and summaries of all four DEdPsy assignments, and, a synopsis of the feedback provided by the main marker for each assignment to ensure that due regard was taken of all advice. The thesis itself was referred to throughout as *Assignment 5,* and the log revealed changes in the title of the project as well as modifications to the research questions as the work progressed.

Other examples of insertions included the changes in status of two of my four pilot participants (Marie and Lorna). They became my *practitioner-consultants* and eventually set up an agency offering training in self-harm. The training agency, HarmLESS Psychotherapy, was found at www.harmlesspsychotherapy.com before being changed to www.mindswell.org.uk on 1st April 2014. My 4th session with the *practitioner-consultants* involved attendance at the launch of their new self-harm

video ‘Hurting to Heal’ (2013) sponsored by the BPS. An extract from the log read as follows: *“...Networking was a useful aspect of holding meetings with my practitioner-consultants at self-harm events. For example, I spoke at length to two of the principal speakers at the ‘Hurting to Heal’ conference, Professor Steve Platt and Dr Amy Chandler, both of whom had published extensively on the topic of self-harm. They were happy to engage in personal communication and willingly made their work available to me (Platt, 2013; Platt, McLean & McCollam, 2006; Chandler, 2010; Chandler, 2012; Chandler, 2013a; Chandler, 2013b; Chandler, Myers & Platt, 2011)…”.*

Annual progress panels which took place in 2011, 2012, 2013 and 2014 also featured in my research log. Timely advice from panel members helped to keep me focussed. And, finally, the log contained reflections on various recruitment issues, ethical concerns, and, talks I gave and seminars I attended on self-harm. Struggles with decisions about the type of qualitative analysis best for this project were noted from time to time as well as why thematic analysis was finally settled upon.

2.6 From pilot to main study thematic analysis and synoptic stories

The video/audio recordings of all six participants were transcribed verbatim. Since every five minutes of recorded discussion took approximately one hour to transcribe, this meant that I spent about 72 hours transforming the data into written form making it suitable for thematic textual analysis. This lengthy process allowed me to become very familiar with the data. My intention was to make use of a form of thematic analysis as my principle method of analysis. I engaged in numerous practice sessions where I would take a passage of text and underline all similar words. Then, using the same text, I would underline all similar phrases. Next, I would underline all

similar ideas. It was these concepts/ideas which I felt were bringing me closer to themes.

Thematic analysis seemed to me to resemble the *BACEI* model of good academic writing (Green, 2008). *BACEI* stands for *basic, analytic, comparative, evaluative, and inferential.* First the student researcher learns *basic* descriptive writing which should consist of comprehensive and accurate content. Then the writing becomes more *analytical* where ideas are broken up into smaller portions in order to facilitate understanding of the whole. Next it is more *comparative* where differences and similarities between one thing and another are looked at in detail e.g. identifying information which is complementing, conflicting or merely co-existing. Then there is *evaluative* writing where the task is to assess the value of, or gauge the merit of, various points of view. And, finally, there is *inferential* writing which synthesises the material, interpretes it, and goes beyond the data. Gradually moving from description to interpretation was like the coding elements of thematic analysis where the researcher moves from largely descriptive 1st order coding (potential sub-themes) to comparative 2nd order coding (potential themes) to largely interpretative 3rd order coding (overarching themes).

Merton (1975) was first to give thematic analysis its name. Since then slightly different versions have been developed by Braun & Clarke (2006), Attride-Stirling (2001), Boyatzis (1998), Joffe & Yardley (2004), Tuckett (2005), and, King & Horrocks (2010). Teachers/researchers such as Victoria Clarke and Virginia Braun have recognised the breadth of approaches now available to those who choose to use qualitative methods (Braun & Clarke, 2013; Clarke & Braun, 2013) though they have privileged thematic analysis. While some researchers clearly consider thematic analysis to be first and foremost a phenomenological method (Guest, MacQueen &

Namey, 2012; Joffe, 2011), Clarke and Braun (2013) *'emphasise the theoretical flexibility of thematic analysis and identify it as just an analytic method rather than a methodology which most other qualitative approaches are'* (p.120).

At one point I had leanings towards a more constructionist thematic analysis tradition (Burr, 1995) that was close to discourse analysis, in other words a kind of *'thematic'* discourse analysis (Singer & Hunter, 1999; Taylor & Ussher, 2001). However, my plan was not to follow formulaic rules, but still to be systematic and to make it easy for the reader to follow what was going on (Patton, 1990). I intended to move back and forward between data and coding and further analysis, and to make report-writing an integral part of the thematic analysis and not just something that was tagged on at the end. The *'feeling of drowning in data'* is not uncommon for qualitative researchers (Holloway & Wheeler, 2010). Occasionally, I felt as if I really was *'swimming in data',* though not quite *'drowning'*.

The phases of thematic analysis look something like this: (i) becoming familiar with the data; (ii) initial, 1st order, or descriptive coding (subthemes); (iii) searching for suitable codes to amalgamate and recode, or to drop altogether i.e. a 2nd order coding slightly more interpretative than descriptive (themes); (iv) 3rd order coding which reduces the number of codes further and involves re-labelling and re-defining the themes (overarching themes); and, (v) final analysis and reporting how and where the overarching themes relate to the research questions (see Braun & Clarke, 2006; Langdridge & Hagger-Johnson, 2009). In reality my analysis did not run quite as smoothly. Much learning by trial and error took place. For example, in the main study, the themes from thematic analysis of Sharrie's transcript influenced the themes resulting from thematic analysis of Martha's transcript and so on. Also, in order not to lose the *aliveness,* reality, impact and power of what I was being told by

participants, I produced individual synoptic stories from overarching themes and relevant data extracts. Synoptic stories in my words were followed by synoptic stories in participants' own words. These synoptic stories were in effect condensations, or synopsis, of the transcripts. They were made up by working backwards from the overarching themes to the raw data in an attempt to preserve the messages and meanings from the participants as I understood what they were saying.

Earlier pilot thematic analysis of transcribed discussions elicited a comment from the marker of assignment 3 that *"...the data analysis was not easy to follow..."* (Jamieson, 2011a; Jamieson, 2014a, p.6). It was almost as if I was carrying out thematic analysis backwards. Having identified themes in the literature, and from clinical experience, I seemed to be searching for quotes to support pre-existing themes rather than constructing themes from the data (Appendices 6, 8, & 9). While I had come to accept that qualitative work could be messy, non-linear, and would involve going forwards, backwards and sideways, I was not prepared to accept an '*anything goes'* attitude. I wanted a system (even if it was my own) which retained a *'playfulness'* (Bateson, 2014, p.35) that is inherent in originality, creativity and innovation (Bateson & Martin, 2013). A doctorate is meant to contain new thinking and ways of working which might not be an exact replica of what has gone before. The confidence to pursue this way of progressing was somewhat reinforced by an observation I made in the summer of 2013. While on holiday in the Lake District I noticed a toddler wearing shorts and tee-shirt, and standing between his parents. On his shirt, emblazoned in bold letters, were the words: *'I make the rules'*.

In thematic analysis of the transcripts from 3 academic supervision sessions there was no attempt to start off with any pre-conceived notions of what the themes might

be. The recordings lasted 47minutes 26 seconds, 53 minutes 14 seconds, and 52 minutes 51 seconds respectively, and took approximately 30 hours to transcribe. I used an orthographic or verbatim method of transcribing not too dissimilar to that of Jefferson (2004). It was an adaptation of the method endorsed by Braun & Clarke (2013). I could have used a professional transcriber but I felt that doing it myself was the best way to become very familiar with the material. I was already aware of the most common transcription errors as identified by Poland (2002). For example, *sentence structure error* arising when the transcriber does not fully appreciate that people do not actually talk in sentences. Great care must therefore be taken when inserting punctuation. *Quotation mark errors* occurring when a transcription does not make it clear, with the use of appropriate quotation marks, when the speaker is actually reporting someone else's speech or even his/her own speech. *Omission error* used to refer to times when the words/sounds articulated are left out because they are thought to be unimportant or because they are not expected and therefore not heard. And finally, *mistaken word/phrase error* happening when a different word or phrase is transcribed instead of the one which was actually spoken, perhaps because it was misheard due to being very like something else. Having separate audio and visual recordings made it possible to switch from one to the other and much easier to avoid many of these kinds of errors.

On each supervision transcription I highlighted everything which was of any interest to me using a coloured highlighter pen, or underlined with a ball-point pen, or both. Other techniques could have been used such as the Microsoft Word Comments Feature, or copying and pasting bits of text into computer files. Also, I was aware of commercial programmes collectively known as CAQDAS (computer- assisted qualitative data analysis software) such as Nvivo and ATLAS.ti which could do

various stages of the analysis, but I wanted to get closer to the data than I felt software allowed.

Computers and their roles in relation to working with qualitative data have been debated for well over 20 years (Fielding & Lee, 1991). Many qualitative researchers are convinced of the benefits of software programmes while others are more sceptical (Lu & Shulman, 2008). Without doubt there would have been some advantages to using computer programmes for handling my data. For example, they could have been used for online filing; for fast searches for codes, data extracts, and links between themes (Konopasek, 2008); for providing reassurance on thoroughness and comprehensiveness with respect to coding; for making the coding and analysis appear more rigorous; for heightening transparency as 'audit trails' could be made more obvious (Braun & Clarke, 2013); and, finally, they can be very useful for handling large amounts of data. However, CAQDAS has disadvantages: the software is not always quick and easy to learn how to use; there is the danger of what Lu & Shulman (2008) call *"usability frustration...despair and hopelessness"* (p.108); even when the researcher has learned how to use it, the end product is not always satisfactory (MacMillan, 2005); too much technology can lead to less immersion in the data; technology can be a seductive distraction from the basic job at hand (Bong, 2002); there can be a tendency to code more than is necessary for the purposes of answering research questions simply because the technology is there (Mangabeira,1995); it is tempting to slip into prioritising frequencies rather than meaningfulness and quality; *methodolatory* (being wedded to one specific method) discussed by Chamberlain (2000) and Reicher (2000) can become an issue if software encourages a different type of analysis from what was originally envisaged (MacMillan & Koenig, 2004); and, finally, programmes may have assumptions of a

methodological and theoretical nature which may not be acceptable to the researcher (Braun & Clarke, 2013). Taking the benefits and deficits of CAQDAS into account, I decided against.

On completion of highlighting/underlining, the first supervision transcript was enclosed in a table consisting of two columns. The second column contained the transcript and the first column the line numbers from 001 to 403 in order to identify data-extracts easily (Appendix 20). This was a labour intensive process. However, at the next supervision session, while treating my supervisor as a pilot participant, and attempting to do some member-checking (Clarke & Walker, 2013), I learned about the Microsoft Word facility which automatically produced numbers with every line. This simple line numbering system was carried out with the next two supervision transcripts (Appendices 21 & 22).

Down the left hand side of each A4 page of transcription I inserted, in my own handwriting, a code in the form of an abbreviation for each highlighted item that continued to hold my interest, either because it cast light on my research questions, or, because it allowed me to take full advantage of academic supervision by bringing to my attention information that would stand me in good stead during the main study. On the back of page one of the first supervision transcript I listed every abbreviated code, and alongside it a clear description of what it stood for e.g. vid v aud = video recording versus audio recording; analy = analysis of raw data; refl.log = reflexive log; and so on. This was the 1st order coding (descriptive coding). Half way down the page, around the middle, I noted the various stages in *my* thematic analysis process. I wrote: *Thematic analysis process – open, unstructured discussion recorded → verbatim transcription → highlighting/underlining everything of interest → 1st order coding abbreviations given to similar items, phrases, sentences and chunks of*

meaning (descriptive coding; subthemes) → 2nd order coding involving dispensing with some codes, amalgamating others, and re-naming and redefining yet others (more interpretative than descriptive; themes) → 3rd order coding that identified patterns; over-arching themes → and, finally, telling the synoptic story of the data utilizing supporting quotes. On the second half of the page I produced a table consisting of 3 columns, with each column headed 1st order coding, 2nd order coding, and 3rd order coding (Appendix 23). Unlike the main study where I would be expecting the research questions to provide direction for the unstructured, open discussions, at this stage I was primarily being driven by the need to practise. On the back of the second page of each transcript, again handwritten, I produced the synoptic story of the supervision session based on the over-arching themes and supporting quotes.

Building on this experience, the procedure involved for the main study thematic analysis took the following form:-The abbreviated 1st order codes (originally placed down the left hand side of each page of the verbatim transcript) were collected together in handwritten form on the back of page 1 of each of the transcripts of the six participants. They were numbered in the order in which they appeared and meanings attached to each one (see Appendix W for excerpts of abbreviated 1st order codes for Sharrie etc).

A reminder of the full thematic analysis process was then handwritten in the middle of the back of page 1 of each transcript, along with symbols which would indicate how 1st order coding would be translated into 2nd order coding e.g. x = take out; ✓= keep in; ↑↓ = amalgamate / change / re-label; ? = don't know. The thematic analysis process was: recording of open, unstructured discussion → transcription →

highlighting or underlining everything of interest (familiarisation) → 1st order coding → 2nd order coding → 3rd order coding from which a synoptic story could be constructed utilising supporting data extracts/quotes. In essence I was moving the analysis gradually from subthemes to themes to overarching themes, and then finally to synoptic stories in order not to lose sight of the original data from which the overarching themes were developed.

The bottom half of the back of page 1 of each transcript (from all six participants) consisted of a three column table outlining the analytical process and the results of moving from 1st to 2nd to 3rd order coding (see Appendix Y, List of CodingTables).

Next, the 3rd order codes (overarching themes) were taken from the tables and written down the right hand side margin of each page of each transcript next to relevant lines of text. And, finally, on the back of page 2 of each of the six participants' transcripts, the overarching themes were re-assembled into **two synoptic stories per participant**. One synoptic story was written in my words along with the lines in the transcript from where the story came. The other synoptic story consisted of the participant's own words, put together utilising the data extracts identified mainly by these lines. The thematic analysis was carried out in the order Sharrie, Martha, Nancy, Mattie, Ellie and Kate, with each thematic analysis being influence by the one preceding it (see Appendix U for an example).

As I made progress on my research journey I was hoping to avoid the *'hazards of orthodoxy'* well documented by Stoppard (2002). Due to an anxiety I felt over the possibility of diluting the impact of raw data on the reader, on-going modifications were made. Eventually I used a matrix-based thematic analysis utilized so effectively by Newton & Bale (2012) in their work on examining perceptions of self-harm in

members of the general public. This matrix-based thematic analysis not only retained a closer link with the data but provided an easy-to-follow, systematic way of proceeding (King & Horrocks, 2010; Ritchie, Spencer & O'Connor, 2003). I still called it thematic analysis though it had elements of a number of other ways of analysing qualitative data as well. Pluralism, by which I mean making use of more than one qualitative method, is not an unworthy way to operate (James, 2013c). Combining core approaches (Frost, 2011; Frost & Shaw, 2014) has been advocated as a defence against what was first called '*methodolatory*' by Janesick (1994), a tendency to become almost religiously wedded to a particular methodology above everything else. Arguments against off-the-shelf methodologies have been put forward by Chamberlain (2012) and others (Hammersley, 2011; Thorne, 2011). Rather than searching for a pre-existing methodology and associated methods / methods-of-analysis my preference was to remain open-minded to various possibilities and to be ready to graft on other ideas. Operating reflexively and critically, modifying research questions, trying out methods which seemed fit-for-purpose, and selecting what appeared to work was how I went forward. Other qualitative approaches such as IPA (interpretative phenomenological analysis), discourse analysis, conversation analysis, and narrative analysis were not without influence on my thinking.

2.7 Additional qualitative analysis considered

IPA as a qualitative method of analysis is relatively new in comparison to some others. It is also currently one of the most popular, and is considered by some researchers to have a dominant position in the field (Smith, 2011). So far IPA has not split into rival camps in the way that, for example, grounded theory and discourse analysis have. IPA gives priority to participants' experiences and their interpretations of these experiences. It arose out of phenomenology and hermeneutics (Braun &

Clarke, 2013). Willig (2008) spelt out quite well its various stages, some of which I have adapted for use in my own brand of thematic analysis. IPA consists of: a) reading, re-reading and taking notes on the left margin of the text until completely familiar with it; b) labelling sections of the text as conceptual or psychological themes on the right hand margin; c) adding a bit more structure by listing themes as they relate to one another as cluster themes; d) producing a summary table that depicts the cluster themes with their associated individual themes and supporting quotes/data extracts; and, e) integrating data from all the participants whereby the summary tables from each participant are compared in order to produce overarching or master themes which illustrate the experiences of the group of participants as a whole; or, alternatively, using the summary table from the first participant to actually code the texts of the other participants.

While there were several strengths in the IPA system which appealed to me, there were some weaknesses too, not least of which was the feeling that there already existed a recipe that I felt had to be followed (Parker, 2005). It seemed to lack the theoretical flexibility of thematic analysis. It was more than just an analytic method and was inextricably linked with a phenomenological and hermeneutic ontology, epistemology and methodology.

Discourse analysis, like grounded theory, but unlike IPA, has broken up into distinct schools. There are at least two, though Wetherell (2001) almost 13 years ago described six. They all have a focus on the role of language in the construction of social reality. In essence discourse analysis is a way of qualitatively analysing text which is underpinned by the assumption that language does not reflect reality as much as it creates it. Language creates meaning. Discourse analysis is concerned with action (i.e. what talk is doing) as well as meaning. On the one hand there is

discursive psychology discourse analysis which is the application of *'fine-grained'* discourse analysis to texts, a very detailed analysis or micro discourse analysis. It looks at what people do with language and how meaning is negotiated in everyday social interactions. On the other hand, there is macro discourse analysis, commonly referred to as poststructuralist or Foucauldian. This type pays less attention to the minute detail of text. Instead, it sees language and discourse as making up social and psychological realities and playing a crucial role in how power is exercised. For example in a study of, say, obesity, the dominant discourse may be medical (e.g. unhealthy), or moral (e.g. 'blaming' over waste) or pride (e.g. fat and happy with it). There is no simple recipe for discourse analysis though guidelines have been provided for the novice researcher (Wiggins & Potter, 2008).

Conversation analysis, along with ethno-methodology and the sociology of scientific knowledge, spawned the discursive psychology version of discourse analysis (Potter & Wetherell, 1987). Conversation analysis is a type of qualitative analysis which pays attention to structure, sequences and patterns in interaction. It tends to be most interested in everyday, naturalistic conversation and arose out of the sociological work of Sacks & Jefferson (1995). However, it is now fairly popular in psychology. Conversation analysis is the examination of *talk-in-interaction* and is especially suited to studying naturally occurring talk. Even though my own research sought to gather data from unstructured, open discussions, and tried to be as naturalistic as possible, the events were *staged* in the sense that they did not happen spontaneously. Hence the orderliness of social interaction, turn-taking and so on, much loved by conversation analysts, did not seem to me to be something that would throw enough light on my research questions. Also, the method itself appeared to be one which was not easy to learn, was very highly structured, and

focussed mainly on the micro-level to help work out how speakers used language to achieve their aims.

Narrative analysis, along with much qualitative research, involves working with what people remember. Narrative psychology specifically addresses participants' accounts of the past. We are story-telling organisms and the stories we tell *do* things (Frank, 2010). The stories connect and disconnect people and shape who we are. While methods like thematic analysis have been accused of *fracturing* stories by cutting across data, the story is kept intact in narrative analysis (Smith, 2013). This kind of analysis puts the story at the centre of what is being achieved. It is about making sense of 'storied' data (Willig, 2008). The term *'story grammar'* was used by Langdridge (2007) because it is the form/structure of stories individuals tell about themselves, and others, which is of central concern. There are different types of stories e.g. romance, comedy, tragedy and satire (Hiles & Cermák, 2008). Gergen & Gergen (1986) categorised narratives in terms of the *progressive* type where events move towards some objective, the *regressive* type where events unravel in a kind of whodunit, murder-mystery fashion, and the *stable* type where it is the plot itself which provides the structure. Most stories have a beginning, middle and end, and there can be a number of different narrative plots e.g. Elsbree (1982) identified the journey, the contest, the experience of pain and suffering, pursuing fulfilment, and, finding a secure place to be. Narrative analysis asks questions of stories like: What kind of story is this? Who are the principal characters? What kind of language is used? Is the tone of the story emotionally exhilarating or flat? Is it comic, tragic, full of optimism or pessimism? What are the themes being promoted and how do they interrelate? Does the story-teller seek the approval of the reader/listener? There are few set rules in narrative analysis and its focus is on the socio-cultural aspects of

experience. It is not bound by a single theoretical position though some narrative analysis is certainly linked to phenomenology and some to social constructionism (Sparkes & Smith, 2008). There did seem to me to be mileage in utilising some narrative analysis ideas for opening up *self-harm* to further scrutiny.

2.8 Summary

This chapter reminded the reader of material covered in Chapter One, as well as commenting briefly on how I went about deciding on methodology and carrying out pilot studies. It identified who the six participants were, how they were recruited, venues for discussions, and how the data were recorded. The procedure employed for the main study emphasised what had been learned from the pilots. Ethical matters were commented upon, some of which were especially pertinent from a qualitative perspective. Some of the contents of the research journal (which I kept between 2011 and 2014) were presented in order to illustrate parts of my journey as the project took shape. I traced the development of my ideas about thematic analysis and described the procedure. Finally, I considered a number of other qualitative methods such as IPA, discourse analysis, conversation analysis, and narrative analysis, and attempted to explain how and why I used, or did not use, parts of them in my own form of thematic analysis and synoptic story writing. Chapter three will now deal with the main study analysis and findings.

Chapter 3

Analysis and Findings

3.1 Introduction

Thematic analysis of the transcripts of each of the six participants was made so much easier by having research questions in focus at each stage of the analysis. These research questions were originally framed in terms of an exploration of self-harm, then made into proper questions, and later re-phrased, and re-ordered. Also, additional questions were inserted to take account of the importance I placed on reflexivity:

1. *What meanings can be extracted from data on self-harm provided by individuals (a) who consider that they have never self-harmed; (b) who have mildly or moderately self-harmed (CASHAS); and, (c) who have seriously self-harmed (CUSHAS)?*

2. *Can personal and epistemological reflexive analysis add value to a qualitative study?*

3. *Do reflections on the processes involved in being a student on a taught professional doctorate contribute to the overall credibility of this type of study?*

4. *What is self-harm from a phenomenological and functional point of view, and has it been appropriately named and defined?*

5. *What implications might there be for support, intervention, and staff training?*

Developments in thematic analysis procedure culminating in synoptic stories continued to take place as I worked on the first transcript (Sharrie).

3.2 Overview of themes (See Appendix Y, Tables 1 – 14)

According to Braun & Clarke (2013) subthemes encapsulate a specific aspect of data, themes identify patterns of meaning across data, and, overarching themes provide a kind of organisation and structure that holds together a number of themes. With regard to my data, I identified subthemes to be some of the 1st order codes which repeated themselves many times in individual transcripts, but not necessarily across transcripts e.g. tension relief/release (9 times in Sharrie), dissociation (17 times in Martha), self-esteem & self-worth (14 times in Nancy), over-eating (8 times in Mattie), attention-seeking (4 times in Ellie), and nail-biting (14 times in Kate). See Appendix Y, Table 7.

I considered themes to be clusters of subthemes which appeared across many transcripts (at least 4 out of 6) e.g. alcohol/drinking, drugs/addiction, smoking, cutting, coping, over-eating/weight issues, pain, cutting, emotion regulation, relationships, abuse, control/power, suicide/anti-suicide, secret/non-secret/communication, and physical/ mental health. See Appendix Y, Table 8.

The overarching themes appeared in all the transcripts. One of the reasons for not using semi-structured interviews was to try to avoid finding overarching themes which too closely matched interview schedule topics. See Appendix Y, Table 9.

However, the first manuscript appeared to have considerable influence on the

others, though it was rather unexpected to find an overarching theme captured by the code *'contradictions or dilemmas'*. This theme presented both sides of arguments, recognised complexities or uncertainties, and was sometimes captured by participants simply saying *'I don't know'*. Researchers like Amy Chandler (2013b) have already begun to highlight contradictions in data from self-harm survivors. She found, for example, that self-harm can create emotions AND kill-off emotions; it can be painless AND painful; and, it can involve communicating with others AND be private and secretive (personal communication, 5 March 2013). See Appendix Y, Table 10 for some examples of subthemes to themes to overarching themes. An excerpt from a table of subthemes, themes and overarching themes can also be seen in Table 16 below:

Table 16. Table of subthemes, themes & overarching themes

Subthemes (e.g.1st order codes; clusters of 1st order codes; items of relevance to research questions): some examples only	Themes (e.g. 2nd order codes; clusters of subthemes): some examples only	Overarching themes (e.g. 3rd order codes; clusters of themes).
Tension relief Anxiety Dissociation Self-esteem Self-worth Alcohol Drinking Drugs Smoking Over-eating Obesity Attention-seeking Nail-biting	Alcohol/drinking/Drugs/addiction Coping Emotion regulation Physical/sexual/emotional abuse Control/power Suicide/anti-suicide/overdose Depression	(1) What self-harm is: CUSHAS & CASHAS (2) Causes & functions (3) Support & intervention (4) Dilemmas or contradictions

3.3 Overarching themes and synoptic stories

Why go from overarching themes to synoptic stories? For me the answer was simple. In the process of thematic analysis from 1st order to 2nd order to 3rd order coding, from subthemes to themes to overarching themes, much was gained in terms of answering the research questions and getting to know the data intimately. However, the reader of this project write-up could never be fully part of the exercise, and was therefore in danger of missing out on experiences which I think contributed to my findings and ultimate conclusions. Thematic analysis has been accused of *fracturing* raw data (Smith, 2013) in a way that can sometimes cause it to lose its vitality, dynamism, and, ability to take knowledge forward. The themes at the level of sub-theme, theme and overarching theme were important, but in order to stay in touch with the 'insider' story of self-harm, I sought to find a way of continuing to kiss the raw data. This was done by using the overarching themes to form synoptic stories, particularly the synoptic stories which were composed of participants' own words.

3.31 **Sharrie**

The overarching themes for Sharrie (and the other five participants) were: (1) What self-harm is - CASHAS & CUSHAS. (2) Causes & functions of self-harm. (3) Support and intervention. (4) Contradictions or dilemmas. From these overarching themes (see Appendix Y, tables 1& 7-14), were constructed the following synoptic stories:

My synoptic story (about Sharrie): She appeared at first to be non-self-harming, assuming that is possible (lines 44-45). However, she did express some doubts (45-47) and was beginning to explore what it meant to self-harm (170-176). There were differences between CASHAS and CUSHAS (319-333, 352-355). She offered many causes of self-harm (line 214) and many functions, the most frequent being 'a cry for

help' (59, 178-179, 181, 215, 447). Her only experience of CUSHAS was with one friend who cut (173-176). She thought this was quite different from her own CASHAS, like smoking and drinking (352-353). She said that her friend was one of the least stable in her little group (189-190; 300-301), but now (age 30) she was one of the most stable (225-226). It was this friend's relationship with her father that Sharrie believed caused the cutting (256-259). Later in our discussion Sharrie said that some CASHAS were actually more self-harming than cutting (401-404, 448, 465). For support or intervention to be effective it was necessary to get to the bottom of why cutting was happening (453-456). Sharrie was not willing to discuss cutting with her friend in case it made matters worse, neither was she able to say much about appropriate interventions (197-200; 460-463). There were a number of contradictions or dilemmas in her transcript to do with friends, partner and family (132-158); exercise, eating and drugs (29-38, 103-108, 68-81); suicide/anti-suicide (423-436); and short-term benefits versus long-term disadvantages (92-98). By collecting together data extracts from the transcript (as identified in the above line numbering) Sharrie's words provided their own synoptic story.

Sharrie's own synoptic story: *"...That stereotype* [self-harm as cutting]*, no that stereotype doesn't affect me. I don't do that. But…I'm smoking. I drink. I don't drink that often but when I do it's…binge drinking…I still think it's acceptable to drink even though I know that I probably am harming myself…It's few and far between the instances when I'm drunk, but when I do get drunk, it's drunk…I don't drink a lot so it doesn't take much…It's probably a release. It's probably a wee de-stressin'... Unfortunately I just find myself drunk...My friend and I have talked about this and when she feels herself getting drunk, she stops. When I feel myself getting drunk, somehow I just keep drinking…It's a release. It's relaxing probably. But then it's*

probably harming...I drink far too much probably and…so that's probably no[t] good for your body. But it's acceptable though...[A friend] said to me: 'D'you remember one of the girls went through a phase…?'At the weekend you do what teenagers do. You go out and have a wee drink when you shouldny. And when she was drunk she kind of run away from everybody, and a few times she'd pick up bits of glass, and I wouldny say cut herself, but kind of scratched herself...It's kind of strange to marry the two together [cutting and drinking] *'cause for me the two of them were not the same thing…For me deliberately cutting yourself or burning yourself was not the same thing as going out and getting yourself drunk, but having spoken about it, and having thought about it, there probably isn't that much separating them...The stereotype in my head, it would be the cutting, or the burning, and the people would do it either as a coping mechanism or a release. Possibly even a cry for help… Thinking about it* [her friend's cutting] *now*, *it could possibly have been a kind of cry for help. She did have a really difficult relationship with her dad*...*I don't think she had the kind of relationship with her dad that she wanted. I think she wanted more from him than he was prepared to give her...She never vocalised it with any of us. She never said 'Look, I'm having a really hard time. I need to speak to somebody about it'…Maybe it wisny a cry for help. Maybe it was just daft behaviour...or looking for attention. That type of thing. But there is probably much more to it than that...I think I always put it down to she drank too much, a bit of attention-seeking, and just being a bit 'cookie' 'cause that was what she was like...She was quite 'flakkie'*...[JJ: ...When you think of her now, and the rest of your friends, is she less stable or...?]...*More stable. Definitely more stable...I think it might have got kinda…to the point for her where she kinda tried everything…to kinda build a relationship with her dad, for him to be the kinda dad that she wanted…and he just didny seem interested……..*

…… .....

You could even say that smoking [Sharrie smokes] *would be even more self-harming than the cutting, depending on the type of cutting you are talking about. If it's superficial cutting they will heal. But obviously the medical advice and the information we've got on smoking is that it is*...[pause]…*I mean it's not good for you...*

……

Are [you] *cutting yourself to have a 5 minute break fae the daily grind, or, are you cutting yourself to deal with some other big issue, you know, like abuse, mental health problems or that kind of thing? I think if there's an underlying problem causing the self-harm then that needs to be addressed...She* [friend] *doesny do it now, so I assume that whatever the problem was, it's maybe been resolved, or she's come to terms with it. And if not, it maybe was just silly teenage stuff, and in either case I never asked about it and I just never thought that she would want to discuss it...If there's an underlying issue that they are trying to deal with, I think it should be treated. It's not necessarily stitching them up and then you go and do it again...And that's not to say that they all have an underlying issue.....*

……

I sometimes just like to have 'me-time'…for a break, where I don't have to consider anyone else....I think all families have got...stresses. It's just the way families are. You've got your disagreements and not quite seeing eye-to-eye……

.....

Exercising... it's supposed to be good for you but I probably don't do as much as I should...Well, for me it probably is...[pause]…*it probably is back to the good old weight...For me it's probably not so much a health issue as...an aesthetic thing. It probably is exercising to lose weight or whatever. I go through periods where I don't*

do any at all and then I'll have a mad episode where I do it all the time...I suggest the harming bit because I go through so long not doing it and then really doing it. I do it the next day and it's sore and it's painful and I probably have harmed my body in some kind of way...If you eat well it's caring. It's fuel for you to do what you do, for you to function, but I'm quite prone to, I don't know if this comes from being female, restricting what I eat quite a lot of the time, and that is down to diet, how you look, thighs, your weight, that kind of thing...A lot of the time I don't eat what I should...I probably should eat more and eat more healthily as well but I tend to eat things that are low…fat or whatever, and maybe skip meals and things like that……..

.....

I suffer quite badly from sinusitis and as a result of this I end up having really, really bad headaches…I've got these headache tablets and you're not meant to take them any more than 3 days at a time but I probably take them at least 2 a day...That probably isn't good for me in the long-term...I don't explore any other ways of the pain management type of thing. As soon as I feel a headache coming on I take 2 of these painkillers just to enable me to get through my day because if I don't take them the pain can be so intense…and I go to my bed. I just canny do that. So I just use that. But…the pills…is probably not the best. They impact on other organs and my body kind of thing…I'm just prone to take a tablet and to say 'Oh, that'll be fine' kind of thing...It's to make me feel better. Obviously, I've got an ailment and that takes it away. But probably, in the long-run, taking these painkillers all the time would be detrimental to my health.....

……..

Do they [self-harmers] *say that they never had the intention* [to kill themselves]*, because I would assume that if you take an overdose then that is trying to kill*

yourself?...What happens if there's no intervention? Ultimately you would die...With the overdose, that's a bit of roulette really, whether or not you're going to live...At least the cutting, from what I would imagine, seems to be superficial, and I wouldn't imagine it to be life-threatening..."

3.32 **Martha**

The overarching themes were as for Sharrie. However, the main one was (2) Causes and functions of self-harm. (See Appendix Y, tables 2&7-14).

My synoptic story (about Martha): She had a long history of serious self-harming (lines 66-76). She was aged 54 and experienced dreadful abuse from her father (78-81). Her sister and daughter have also cut (267-269). The causes and functions of self-harm dominated our discussion (271-273). Mother spent long periods in a mental hospital (82-83) and father was abusive to all the family (221-225). The functions of her self-harm were numerous. She spend much of our session trying to explain how she came to be the person she was (229-232; 233-238; 239-251; 254-265; 274-291; 294-306; 307-311; 381- 421; 428-430; 431-438; 443-460; 462-463; 493-513; 558-566). She defined self-harm (656-658), linking CASHAS and CUSHAS (669-271). She was the victim of assaults, sometimes the aggressor, and at other times invited people to hurt her (395-397). Her neck was broken in a violent incident and she was now wheel-chair bound (236-237). She loved her father because he was her father, but hated him for being violent (303-306), abusive (197-203), and a drunkard (84-86). The contradictions or dilemmas in her transcript were coded as pain, parents, power and control, survival, and violence (98-107; 192-196; 118-125; 276-285). By collecting together many data extracts from the transcript (as identified

in the above line numbering), Martha's words below provided their own synoptic story.

Martha's synoptic story: *"...When I was a youngster I cut my emotions off... because of what my dad did to me...I stopped laughing. I stopped singing. I just became a blank sheet.....……*

…….....……..

I had quite a lot going for me…being very sporty, being very athletic, being top of the class…When my dad came back from the forces everything changed...My dad was a...[pause]…*well…he married a 9 year old girl when he was in Borneo...I was my mum's best pal. She told me everything. I was her confidante……*

…….....

My self-harm was extremism. I used to exercise to the extreme and I would be shaking and falling on the floor...I'd starve myself to see how much I could live on. I'd scrub myself clean after my dad hurt me and I'd feel dirty all the time. I'd scrub myself till I bled...That started with me when I was about 9...My sister was a self-harmer 'cause, obviously, living in that same atmosphere…She used to cut...My daughter was one as well but only lasted for a little while. It was the cutting one they did...Mine was to get rid of my anger and the pain, with the scrubbing to make me feel fresh and clean...He [dad] tried to rape me…And I just flipped and I don't remember anything. I just conked out the brain. I just shut off…Inside I was just screaming...He did other things, abusive things but things that weren't sex. There are other ways of doing sex…My mum wasn't there 'cause she was in the mental institution at the time...My mother never did anything about it 'cause she was too scared…He had control over her mentally, physically and sexually...She's quite a strong woman, even though she's got her failings …But I still can't forgive her for her

failings 'cause I was strong for her as well...That's why I was so physical, more like a man. I didn't look like a man but I was physically very strong. I did a lot of martial arts. I did a lot of sports 'cause I didn't want to be as weak as my mum. But in a way my mum's not weak……..

.....

I had a bit of a drink problem. I was a binge drinker…I could go years without a drink …I was in the wrong place at the wrong time and I got hit on the back of my head. I fractured my skull, fell down 15 stairs and broke my neck……..

.....

When that compulsion takes over you, you see it coming, but once it's got you, there's no way of stopping it...I haven't drunk for years. I've no desire to do it either – my choice…my control...I have a compulsion to make sure I've got too much food, too many clothes, my house is spotless...When you're a youngster and sometimes you'd go 4 days without food, you want food there. My cupboards are chock-a-block with food. Somebody takes a bit of food out, I'd go and put it back in again. You know, if they take a tin away, I've got to replace it. I need the food to be there in case no money comes in… Security, yeh? ...I'm a very prepared person……....

…….....

The worst [form of self-harm] *was scrubbing...You make your body bleed to get rid of all the dirt…and there's no dirt there…I always felt dirty 'cause of what my dad*... [Martha stops abruptly]...*It became a problem with sex and things like that…If I had a relationship, I had to go and scrub myself 'cause I felt dirty...The scrubbing was one of the worst ones 'cause it made your skin red raw…I'd say that was worse than taking the overdose 'cause the overdose...was like giving up, couldn't cope with… feeling the anger, the shame. Shame was always there. The disappointment in*

myself…..

……

I was always there to protect them [brothers and sisters]. *I took a lot of the abuse on. I took a lot of the beatings on. Now this might sound really illogical. I knew the power I had over my dad...I could 'manipulise'* [possibly a conflation of 'manipulate' and 'monopolise'] *him…It kind of distorted my brain for when I did meet men, 'cause I would destroy them. I went out to destroy them. Because I knew how to manipulise my dad, made it easier to manipulise other men...I had to get mum's money out of him...If I took the blame for the boys doing something bad - it might be something minor - I used my smiles and my giggles. I got to know what men liked. I could get him to come round to me nice, instead of being…violent…I had to do it…It saved my brothers getting a beating...But that can be very strenuous...You can't be the person you really are...You can hurt yourself in some way and it brings you back to reality. It brings me back to 'I'm here'…You need something else to make you feel that you're real. If I'm playing a game, I'm not real. And I need something to make me feel real. So…I hurt myself…exercise myself...scrub myself…do something really painful to myself……*

……

…With violence in the family…if you don't get it you think there's something wrong. If someone's not violent or aggressive, if a man's nice to you, you say, 'What the hell's this?' 'cause you're not used to it. If you see someone being violent all the time, you get used to it. And if someone is nice to you, you go, 'Oh, oh…not used to this', and panic...You're very suspicious...See, my dad…when he walked in the door the whole atmosphere changed…So we were used to a violent atmosphere…And when it's not in the air, you have to find it...And that's why I think a lot of us [abused females] *end*

up with violent men, because we know what we're working with. It makes us feel comfortable. 'I can handle this'……

.....

I was a very aggressive youngster. I was even scared of my own self...because I had so much anger in me…Once my friend...was doing something and I said, 'If you don't stop that I'll cut your hand'. And I took a knife right across her hand and I felt nothing... So I had to get myself out of that…I'd get into fights and I didn't care what happened to me....I didn't care if I got beaten up…I...FELT...NOTHING [she says the words slowly and precisely]…*No remorse, no anger, no nothing*…[Yet] *I'd be the first person out if someone was getting hurt, like a child, or a dog…But adults - forget it. They can look after themselves...It's the children I worry about…I think it goes back to my childhood, watching my brothers' eyes…It was such a horrible thing to see, having kids dragged up in the middle of the night and made to eat slops. I'm standing in the middle of the room and my dad's saying, 'Who do you love?'…That's the most horrendous thing to do to a child. You've got mum one side, and dad the other side. And they* [brothers and sisters] *are just standing there and they wee themselves because they don't know who to go to…And for me to go in there, and do something about it, made me feel powerful…I would manipulise my dad: 'Come on dad, now you come with me'.....……..*

……

What children need is basic. It can be a mum. It can be a dad. As long as they've got that one person they can rely on...I said when I was going to kill myself when I got my broken neck and everything, 'I'm useless to human society'…And it was my youngest son…that come in and says to me… 'You're not going to do anything to yourself, mum. You might be a broken mum, but I love you'. I thought, 'That's put me

where I'm supposed to be'…That's the point for me, having a purpose. I think if you give someone who has nothing even a little puppy, and say, 'This is a puppy that needs you to look after it. You're the one that's to feed it'…you give someone something……..

……

Your self-harm is all about you…I need to get rid of this anger, to get rid of this pain, to make me feel like something...With sport or using your brain to go to college, you're not thinking about yourself 24/7. If I'm in a lot of pain, and I'm talking to you, or I'm studying, or I'm watching after the children… my mind's somewhere else. The thing is to take the person away from the self-harm…and put something else in the place of it. So for that split second, I go, 'No, I don't want to do that'……...

……

An overdose [is different]*, you've made up your mind, 'I'm doing it'……....*

…….....

I've been around social workers all my life. The nicest one I ever had was Mr Highbodgiball. He was a black man...I was about 15. He listened. He didn't judge me. He was nice…He smiled…I've been to psychiatrists and all they have ever said to me is, 'How's your sex life?'...They don't seem to listen. They have their own agendas…Sometimes you want to talk and sometimes you don't want to talk……...

…….....

With self-harm you've got to get down to WHY [said loudly and slowly]*…There's got to be an underlying reason why somebody's hurting themselves.* [JJ: You know why?]*. Aha* [yes]*...Self-harm is an invasion of your body. You're doing something in human nature you're not meant to do... 'Cause we have this fight or flight, don't we? …Why would you want to hurt yourself? It doesn't make sense...It's the same with*

drinking too much, taking drugs too much. Self-harm is exactly the same…You're trying to get out…[Martha gesticulates as if she is trying to propel something out of her body]*...Exercising too much…It's getting rid of something out of you……...*

……. ….....

I would let people self-harm to harm me. We used to have competitions to see who could take the most pain. You'd whip yourself with a wire across your arm, you know. People would challenge you to see how long you would go. And I'd get my arm ripped open with this wire. And people would say, "Is that no[t] hurtin' you?", and I'd say, "Nup!" 'cause I'd cut myself off. I wanted to feel a bit of pain. It gave me emotion. I liked pain. And that might seem illogical. It made me feel I was alive 'cause I felt like I was dead. So I cut myself to feel alive. I didn't want to be mentally hurt. You could hurt my body but you couldn't get in here [Martha points to her head]. *I could cope with that but I couldn't cope with the mental hurt……...*

.....

I still love my dad. My dad's my dad…I was quite lucky...He taught me all my sports…He showed me off like a Barbie doll...".

3.33 **<u>Nancy</u>**

The overarching themes were similar to the previous transcripts, however, the two main ones for Nancy were (2) Causes and functions of self-harm, and, (3) Support and intervention. (See Appendix Y, tables 3&7-14).

My synoptic story (about Nancy): This participant was a female advocacy worker, aged 32, who had started self-harming when she was about 19 (lines 111-112). She did not say that she would never self-harm again but hoped not (81-90). When I asked her why she chose 'cutting', she replied with the question, 'Why not?' (297-

300). She was employed by an agency which supported individuals who had mental health problems of a variety of types (513-515). Her brother had no mental health issues unlike her parents (406-419). Her parents (mother a GP) separated when she was 11 years old (385-394). Her mother knows that Nancy self-harms but she was not sure whether her father has ever known. She has not seen him since aged 17 (402-404). Because she had a diagnosis of BPD, and considerable experience of being a patient (and one who self-harmed), she felt she could operate more effectively in her job (613-634). Her partner had recently moved to Bristol and she was having difficulty finding a job there, and was now beginning to feel that the BPD label was not so helpful afterall (634-637). Labelling could have advantages and disadvantages (639-649). Her job has resulted in her understanding of self-harm being coloured by the self-harm experiences of others (74-79; 91-108; 113-117; 124-127; 149-157; 162-163; 234-253; 255-259; 273-276; 284-293; 301-319; 322-327; 329-332; 334; 347-351; 353-355; 362-366; 369-372; 375-381; 507-510). While she struggled to define exactly what self-harm was, she was comfortable with that uncertainty (64-66; 81-84; 87-92; 136-137; 147-148; 232-237; 429-433; 513-515; 576-583). Nancy had extensive personal experience of support and intervention in Scotland and Germany (143-147; 151-157; 163-164; 168-178). She preferred the German system. She acknowledged many contradictions and dilemmas associated with self-harm (183-192; 195-225; 391-394; 443-464; 473-480; 486-492; 495-507; 515-517; 519-531; 533-556; 559-563; 570-572; 603-608; 665-668). By collecting together data extracts from the transcript (as identified in the above line numbering), Nancy's words provided their own unique synoptic story.

Nancy's own synoptic story: *"...Generally I would cut myself…I would tell myself that if I used just my finger nails…then it's less of a big deal…I've never done*

anything that drastic…When I was younger I used to fast…and I think it's probably kind of connected but I didn't sort of try to physically hurt myself till I was a bit older [age 19]*...Someone was asking…'I don't understand why you would start* [cutting]*…'. …I think that's really difficult because…my answer will almost be, 'Well, why not?'...A really difficult part of working in health, and mental health in particular,* [is that] *sometimes there isn't an easy answer……*

…….....

My parents divorced when I was about 11 and I haven't seen my dad since I was about 17…My mum…initially was very much like…'My God what are you doing?' And you'd go home and find that you couldn't find a pair of scissors or anything like that…I think [she'd] *find it very, very difficult and… thought it was partly her fault in some way. But also, I guess, try to skirt…around it and not talk about it and say, 'Have you been at yourself again?' 'Now' is actually quite different. My mum has just retired from being a GP, and what I find latterly is that she's actually coming to me for advice when she's working with someone who self-harms. And I've said to her… if her premise is just to get them to stop, then it's a bit of a non-starter. You're not on the same page.....*

……

With my dad, frankly, I don't know if he knows that I self-harm. He knows I've got mental health issues and stuff, but…whether he knows any more than that I genuinely don't know...My mum's had quite severe depression…I've got a diagnosis of BPD…My brother said to me, 'D'you think that our dad has the same?…And I thought, on the balance of probabilities, I would say that's probably likely…I think he's been treated for depression but I think it's more… complicated than that...[My brother] *he's just quite normal... When I was first diagnosed with it* [BPD] *I was living*

in Germany…I felt that it did kind of capture my experience...I…joined an online support forum…and…I learned…that it was a really 'badly-thought-of-label', and that it was really potentially quite damaging to go through services trying to get support with this label. So when I came back here I didn't tell anybody...And my therapist from Germany wrote me this letter in which she also didn't mention it...Subsequently they diagnosed it again…I think it's helped me to get a framework of understanding. I think it's helped me to meet other people with the same [diagnosis] …*but I don't think it's a very helpful label…At the moment my partner has got a job in Bristol and I'm in the process of trying to get a job down there…In this organisation* [current job], *my experience of mental health services is seen as an asset…What I'm finding now is that I'm applying for jobs,…*[having] *almost owned this as part of my identity…I feel I might have to hide it again…People* [in my current job] *are not making…assumptions based on the label. They actually know who I am…And so the thought of actually going to Bristol, and to potentially having to use services there, and being back at the beginning…is a really difficult thought…I've spoken to a lot of other people with that label…The majority view seems to be that…it's useful to have an idea of what's going on but it's not a useful label in itself…The consequences of having that label in your notes can be really quite…damaging…….....*

.....

The way I feel when I self-harm as opposed to the way I feel when I'm not self-harming are very, very different states of mind…It's almost like being a different person...I wouldn't like to say that if I had a really, really low period again that I wouldn't self-harm because I don't feel that I have the same level of control in that situation...I think it was partly a way to kind of express that I felt frustrated and upset and angry and I thought if I did this then people would maybe notice and they would

ask me about it...It was a kind of attempt to communicate how I felt...I think partly it's kind of changed over time, what it's been about…It's definitely not about wanting people to notice…I think it's maybe a way of…if there can be such a thing… communicating with yourself, if that makes sense...You don't feel able to express… distress or anger…At other times I've just wanted to cause myself some damage. And it's been a kind of punishment thing…I do see it as some sort of communication, but who is that communicating to? I'm not quite sure 'cause I don't think I've ever used self-harm to communicate to other people just how bad I feel...I've felt very trapped in a situation…I've self-harmed and I'd felt it would make me feel better. And it would also be proof of how bad I felt. But it's not to sort of show to other people. Maybe to be able to tell them that I've done this but it's not been about drawing people's attention or anything like that.....

……..

At different times it's been for different things, but maybe not at the same time. So maybe more recently I wanted to do some damage, and, you know, show that I'm a bad person. Whereas at other times it's been a kind of release of emotion or it's been about gaining control...For some people it maybe just has one function but for other people it can have more than one function. So it probably depends from person to person...I'm not just stuck with the understanding I came to when I was, say, 22…Having an understanding of why I might be doing it, and knowing that it's for different reasons at different times…makes it one step easier for saying…'Ok, this is something that I'm not going to do anymore 'cause I know why I'm doing it'...If you'd asked me when I was younger, I would have said, 'It makes me feel better', or, 'It's what I need to do'...I've come across people who I've tried to [help] *stop drinking alcohol because they deliberately drink it to damage themselves…They know that*

*it's not good for them…They know…that it's going to make things worse…It's…not so much about what someone's doing, it's about why they're doing it…I'm sure there are many people who go out to get drunk just because they go out to get drunk, or go out to have a good time. But there will be other people who are using it as a way of…losing time, or…using it to get out of themselves, to get away from how they feel. They will drink to the point where they black out because they want to be unconscious…I think there's a difference between those two things...I don't think everybody is doing it to damage themselves. I think it's more about intent...People wouldn't necessarily recognise what they were trying to do…*So *I don't think it's as simple as saying, 'What was your intent when you were caught drunk, or took these drugs, or cut yourself…?', 'cause people might say, 'I just wanted to', or, 'I wanted to feel better' or 'to be out of it', or, 'I wanted to be disconnected', or, 'I wanted to feel more real', or, 'I wanted to feel more connected'...Some people would use alcohol or drugs…in a self-harming way, and at other times just in a way to enjoy themselves…*

…… .....

……(See Appendix A for continuation of Nancy's synoptic story)……..

3.34 **<u>Mattie</u>**

(See Appendix Y, tables 4&7-14). The overarching themes were as before, however, the main overarching themes in the Mattie transcript were (1), (2) and (3).

My synoptic story (about Mattie): Mattie was in her 50s and was the mother of two daughters, one of whom seriously self-harmed (lines 189-192). In addition to being a hypno-analyst (56-58) she also taught psychology in a secondary school in England and was often the first port of call for pupils who were self-harming and needed

someone to talk to (158-188). She unexpectedly volunteered to become a participant when I was recruiting others. Mattie was an OU tutor. It had been her intention to discuss one of her daughters (39-40; 189-192), however, initially she focussed on herself and pupils at school. When talking about the causes of self-harm (e.g. overeating, 31-32; 34-36), the functions of self-harm (e.g. in relation to obesity, 38-50), the intention to be secretive or non-secretive (214-218), and, the role of control in self-harm (169-172), she drew heavily on her experiences as a mother who separated from her husband when her daughters were 11 and 13 years old. During much of our discussion she was emotional, and partly blamed herself for being a bad mother (242-245; 261), though she was comforted by the fact that she had two daughters and one did not engage in CUSHAS (345-346). She was not convinced that CASHAS were qualitatively different from CUSHAS anyway, but did not want CUSHAS to become CASHAS (423-425). The cutting, punching, anorexia, and bulimia of her daughter 'G' had taken its toll on both mother and daughter (56-58; 59-63). She had extensive experience of G's CUSHAS and her own CASHAS (86-87; 115-130; 168-177). While only two years in age separated Mattie's daughters, they were completely different in personality and behaviour (341-346; 399-402). They did not like each other as children but were relating better as adults. It was suggested by Mattie that her daughters' relationship improved after both had children. Their father was a more effective grandfather than he was a father (402-406). Mattie only latterly became aware of the support/intervention that was provided for her self-harming daughter. For 10 years the self-harming happened in complete secrecy (193-200; 217-222; 223-225). The girl's father has still not said whether or not he knows (403-404). The NHS came in for severe criticism (356-358; 360-363; 410-411). Private sector involvement obtained via employer health insurance fared considerably better

(358-360; 363-368). There were a few contradictions and dilemmas in the transcript. These tended to emerge within all themed areas. Examples included what was said about alcohol then partially retracted (95-113); comments on obesity and societal attitudes to being fat (26-36); and, fierce criticisms of the NHS later tempered with some understanding of why nurses could become exasperated by self-harming patients (410-413). By collecting together some of the data extracts from the transcript (as partially identified in the above line numbering), Mattie's words provided their own synoptic story.

Mattie's own synoptic story: *"...One of my issues as you see is overweight...My weight goes up and down in this 4 stone band...My wardrobe goes from size 16 to size 22… And I've done that pretty much all my life…I would say that over-eating, which is a form of self-harm in my opinion, is becoming culturally unacceptable in a way that it used to be okay. Smoking and drinking too much were bad, but over-eating was okay, but...now…has been demonised to the extent that people are saying that fat people are using up the NHS's resources…without actually going, 'Now hold on, why are these people fat?'...But actually there's functionality to being obese…You know, I wasn't going to talk about me...When I've lost the weight, I can see that it had a function…Towards the end of my marriage I was nearly 18 stone, and that is BIG,* [emphasises 'big' and repeats it]*...When your belly comes down, it covers up your genitals…and it effectively goes, 'Look, no way'...Think about the body shape that an obese person takes. It becomes almost infantilised…You're going, 'No sex here'...In the last 4 years I've had a lot of stress...What I'm doing is reverting, regressing to an earlier stage. I mean, if I go back to when mummy looked after me, all the bad bits will go away...Nothing's by accident and there's always a reason...So one way of coping with a whole bucket-load of stressful situations is to*

eat. Food is emotionally comforting……..……..

…….....

I smoked for years and years and years and then I gave up for 10 years, and then I took it up again...I gave up 8 years ago but I took it up again for a period of…7 or 8 years...How crazy is that?...The smoking, it's more like bravado...It's more like, 'I can do this and get away with it and I'm going to be okay'...So now...I have asthma and I wake up in the middle of the night and there's no air in my lungs, and I'm thinking, 'My God, 30 years of smoking, that wasn't bright'...It's like an extreme sport. But for me that's totally different from the over-eating which I know is self-harming...Smoking was never comfort smoking…….....

.....

I don't do alcohol at all. I mean, I had a G and T [gin & tonic] *last night, and I'll have half a glass of wine with my Sunday lunch, and that's it...I could go from one end of the month to another without one drop of alcohol and it wouldn't bother me in the slightest...However, if I'm going out on the lash I can down a considerable amount to the point where I can't stand...It's like, 'I'm going drinking', so I would really drink, but 99 days out of 100 I would have no alcohol at all...Say I invited friends for dinner. I like to cook, and I would reach the point where I was incapable of clearing the table. I would just have to leave it for the next night...You're fine until you've opened the second bottle and the thing in your brain goes, 'Let's open another bottle shall we?' And then you go, 'That's it, I've had it!'...I suppose it is binge drinking, and it probably only happens once or twice a year...I do wonder if that's linked with, you know, over-eating…It's like I don't have to be grown-up and I don't have to be responsible...I've made a decision tonight and I've put my grown-up to one side, and I'm going to get absolutely lashed, like a teenager would, because I can.....*

……

Self-harming, as far as relationships go, I only ever meet complete bastards...I've worked out that that's a form of self-harm....You sort of know this is a bad boy. Don't play with this one. Well, then you do anyway….It's, 'Why don't you go out and pick another bastard that'll upset you?'...Interestingly, it's the kind of thing you can see when somebody else is doing it. So, if you have a close friend or somebody, you go, 'Really, you've picked another one, mmhhmm, is that a coincidence? Why don't you ever learn from this pattern of behaviour?' So I think it's a clear pattern...It is self-harming.....

……

We have serious issues with self-harming in school...About 4 or 5 girls a year will sidle up and say, 'Can I talk to you, Miss?', and you think, 'Right this is either anorexia or self-harm, isn't it?'...I don't know if it's all part of the same package...I find a lot of girls from the Asian community...have no control over anything...They want to be Western girls, and they are so restricted, and they are so pressured, and it's the only thing they have, you know...They do tend more to bulimia than anorexia. Not eating is offensive…'Look your auntie has brought you pie'...Well, they almost get force-fed, so they tend to bulimia rather than anorexia, and with the bulimia comes the self-harm...Mostly cutting their arms...Some of the Asian girls cut their legs...It's very difficult to get them to talk about it but the feeling I get is that they get to the stage when they just have to do something……

.....

It's easier to talk about other people. She [daughter 'G']...*she's a serious self-harmer to the point where there's almost nowhere on her arms…that wasn't already cut... She hasn't cut for 2 years, but she's 30 and she's been self-harming since…she was*

8 or 9...And I didn't know about it till she was 18...I honestly didn't know. I honestly didn't know. I really, truly, didn't know. And people go, 'The mother must know'. I really didn't know. She can tell me now that…at the age of 8 she started hitting herself in the face and punching herself with stuff...I think cutting probably started when she was about 14, the occasional nick here and there, and I would go, 'You've scratched yourself' and she would go, 'It's nothing, it's nothing'. But certainly when she got to sort of 17, 18, it got quite severe. And when I finally realised what was going on, it was…like a bereavement. I couldn't breathe...This was my precious baby. I didn't know what to do. And I just, 'Just fucking stop it. Don't do it'...And she went, 'Mum, you know nothing'…She had stitches in her arm…Both arms completely covered, this leg and this breast...She used to take herself to A & E and apparently had a false name and a false medical file...She's given them a different name and a different everything, so that it wasn't linking back to the family doctor...Nobody was to know. So when people say, 'Oh, it's done for attention', she could not have been more secretive...I really didn't know...She was going through a really bad time. I mean, nobody knew at the time. She has MS [multiple sclerosis] *...She got her diagnosis about 4 years ago...She's now reached the point where she's permanently in a* [wheel]*chair. So, looking back I can see at, sort of, 16, 17, 18, she was probably feeling pretty rubbish about herself...I think she was just exhausted and feeling crap...So I think it was feelings of self-hatred……..*

……....

And she was also bulimic and had been for a long time...Bulimia might be a way of controlling weight but it's a fairly crap way because an average binge takes in 5000 calories and an average purge releases about 2000 of them...You can see the scars … on her knuckles from her teeth. So I was such a crap mother. All this was going

on and I had no idea [Mattie very emotional at this point]*...He [dad] wasn't there from about the time she was 11...He was a crap dad...Both kids were quite happy when we split*……..

……

…….(See Appendix B for continuation of Mattie's synoptic story)……

3.35 **Ellie**

(See Appendix Y, tables 5&7-14). The overarching themes were as before, however, the main overarching themes were (1) and (2).

My synoptic story (about Ellie): She was a 26 year old primary school teacher who did not consider herself to be a self-harmer (lines 270-292; 448-449). However, she was critical of a friend with badly picked finger nails who did not see *herself* as self-harming either (320-322). Ellie was beginning to wonder about a time (17 years old) when she lost a lot of weight following an appendicitis operation. She was refusing to eat (36-98). Her mother was very concerned about weight loss, her father less so (93-94). She had limited knowledge of self-harm (cutting). Her first boyfriend (at age around 13 or 14) was so upset when their relationship ended that he made verbal threats to end his life. He showed scratches on his arms to mutual friends (197-213). The other bits of knowledge about cutting came from a student-teacher friend who was left to supervise a class of 10 year olds while the teacher went to get help for one boy. The misbehaviour escalated. He began to cut his stomach with an instrument of some kind (158-179; 185-195). Ellie was fairly clear about the differences between CUSHAS and CASHAS. There had to be severity and regularity before she would place behaviours in the 'real' self-harming category (216-224). Otherwise they were only superficial and attention-seeking. Some children in her own class of 8 year olds deliberately misbehaved to incur teacher disapproval e.g.

telling tales that were obviously untrue (170-179). Ellie had a lot to say about self-harm causes and functions (225-245; 233-237; 249-257; 309-317; 331-336). Support/intervention she thought should focus on recognising that people are all different. Carers should not over-react (367; 377-382; 384-402; 404-408; 417-419). Some of the data in this transcript also contributed to the theme of 'contradictions or dilemmas' (176-179; 180; 194-195; 217-227; 257-258; 260-265). By collecting together extracts from the transcript (as partially identified in the above line numbering), Ellie's words provided their own synoptic story.

Ellie's own synoptic story: *"...Perhaps if I was a self-harmer I'd find it useful to find out what other people's experiences are like...I probably see myself in the non-self-harmer* [category] *edging slightly towards, you know, maybe I don't look after myself enough...I don't smoke at all. I drink but I drink moderately...If I go to a pub, I'd probably have maybe 2 or 3 glasses of wine...I never drive if I drink anything at all...I probably do drink more if I go to a club or something like that, but that's not very often. That probably would be classified as binge drinking, but I wouldn't consider myself to be a binge drinker...I think it is possible to be drinking till, even if it's unconsciously, you're harming yourself. But I think there are lots of reasons for drinking, and I think one of them is, almost like that tension thing, you're letting out steam. I suppose a culturally acceptable way of letting out steam, and I suppose that might be a form of self-harming. But...if you went out to the pub and said you had a hard day at work…went home and cut…people would be really shocked and upset and worried about you. But if you went into the pub and said, 'I'm going to get absolutely 'trollied' tonight. I'm going to have lots to drink', people would probably go, 'Excellent, I'll join you'……*

……...

I've got a friend and...she suffers from depression and...she said to me that she's not a self-harmer, but if you look at her finger nails she's got calouses and cuts from where she picks her nails...She's talking to you and she's picking and it doesn't matter what the conversation is. Whether she's quite happy…[or]*… animated, she's picking away…You can tell when she's stressed. She digs higher. She scratches up her fingers...It's...not what you'd usually call self-harm.....*

……

When I was…17, my 1st year of my A-levels, my appendix burst…at the beginning of the summer holidays...I lost almost 2 stone...At the end of it I was really skinny...So over the summer holidays…while I was just feeling ill, my parents were trying to get me to eat to build myself back up again 'cause I was going to start my A-levels in September...I'm 26 now, so almost 10 years ago…Looking back it almost became a slight psychological thing, almost self-harming thing...When I ate it made me feel uncomfortable. It made me feel sick…but there was something deeper to it as well...I was a bit nervous about going to 6th form and starting my A-levels, and I think I had in the back of my mind, 'Well, if I'm not well enough to go, I won't be able to go, and I'll just stay at home, and it'll be all safe here, and I won't need to start something new with all these new people, which is quite strange really 'cause I'm not [an] *especially shy person...I'm quite confident in these situations...But apart from that, I've never really thought of myself as a self-harmer, or that I've had any kind of eating disorder or anything like that...At the time, I just kind of thought, everybody is trying to make me eat, 'Oh just leave me alone. I'm not hungry. Leave me alone and I'll be fine, and just let me get on with it, and just let me have a bit of time to myself' ...My mum was so worried...Perhaps if she had left me alone, I would have come back round to it naturally, but perhaps I would have carried on and made myself*

ill…….

.....

I had a boyfriend, my first boyfriend actually…We were about 13 or 14, and…when we split up…[it] *was all traumatic and awful...He said to another one of our friends, 'Ahh, I'm going to kill myself. This is really awful'...I spoke about it to my mum and she said, '...He's trying to upset you'. But then, a week later, he came into school and he'd been cutting his arms…with the bits of insides of* [pencil] *sharpeners, the metal bits…My friend who told me was saying, 'K is just doing it for attention 'cause he's trying to upset you'...He'd just been wearing a short-sleeved shirt to school which he didn't usually wear… My friend… told me… her mum...had quite a dramatic experience as a child…She'd self-harmed and she'd tried to commit suicide...He* [boyfriend] *is doing it for attention, not like…* [her] *mum who's a real self-harmer...I think people self-harm for a whole variety of reasons...The boyfriend…I think he almost thought, 'Look how much pain I'm in. This is really bad'. My other friend's view was, 'Well, it's not that bad, look at my mum, she's had a really bad experience. You shouldn't be doing this to just try and get attention'...I think, because I knew him better…there must be something bigger going on...We did talk about it and he was finding things at school difficult, and his dad was a policeman… and I think he was a bit of a rebellious teenager, and he didn't get on very well with his dad, and he found that a very challenging relationship...What was said was: '...I can't believe you did that to yourself because of me'. And he said, 'It was not just because of you. I find things difficult'...I think there is an element of getting attention...I think it's very easy to make it sound superficial, that someone's trying to get attention... Attention more like, 'I would like someone to help me, I'm struggling'...But I don't think that's the case all the time…….*

……..

[Another] *friend…was on a teaching placement and was teaching year 5…One of the boys had got into trouble with the teacher...And he started having a temper tantrum and she* [class teacher] *went out to go and get somebody to help 'cause he was breaking things...And my friend was left alone…The little boy lifted his tee-shirt and started scratching himself across the stomach with some sort of stationery that he just grabbed off the desk and started cutting himself... I've never heard anything like that before or since……*

……..

I've got children with what might be called self-destructive behaviour… children who …get themselves into trouble for attention and… when they go home they tell things that happened at school that are not necessarily true...It made me think of the children I have in my class…of whether they are doing something that makes them unhappy almost intentionally...She [student-teacher friend] *said…that* [the boy] *had quite a difficult home life...That particular day it built up to, obviously, quite a dramatic thing…Maybe some kind of cry for help……...*

.....

There's the release of tension. You hear quite a lot of people saying, 'It makes me feel better'. And, I think, there's a slight, perhaps unconscious element to self-harm ...I used to think it was…deliberately harming yourself in almost a conscious way… because you're depressed or whatever...But now I wonder if it is. It can be a whole range of things...I wonder if it can be something that you're doing to yourself without even realising...I wonder if some people don't know where the tension's coming from...There's deeper psychological things…There's a lot of celebrities who suffer from bipolar...I wonder if there is a correlation with...almost an extreme personality…

If you do have that real focus in life to get your gold medal or publishing a piece of work or going on television, if you've got that kind of personality, perhaps...it lends itself to [self-harm]…….

……..

I think everybody can be helped in different ways...I think there's a certain element of wanting to be left alone...The forums on the internet, and the idea of people who have self-harmed in the past talking to each other, I think it's very easy to say, 'That's really negative, promoting it and things', but I think there is perhaps something to be said for the benefit of that. You're talking to someone who understands a bit of what that's like…".

3.36 **Kate**

Again the overarching themes were similar to the other participants (see Appendix Y, tables 6&7-14).

My synoptic story (about Kate): Kate was 21 years old (line 21) and had a number of jobs before finding work as a data controller (one day per week). This suited her part-time student status (103-122). She was bullied mercilessly as a young child in primary school due mainly to her size and inability to socialise (5-40). She did not have any direct experience of culturally unacceptable self-harming activities (126-139), however, had a close friend who was bullied, was a serious cutter, and subsequently abused alcohol and drugs (140-168; 189-195). Kate attributed some of her friend's CUSHAS to causes similar to her own CASHAS. Kate had repeatedly tried to stop nail-biting but unsuccessfully (47-51; 54-63; 66-68). Comfort eating was another activity with self-harming overtones in which she engaged frequently (68-85). She suggested causes of self-harming such as stress over meeting new people, worry about exams; and, functions of self-harming e.g. tension release or

substituting one worry for a different one (76-79; 80-82; 206-216). She talked about the differences between those traditionally seen as self-harmers and others (66-68; 225-240). In relation to support/intervention, she stressed that those who seriously self-harm must recognise what they are doing (232-240; 315-320); secondly, they need someone they can trust implicitly, and to whom they are able to talk freely on an equal basis (197-205; 332-347; 358-375; 379-405); and, thirdly, they must be given time to progress at their own pace (388-390). There were not many contradictions or dilemmas in our discussion though she commented on wanting/not wanting to stop self-harming, and, recognising/not recognising self-harming. By collecting together data extracts from the transcript (as partially identified in the above line numbering), her words provided their own synoptic story.

Kate's own synoptic story: *"...I was bullied a lot at school...I was…the chubby, out-group, teacher's pet…I got a lot of stick for my weight…At Primary school…I was an early developer…and I got some stick for that as well...It used to make me quite angry with myself…that I never did anything about it…I never really spoke to anyone about it. I didn't talk to my mum about it, or my teachers. I started to at Secondary school…I found that I had a more secure group of friends around me, so I felt more comfortable talking to them…At Primary school I was so in and out of friends…A lot of my friends moved school. Their families moved away. I had a lot of really good friends taken away from me at various times, and I had to start all over again with new friends…I could have included myself in what was going on but I felt more of a watcher than anything else…By the time I got to college I really started to get to know a lot of people……...*

.....

I've got one friend who's been a serious self-harmer for a while…She cut herself…

but she was bullied even worse than I was at Primary school…I don't know if that was a release of stress or tension...She was very, very quiet at Primary school. I guess she was a little bit like me…[At Secondary] *I think she was a lot more timid than she was making out to be. That was stressful for her, maybe to be somebody that she wasn't...But being so completely different to the way she was just like that* [snaps her fingers]*, I think was very, very stressful...She got over that* [cutting]*...I think her mum tried to get her to go to counselling……..*

.....

Then she started drinking, and right up until very, very recently she was a very, very heavy drinker. I guess she went from...a socially unacceptable to a socially acceptable form of self-harm. She suddenly had a big group of friends...She was going through…90 units a week...The drinking she spoke to me about a lot. It was just, 'Oh we went out again last night and I wasn't going to drink that much but I had this and this and this…'. It started off on the weekends and all of a sudden she was drinking every night of the week...Her and a friend would get together, and then she'd get together with another friend, and another friend…She'd make sure she had someone to drink with all week...I don't think [her mum] *was less worried 'cause... she still ended up in hospital for over-drinking……..*

.....

I found out very recently she was in hospital...for…drugs as well...That's the one thing that I didn't know about and I found out about much later...Every now and again, even when she was a heavy drinker, she and I would go out. And I'm not a heavy drinker. I'm too much of a lightweight to drink too much because I'd still like to be able to get myself home… I'm not loud or anything like that. I'm kind of the complete opposite……

.....

Nail-biting...I'm a really bad nail-biter...And it's something I've tried so many times to stop, and I can't do it...I don't remember not doing it...It gets worse when I'm worrying about something, when I've got an exam coming up…I do martial arts classes, and once a year we have loads of people come over...There are lots of new people that I'm going to meet and that worries me…They get a lot worse when I'm worried about something…It's not something I seem to be able to do very much about. I have tried. As soon as something stresses me out…I just go back to it [nail-biting]*…I guess it's painful sometimes but I still do it……*

……. .....

Ehmm, I think it [self-harming] *covers a multitude of things. I think it will be something different for each person…Biting my nails doesn't give me any relief from what I'm worrying about. It's just something I do when I'm worried...I'm a comfort-eater as well. I eat a lot more when I'm worried. And the problem I have when I stop biting my nails is that I eat more...And if I'm trying to lose weight, and I cut down on my eating, then my nails get worse. So the two seem to balance each other out so that I'm not doing too much of the one or the other. I guess I have two coping mechanisms, and if I try and take one of them away, the other one gets worse...I get some sort of, I don't know…not really a calming effect, I stop worrying about what I was worrying about and I start worrying about eating more than I should have done... And sometimes worrying about what I've just eaten isn't as bad as whatever exam I've got coming up. So I guess… it does provide some sort of relief...But I think from a…'liking myself perspective' it's not good...I don't think I need to* [bite my nails] *but I wonder if it's now just a habit...Like I say, I can try to stop biting them but I can't just stop. It doesn't seem to work 'cause sometimes I don't even seem to know that I'm*

doing it. I just find myself doing it…I've tried. The longest I've managed is about 6 months, and they've started to actually look really good but…then I broke up with my ex-partner…and that was it, just gone, all of them [finger nails]…*I've not really tried again since…It's hard. It's really, really hard*……...

.....

Food, I think, is something quite different...It's something you need to survive. You just can't cut it out altogether...The temptation is always there to have something I shouldn't have, or, to have more than I should...Biting…[finger] *nails isn't something that I should have to do to live. It's not something that's essential to my survival. But it's something I use to cope, obviously, if something stresses me out. I guess it's the same thing whatever your vice is, be it socially acceptable or not. You've got to be in a place where you want to stop...which is a difficult place to find…if you don't have the desire to stop, if you personally don't think there's anything wrong with it…You've got to want to stop...My mum was a nail-biter as well...Right up until she was about 38 she was a nail-biter. And then all of a sudden she decided, 'I'm gonna stop now', and she had false nails put on so that she couldn't bite them anymore… I did try to have false nails put on when my mum got married…But I can't actually have them put on because I've been biting them for so long that the…tops of my fingers actually are higher than the levels of my nails. And so the glue won't stick*……...

……

I've found that…with my partner…I can talk to him…We were friends before we got together…From the day we started talking, he's always been very open, and I've felt very non-judgmental towards me…I pretty much talk to him about anything now... absolutely anything that's worrying me, that's made me angry, whatever…And then I can move on from it...He's a shoulder to cry on…He'll show me a comedy clip or

something to make me laugh, and I'll feel I've had that release...I wouldn't talk to someone the way I talk to my partner if I felt that they were any way of a different power-relation…to me. I feel completely on a par with my partner, both… intellectually and everything else…And I think that part of the problem with therapy is maybe the feeling that this person is looking down on you...They're looking down on you as someone with a problem, and they're going to try and fix you. And I think that's a perception that needs to be broken...I think that's the problem with the "therapist" terminology…You're going to go to the doctor…and they're going to sort it out for you…And I think a lot of self-harmers don't think they've got a problem… And they reject…people telling them that they need to go and see a therapist...I think the biggest problem is the desire to want to stop...If the person doesn't want to stop, be it a peer group, a therapist, whoever it may be, you're going to struggle to get that person to really appreciate whatever help you're trying to give them 'cause they don't feel they need to change.....

……

Maybe moving people from a socially unacceptable self-harmer, particularly if they're really creating a danger to themselves, try and move them on to something that's less harmful to them...At the moment they're putting themselves in danger and you'd like to offer them an alternative. As opposed to, 'No, you just need to stop'. I think that's maybe a good way to go…I'm one to talk 'cause...I bite my nails. But I don't really have the desire to stop, and so I don't. But then...I don't think I'm causing myself any particular danger...".

3.4 Towards a new understanding of self-harm

I was struck by both similarities and differences among the data provided by the six participants, two of whom were seriously into CUSHAS (Martha & Nancy), three had

only ever engaged in CASHAS (Sharrie, Ellie, & Kate) though they knew about others who deliberately cut, and, one (Mattie) was the mother of a daughter ('G' aged 30) who had carried out CUSHAS for years while Mattie herself had struggled with CASHAS like over-eating, smoking, drinking, and choosing destructive relationships with male partners.

Categorising into non-self-harmers, mild/moderate, and severe proved to be unworkable. While four of the six participants did not classify themselves as *'self-harm survivors'*, all were able to see some behaviours in which they engaged as undoubtedly harming their bodies. All were able to talk about causes and functions of self-harm. All struggled to define self-harm which separated out a distinct group of '*real'* self-harmers, and, all made remarks which were at times contradictory, or at least highlighted dilemmas.

The beginnings of a new understanding of self-harming, I felt, were taking shape. I could see no value in calling it so many different names, such as: *'self-harm'* (Crouch & Wright, 2004), *'self-mutilation'* (Stanley, Gameroff, Michalsen, & Mann, 2001), *'self-injury'* (Crowe & Bunclark, 2000), *'self-destructive behaviour'* (Firestone & Seiden, 1990), *'aggression against the self'* (Parfitt, 2005), *'self-inflicted trauma'* (Taylor & Cameron, 1998), *'self-abuse'* (Weber, 2002), *'attempted suicide'* (Shaw, 2002), *'parasuicide'* (Kreitmann as cited in *The Psychologist*, 2013, p.171), *'wrist-cutting syndrome'* (Menninger as cited in Block & Singh, 1997), or, *'NSSI, non-suicidal self-injury'* (DSM-5, 2013). Over 35 years ago, Ross & McKay (1979) had already found no less than 33 terms in common use, a few examples of which were: *little or small suicide, attenuated suicide, focal suicide, autoaggression, deliberate self-harm, deliberate self-injury, masochism, self-assaultive behaviour, self-injurious*

behaviour, self-poisoning, self-punitive behaviour, self-wounding behaviour, symbolic wounding, and, *purposive accidents*.

I was also beginning to sense that a new definition was needed. Was self-harm: *'...a purposeful, if morbid, act of self-help'* (Favazza & Conterio, 1989), *"...the deliberate destruction or alteration of one's body tissue without conscious suicidal intent"* (Favazza, 1996, p.*xviii*), *'...behaviour that results, whether by commission or omission, in unavoidable physical harm to the self…'* (Turp, 2003, p.36), *'...deliberate damage to one's own body tissue without suicidal intent'* (Nock & Prinstein, 2004, p.885), *'...any non-fatal self-injurious act purposefully carried out regardless of underlying intent'* (Oldershaw et al., 2008, p.140), *"...self-poisoning or self-injury irrespective of the apparent purpose of the act"* (NICE, 2004), *"…non-accidental self-poisoning or self-injury…"* (Platt, 2011), *"...deliberately inflicting pain and/or injury to one's own body but without suicidal intent"* (Babiker & Arnold, 1997, p.2), *"...any act that causes psychological or physical harm to the self without suicidal intention, and which is either intentional or accidental"* (McAllister, 2003, p.178), *"...direct behaviour that causes minor to moderate physical injury, that is undertaken without suicidal intent, and that occurs in the absence of psychoses and/or organic intellectual impairment"* (Magnall & Yurkovich, 2008, p.176), or, '…*a wide range of behaviours with motives ranging from coping and survival to attempts to seriously injure oneself or even kill oneself*' (Hewitt, 2003, p.1)? Whatever else it might be, the topic of self-harm, I thought, fitted more correctly into ordinary human psychology than psychopathology.

My new name for self-harm was BODY self-harming (BSH). My new definition was beginning to sound something like: *"Body self-harm (or body self-harming) is behaviour which occurs when individuals, intentionally or unintentionally, give*

precedence to their mental health over their physical health by the process of damaging their own bodies". My preferred label *'BODY self-harming'* meant that the acronyms CUSHAS and CASHAS would become CUBSHAS ('B' for BODY) and CABSHAS. The next chapter will have more to say on these thinking-shifts.

3.5 Summary

Four of the six participants (Sharrie, Mattie, Ellie & Kate) were recruited via the Open University (3 students and one tutor). The other two (Martha & Nancy) were volunteers from a self-harm conference. The chapter presented an overview of themes and the synoptic stories derived from them. I eventually suggested that a new understanding of self-harm may be required, including a new name, and a new definition, and, that it may be as useful to turn to normal psychology as to abnormal psychology for further insights on this topic. The following chapter will discuss the analysis and findings in the context of previous research and clinical experience.

Chapter 4

Discussion

4.1 Introduction

In this chapter a discussion will take place of the analysis and findings from the main study in the context of my clinical experience, the initial pilot studies, and relevant self-harm research. A new name for self-harming behaviour, a new definition, and the beginnings of a new conceptual framework will be explored. Finally, a reflexive analysis will highlight how, as the researcher, I have influenced the process and the outcomes of this work. 'Error' and 'bias' are words more closely associated with quantitative, positivist research where they are seen as entities which should be controlled for, or eliminated. In my view, and the views of other qualitative researchers (e.g. Braun & Clarke, 2013; McLeod, 2001; Willig, 2009; Yardley, 2008), the presence or absence of 'bias' is not a valid way of critiquing qualitative research. Instead, by embedding reflexivity in the work, 'bias' can be put on display and become a useful part of the research. However, it is by no means easy to write well reflexively. Descent into the frivolous is a danger (Howitt, 2010). There is also a risk that reflexivity can become too much of a focus for the research (Rice, 2009). In my opinion, it is a risk worth taking.

4.2 Some additional comment on existing research and my study

While self-harm has been around almost since historical records began (Alexander, 1967; Rinpoche, 1975; Schiller, 1972), academic writing on the topic has not always been easy to share with a wider audience. For example, the first edition of Favazza's book *'Bodies under Siege'* (1987) was turned down by 15 publishers before eventually seeing the light of day. In the second edition, Favazza (1996) recorded the remarks of a number of those who initially rejected his work. One wrote that it was *'disgusting'*; another that it was *'a good diet book because he felt like vomiting whenever he tried to read it'* (p xv); and, there was an accusation by another that Favazza himself must be *'somewhat strange'* to pick this topic to investigate in the first place. However, at least one of his participants had no doubt about the value of the work: *'Thank you for the opportunity to express my feelings and for the attention you paid to my problem. I believe there is a larger truth at work in the riddle of self-harm which is important for society as a whole to penetrate. May you find the answers which you seek'* (Favazza, 1996, p.v). I noted the similarity of this remark to comments made by one of my own participants: *"...I would love to know what you find...It's something I wish that I, kind of, could carry on with you...I hope I may have said something vaguely sensible and useful for you...Thank you...".* (Kate, lines 452-453; 469).

Some researchers privilege the point of view of participants to the extent that their own voice is weakened, none more so than Maisel, Epston & Borden (2004) who worked mainly in the area of anorexia/bulimia. They wrote that *"...the real experts on problems are those people who experience them first hand...people who have lived through the problem and have the most intimate knowledge of it. These knowledges have been referred to as 'local', 'indigenous', 'experience-near', and 'insider', in contrast to 'expert' or 'professional' knowledges. We regard these local knowledges*

as more trustworthy than systemised professional knowledges...' (p.81). While I have previously written on the dangers of being too respectful to *experts* (Jamieson, 1995) I would not go as far as Maisel et al. (2004). Insider knowledge is not necessarily better than professional knowledge. It is different, and is being used more extensively than ever (e.g. Preston, 2014). I have tried to allow insiders to speak through the quotes I have presented. But they are, of course, *selected* quotes, *'selected'* by me. By merging knowledge from different sources my intention was to provide answers which were derived from the best of several worlds.

Studies of the knowledge, perceptions and attitudes of doctors and nurses in A & E departments (Law, Rostill-Brookes & Goodman, 2009) have revealed that those who engage in CUSHAS are viewed negatively and are treated less well than other service-users (Hadfield, Brown, Pembroke & Hayward, 2009). Evidence of poor treatment has been available from patients themselves for many years (Harris, 2000). The words of Mattie add further confirmation of this: *"For 'G'* [Mattie's daughter] *THE... NHS ...HAS ...DONE ... NOTHING* [said very slowly]*...except bad tempered nurses patching her up inadequately..."* (lines 356-358). And Nancy commented: *"…people who are providing support and services need to recognise that sometimes the way that they're responding to self-harm is a lot about their own anxieties, and their own needs, and their own fears, rather than about what's best for the person…" (450-453).*

The opinions of the general public on self-harm are less well-known and have only recently begun to be given much attention. For example, Newton & Bale (2012), studied individuals with no personal experience of self-harm and found that while cutting, burning and eating disorders were viewed as definitely self-harming, body modifications, piercings and tattoos were not. Their participants were mostly

sympathetic to people who were self-harming but they surmised that society's view as a whole was unsympathetic (Bale, personal communication, 2 August 2012; Newton, personal communication, 28 January 2014). Public perceptions were also considered in a study by YoungMinds and Cello plc (Talking Self-harm, 2012). A national sample of 2461 was selected to which were added participants from online forums and social media (Goodlad, 2013) in order to get a whole community view. The study by YoungMinds revealed that for many people self-harm was still a strange phenomenon e.g. *"It's very sad and everything, but I can't say I completely 'get it'; I mean, I couldn't do it"* (teacher, Talking Self-harm, 2012).

Chandler (2014) has outlined some of the media myths of self-harm such as: only young women engage in self-harming when in fact community samples reveal as much as 25% male; ever increasing numbers of people are doing it when a lot of self-harming is carried out in secret and attendances at health services therefore provide a distorted picture; and, it is mainly young, middle class white teenagers reacting to stress and bullying when the distribution is far wider than that. The need for practice-based evidence in educational psychology has been stressed by MacKay & Malcolm (2014) in relation to child abuse and protection, however, Warner & Spandler (2012), with a particular focus on self-harm, have called for new strategies across various professions for practice-based evidence. They wrote: *"…We identify three distinct problems with current dominant approaches to research in this area… Insufficient clarity about target issues, an overreliance on predetermined outcomes which prioritise behavioural measures (such as self-harm cessation) and an undue focus on treatment techniques…Research requires flexible, user-centred and practice-based methods, informed by a focus on principles instead of techniques… Traditional behavioural approaches to research can be enriched with*

more qualitative cognitive and emotionally based data…Such strategies provide thickened, meaningful and context-specific research which is more relevant…" (p.13).

My piloting work produced 8 themes (addiction, control, coping, depression, emotion regulation, anti-suicide, suicide, and miscellaneous). But by the time I had completed my analysis in the main study, alongside on-going reading of the literature, the number of themes had grown by at least another 11 (purpose in life, pain, punishment, attention-seeking, attacking to be attacked, unattractive / attractive, communication, cry for help, dissociation, someone to look after, manipulation).

4.3 Overview of theme discussion

Scrutinising the academic and practice literature on the topic of self-harm and finding numerous labels for the behaviour, and an equally large number of definitions, did not fill me with confidence that I would be able to find all of the answers I was looking for from this source. I wanted to find out as much as I could about self-harm and begin to answer some of my research questions (see chapter 2, section 2.1). Unlike some researchers who have fretted over the dearth of information on the topic, I found an abundance, much of it stemming from work carried out by people from different disciplines. Some of my questions such as the ones about functions of self-harm had already been tackled by workers like Babiker & Arnold (1997) who produced five categories of function, namely, 1) functions concerned with coping and survival (e.g. emotion regulation and present moment survival skills); 2) functions concerned with the self (e.g. to do with identity, who you are as a person, a sense of autonomy, control, being in charge of yourself); 3) functions concerned with dealing with one's experiences (e.g. traumas in childhood and/or adulthood related to sexual

abuse); 4) functions concerned with self-punishment and sacrifice; and, 5) functions concerned with relationships with others. Two years previously, one of these authors (Arnold, 1995) had already looked at the aetiology of self-harm as seen through the eyes of women *self-harm survivors*. She found that initial causes tended to consist of childhood experiences of sexual, physical, and emotional abuse and neglect, as well as loss, separation, bereavement, and having a parent who was ill or alcoholic. Adult experiences too were disclosed by these women to be causes e.g. rape, having an abusive partner, or, simply lacking suitable supports during periods of crisis in their lives.

I also came across assessment tools such as the FASM (Functional Assessment of Self-Mutilation) developed by Lloyd (1998) and used by researchers like Nock & Prinstein (2004). The FASM consists largely of different methods of self-harming (12) and different reasons for self-harming (22). A number of similar instruments can be found in Walsh (2012).

My overarching themes arrived at through analysis of the transcripts of the six participants were: (1) What self-harm is - CUSHAS & CASHAS; (2) Causes & functions of self-harm; (3) Support and intervention; and, (4) Contradictions or dilemmas. I will now discuss these overarching themes in the context of subthemes, themes and supporting quotes leading to answers to some of my research questions.

I identified subthemes (see Appendix Y, table 7) to be some of the 1st order codes which repeated themselves many times in individual transcripts, but not necessarily across transcripts. I considered themes to be clusters of subthemes which appeared across many transcripts. It might seem strange that I was making some use of

counting in the identification of subthemes and themes. However, as I have pointed out elsewhere in this thesis, I am comfortable with pluralism (Josselin, 2014; Josselin & Willig, 2014), triangulation (King et al., 2008; Tracy, 2010), and mixed methods (Mason, 2006; Mertens, 2005; James, 2013c) if they are in any way able to facilitate answers to research questions. However, as a mainly qualitative researcher and clinician, the maxim *"words should be weighed, not counted" (*McLelland, 1998, p.288) sits more comfortably with me. McLelland also noted that *"curious people ask questions* [while] *determined people find answers"* (p.71). On the subject of self-harm I was both curious and determined and not willing to ignore any potential source of illumination.

With regard to the first overarching theme (Appendix Y, Table 11) identified as what self-harm actually is, all six participants appeared to start off from the position that it is something quite different from the kinds of behaviour in which ordinary people would engage e.g. "...*My gut instinct was probably the stereotype of self-harm...cutting..."* (Sharrie, lines 42-43). Perhaps this should not be too surprising given that thinking on such matters will be determined to a large extent by the culture in which we live. We view things through cultural lenses (Bem, 1981, 1994; Hall, 2013). However, within the context of a brief discussion inviting exploration of what self-harm is, it was not long before each participant began to question just how different CUSHAS really are from CASHAS e.g. Sharrie continued: *"...After thinking about it kind of more...that stereotype…I don't do that. But then thinking about it, I'm smoking, I drink. I don't drink that often, but when I do, it's probably what would be called binge drinking. So I drink more than I should. So that's harming..."* (44-47).

There began to emerge a view that the kind of behaviour we all indulge in may not be significantly different from CUSHAS. Even when the terms culturally acceptable

and unacceptable were not used by participants, they were entertaining the possibility that behaviours like smoking, drinking to excess, nail-biting, over-eating etc. were variations of the same theme e.g. Kate said: *"...nail-biting...I'm a really bad nail-biter...I've tried so many times to stop and I can't do it...I don't remember not doing it...It gets worse when I'm worrying about something*...[JJ: So is that something you would categorise as self-harming?] ... *Ehmm, to a certain extent. I guess it's painful sometimes but I still do it..."* (47-51, 54-63). And, Mattie said: *"...One of my issues as you see is overweight...My weight goes up and down in this 4 stone band...My wardrobe goes from size 16 to size 22...I've done that pretty much all my life, and I would say that overeating…is a form of self-harm..."* (27-31). Similarly, the other three participants had this to say about what self-harm is:

Martha – *"...I'd scrub myself clean after my dad hurt me...I'd scrub myself till I bled...I used to exercise to the extreme and I would be shaking and falling to the floor...I'd starve myself to see how much I could live on...".*

Nancy – *"...Generally I would cut myself...that was the main thing...When I was younger I used to fast...I think it's probably kind of connected...".*

Ellie – *"...if you went out to the pub and said you had a hard day at work...went home and cut...people would be really shocked...I probably see myself in the non-self-harmer* [category], *edging slightly towards…I don't look after myself properly...".*

With regard to the second overarching theme (see Appendix Y, table 12) identified as the causes and functions of self-harm, I will deal first with causes and then with functions. In terms of personal knowledge and experience of CUSHAS, it is worth bearing in mind that the six participants divided roughly into two groups. The first group consisted of Martha who had been seriously self-harming for most of her life;

Nancy, who had been self-harming to a slightly lesser extent but whose general knowledge of the area was vast given that she was an advocacy worker for people with mental health issues; and, Mattie, who did not engage in CUSHAS but whose daughter 'G' had been self-harming for about 20 years. The second group consisted of Sharrie, Ellie and Kate, none of whom had personally carried out CUSHAS.

Looking firstly at the causes of self-harm, the literature is replete with likely causes which mostly stemmed from the distant past. These causes were not unlike the ones proffered by my participants, particularly, the ones with experience of CUSHAS. For example, Martha commented: *"...He* [dad] *tried to rape me...and I just flipped, and I don't remember anything. I just conked out the brain. I just shut off...Inside I was just screaming and screaming and screaming ..."* (78-81). Sexual and emotional abuse by Martha's father was identified as the origin of her self-harming which included trying to scrub herself clean till she was bleeding, cutting many different parts of her body, exercising to the extreme, starving herself to see how little food her body could survive on, and, overdosing on drugs. On the other hand, Nancy was unsure why she resorted to cutting e.g. *"...I think…it can be for different reasons at different times..."* (259). Nancy made no reference to trauma such as sexual abuse. She was 19 years old before she cut. Her parents separated when she was about 11 years old. The family home was not one where she felt able to verbally express how she was feeling. She said: *"...I think it's quite a long process to understand why you might be doing it* (143-144)*...My parents…in many ways… were not able to give emotionally to me…Quite invalidating of…experiences and… emotions and being allowed to express them..."* (375-379). A parent's point of view on causes was expressed by Mattie whose daughter 'G' was cutting: *"...I think a lot of the problem was when she was a teenager, and, of course, when she was a teenager that was*

when I left work and went to the university. And I think she found that quite difficult to cope with..." (338-340). 'G' had also been diagnosed with multiple sclerosis. *"...I'm not surprised that she feels really rubbish about herself. So I think it* [cutting] *was feelings of self-hatred..."* (236-237). The other three participants, with much less direct experience of CUSHAS, also had views about possible causes:

Sharrie – *"...I don't think she* [friend who cut] *had the kind of relationship with her dad that she wanted...She had a boyfriend at the time... but it was really one-sided…He didny really give her anything back..."* (179-180, 182-184).

Ellie – *"...My first boyfriend...we were about 13 or 14...when we split up...A week later he came into the school and he'd been cutting his arms..."* (198-203).

Kate - *"...I've got one friend who's been a serious self-harmer for a while...She cut herself ...ehmm...but she was bullied even worse than I was at primary school..."* (126-127).

Looking at the functions of self-harm (see Appendix Y, table 12), while there is no shortage of likely functions to be found in the extensive literature on the subject, my participants also had views e.g. Sharrie commented in relation to her friend that: *"...it* [cutting] *could possibly have been a kind of cry for help...I always just put it down to...a bit of attention-seeking, and just being a bit 'cookie'..."* (178-179; 189-190). Ellie tended to play down the significance of her ex-boyfriend cutting after their relationship ended: *"...He was just doing it for attention...not like* [the mother of another friend] *who's a real self-harmer..."* (220-221). The other participant without direct, personal experience of CUSHAS tended to emphasize the tension release aspect as a principal function. Kate said of her friend who went from cutting to alcohol to drugs: *"...There was still a need to have some release from whatever she*

needs a release from..." (177-178). The other three participants spoke about functions based on personal experience e.g. Martha said: *"...I'd cut myself off. I wanted to feel a bit of pain. It gave me emotion. I liked pain. And that might sound illogical. It made me feel I was alive 'cause I felt like I was dead. So I cut myself to feel alive. I didn't want to be hurt mentally. You could hurt my body but you couldn't get in here* [points to her head]*..."* (102-105). She dissociated as a way of distancing herself from sexual abuse and subsequently would try to re-unite her body and mind by cutting because the dissociation had brought its own problems. In contrast, Nancy remained open-minded with respect to what function self-harming served for others, but, for herself, cutting was *"...partly a way to kind of express that I felt frustrated and upset and angry and I thought if I did this then people would maybe notice and they would ask me about it so I think it was a kind of attempt to communicate how I felt..."* (91- 93). And, Mattie chose to focus on her own CASHAS when she commented on function. She said: *"...Towards the end of my marriage I was nearly 18 stone, and… that is BIG* [emphasising the word 'big']...*Well, when your belly comes down it covers all your genitals and you end up with an apron and it effectively goes: 'Look no way'...It's a way to make yourself not sexual, I think..."* (42-47).

With regard to the third overarching theme (see Appendix Y, table 13) identified as support and intervention, Mattie was particulary scathing about the lack of support from the NHS for her daughter. By way of comparison she described the private treatment 'G' was able to get through her employer's health insurance scheme as excellent: *"...She went to...a lovely place called the Cardinal Clinic in Windsor…It really, really helped her...Her psychiatrist, Shyvonne…she built up a really good, trusting relationship..."* (363-366). The NHS also faired badly in the opinion of Nancy, despite the fact that her mother was a GP. It was not until she went abroad that she

found any effective support: *"...I lived in Germany for a while and a therapist there actually showed an interest in trying to help me work out why I might be doing it* [cutting]...*Maybe it was just the fact that someone showed an interest..."* (163-167). Taking a genuine interest and being available to listen seemed to be such an important thing for all my participants. Martha said: *"...I've been around social workers all my life. The nicest one I ever had was Mr Highbodgiball. He was a black man…He listened. He didn't judge me. He was nice...I always remember that man for listening to me. He made a big difference in my life 'cause he listened to me…I've been to psychiatrists and all they ever said to me is: 'How's your sex life?'...They don't seem to listen. They have their own agendas..."* (500-509). Kate got a listening-ear from her partner: *"...I've found that, especially with my partner...I can talk to him…He's always been very open and, I've felt, very non-judgmental towards me…I pretty much talk to him about everything..."* (197-201). Ellie could see the value of peer support, even online, for example: *"...The forums on the internet and the idea of people who have self-harmed in the past talking to each other. I think it's very easy to say that's really negative, promoting it and things, but I think there is perhaps something to be said for the benefit of that…You maybe need somebody who's almost at your level..."* (384-392). However, Nancy was not convinced that a friend or partner or peer was sufficient: *"...I think I would find it very difficult to talk to a friend about it because people's emotions are very involved…and ultimately very: 'Look, just don't do that'. And I think it's very difficult to stop if you don't know why you're doing it in the first place. So to be able to talk to someone who is impartial…'How can I help you to unpick that and unravel that so that it makes sense to you?'…"* (172-176). It was only Sharrie who talked about taking a somewhat less tolerant and less supportive role. She said in relation to a friend who cut: *"...At the time I can*

remember being quite dismissive of it and going, kind of, 'Don't be so stupid. What are you doing that for? Get a grip' (176-178)*...It maybe was just silly teenage stuff...I never asked about it and I never thought she would want to discuss it* (198-200)*...I didny want to kinda go, 'Are you alright?' giving her the attention in case it escalated..."* (284-286).

With regard to the fourth overarching theme (see Appendix Y, table 14) identified as contradictions or dilemmas, Sharrie later revealed some ambivalence towards, firstly, the kind of support she should have offered her friend, and, secondly, what self-harm actually is: *"...We all as teenagers…talked about everything and told one another everything. There was obviously something that held her back… She… never spoke about it…Maybe I'm just excusing my own behaviour now but I think that's why maybe I did dismiss it as being attention-seeking rather than as being an underlying problem..."* (217-222). And, secondly, with respect to what self-harm actually is, Sharrie said: *"...I don't do that* [self-harm]. *But then thinking about it, I'm smoking. I drink. I don't drink that often but when I do it's… binge drinking..."* (46-47).

Alcohol featured in all six transcripts but contradictions or dilemmas were most evident with Mattie and Ellie. For example Mattie said: *"...I don't do alcohol at all..."* (95). But a few lines further on she said: *"...If I'm going out on the lash I can down a considerable amount to the point where I can't stand...It's like, 'I'm going drinking', so I would really drink..."* (98-100). And Ellie showed similar confusion: *"...I drink but I think moderately...If I go to a pub I'd probably have maybe 2 or 3 glasses of wine...I probably do drink more if I go to a club…but that's not very often. That probably would be classified as binge drinking...I think it is possible to be drinking till…you're harming yourself..."* (272-285).

Instances of contradictions or dilemmas on various themes could be found in other transcripts e.g. in relation to self-harming and pain (Martha), self-harming as communication (Nancy), and stopping/not stopping nail-biting (Kate):

Martha on pain and self-harming - *"...I've got pain in my body. I've got neurological pain. There's nothing they can do for it. I've got a broken neck...I get all the pain that goes with it. So I have pain, constant pain from my chest down. But I quite like that pain because it tells me where my body is, doesn't it? If I've got pains in my legs, I know where my legs are. It's only when another pain comes along, then I'll take a paracetamol or a drug. I'll not take anything for the other pain because my brain can cope with that pain...It's horrendous pain...It's…burning, like rods going through your legs, but I can cope with that. I can accept that pain. And this sounds really odd, it's quite an enjoyable pain. I feel like I'm here...I don't need to hurt myself anymore 'cause the pain is there constantly..."* (131-142).

Nancy on self-harming as communication or not: *"...It* [self-harming] *was partly a way to kind of express that I felt frustrated and upset and angry and I thought if I did this then people would maybe notice and they would ask me about it. So I think it was a kind of attempt to communicate how I felt…*[pause]…*It's definitely not about wanting people to notice...I think it's maybe been a way of, I don't know, if there can be such a thing, communicating with yourself, if that makes sense..."* (91- 100).

And Kate on stopping/not stopping nail-biting: *"...I'm a really bad nail-biter...And it's something I've tried so many times to stop and I can't do it...It's not something I seem to be able to do very much about. I have tried..."* (48-49). Yet, further on in our discussion she said: *"…I bite my nails but I don't really have the desire to stop, and so I don't..."* (405).

4.4 The beginnings of a new conceptual framework

Babiker & Arnold (1997) wrote that self-harm (they called it *self-injury)* is *"...a language which we as helpers are called upon to comprehend in all its meaning"* (p.144). But what is its meaning? What was I able to find from the literature, my clinical experience, the pilot studies, and the six main study participants who ranged from individuals with very little personal knowledge of CUSHAS to those with immense, in-depth, first-hand involvement?

The intensity and severity of self-harming behaviour seemed to be a factor for all participants. For example, in relation to her own self-harming, Nancy said: *"...I would tell myself that if I just used my finger nails* [to cut] *or something like that then it's less of a big deal..."* (82-83). And Ellie reported that her former boyfriend who cut himself was said by another friend to be *"…just doing it for attention, not like my mum who's a real self-harmer..."* (220-221). The father of a young person with an eating disorder (Maisel et al., 2004) captured quite well my own view when he wrote that self-harming is best seen as part of a continuum: *"I came to feel that we all 'have' anorexia to some extent. So I think of the person 'with' anorexia as just 'having' more of it than the rest of us"* (p.268). Self-harming is not something you have or do not have. It is something in which we all engage. However, some have chosen more, and some less, culturally acceptable ways to do it.

If we all harm our bodies, what is it for? What is its function? Some theories which sought to explain self-harming were covered in chapter 1, section 1.3. These included theories of self-harming as a symptom of mental disorder (or mental illness itself), psychosexual theory, dissociation/depersonalisation, interpersonal/ psychosocial explanations, suicide or attempted suicide, reductionist or biological level perspectives, environmental or behavioural theory, mood regulation, and cultural theories of self-harm. None of them was entirely satisfactory though I felt that

mood regulation theory and cultural theories of self-harm had possibly the most to offer by way of making the phenomenon more understandable. Relevant material on mood regulation from my participants included the following:

Martha – *"...I think self-harm is when you do something to your body...which hurts you or gives you a feeling of worth, a feeling of being there…When I was a youngster I cut my emotions off...I cut my emotions off because of what my dad did to me…I just became a blank sheet and that was the easy way for me to cope..."* (64-67).

Ellie – *"...I think it is possible to be drinking till…you're harming yourself. But I think there are lots of reasons for drinking and I think one of them is almost like that tension thing. You're letting out steam. I suppose a culturally acceptable way of letting out steam..."* (284-287).

Kate – *"…Biting my nails…get*[s] *a lot worse when I'm worried about something... It's just something I do when I'm worried. I'm a comfort-eater as well. I eat a lot more when I'm worried…The two seem to balance each other out so that I'm not doing too much of the one or the other. I guess I have two coping mechanisms and if I try and take one of them away, the other one gets worse...I stop worrying about what I was worrying about and I start worrying about eating more than I should have done...And sometimes worrying about what I've just eaten isn't as bad…It does provide some sort of relief..."* (54-82).

Nancy – *"...The last time that I was self-harming, what I really felt was that I wanted to do myself some damage because I deserved that...This is going to sound a little bit odd, but I think part of it is knowing that you can still do it, that you have still got that avenue open to you. So I think that was part of it…I think I felt that…I was really*

evil inside and if I was to cut myself open there would be all this black gunk coming out of me rather than blood…But I don't think that that's really the whole story..." (284-305).

And with self-harm, it never seems to be the whole story, as can be seen in the next few data extracts linked to sub-culture/culture:

Some of the participants were struggling to make sense of their own behaviour in comparison to that of people who engaged in CUSHAS. For example, Ellie initially described herself as a moderate drinker, then, after telling me a little about some of her drinking exploits, she said that she may be a binge drinker. She had no direct experience of CUSHAS, and pointed out that *"...if you...went home and cut... people would be really shocked and upset and worried about you. But if you…said, 'I'm going to get absolutely 'trollied' tonight. I'm going to have lots to drink', people would probably go, 'Excellent, I'll join you'..."* (288-292). On the contrary, Martha, who had extensive experience of both CUSHAS and CASHAS, appeared at times to lump them together as just something people did e.g. *"...My sister was a self-harmer 'cause, obviously, living in that same atmosphere…My daughter was one as well… cutting, you know what I mean...Mine was to get rid of my anger and the pain, with the scrubbing to make me feel fresh and clean. I felt clean and my body felt, like, brand new…"* (267-271). While *cutting* was certainly culturally unacceptable, *scrubbing* was too e.g. *"…The worst one was scrubbing…You make your body bleed to get rid of all the dirt off you and there's no dirt there…Always felt unclean, used, that kind of thing, and I hated that feeling, feeling dirty…"* (254-257). However, Martha also engaged in many CASHAS: [JJ: Do you see drink and drugs like self-harm or are they a different…?] *Yes…I think it's a shutting-off mechanisms. I think it's a mechanism to cover up…A lot of people drink to cover up…Sometimes it*

becomes an addiction…You can be with your pals on a Friday night and you're having a wee drink and then you go on to Saturday night and on to Sunday night and before you know it that craving sets in. It's like chocolate…you put it in the fridge with all good intentions, and before you know it you take another bit …And the same with alcohol…" (361-373). Other activities which Martha seemed to take to extreme lengths included sports: *"…I was the first woman…to play rugby for Scotland… I play it in the wheel-chair…"* (39-41); and, exercising to the point of complete exhaustion *"…My self-harm was extremism …I used to exercise to the extreme and I would be shaking and falling on the floor..."* (72-73); and, depriving herself of food for long periods of time *"...I'd starve myself too. I'd starve myself to see how much I could live on..."* (73-74).

William of Occam, a 14th century English logician and theologian, is credited with what has become known as Occam's razor. His Principle of Parsimony states that the simplest is usually the best. It is a heuristic (a rule of thumb) of good science. When competing hypotheses are equal in other respects, Occam's razor suggests that we choose the one which makes the fewest assumptions to explain the phenomenon in question. I have tried to take account of Occam's razor when considering theories of self-harm and have moved towards 'critical' but mainstream psychology and away from abnormal psychology and psychopathology in an attempt to explain my findings and produce the beginnings of a new conception of self-harming. By 'critical' psychology I mean an approach which takes a critical/evaluative stance in relation to the mainstream, challenges core assumptions, refuses to accept blindly taken-for-granted positions, and scrutinises so-called 'truths' about experience or subjectivity or the way the world is thought to be (Braun & Clarke, 2013). Novelist Isaac Asimov put it well when he wrote: *"Your assumptions are your*

windows on the world. Scrub them off every once in a while or the light will not come in" (The Week, 2014d, p.25).

The idea of what is *normal* and what is *abnormal* is not clear-cut, irrespective of whether the issue is dyslexia, dyspraxia, ADHD, ADD, schizophrenia, personality disorder or self-harm. There is no objective test that can be carried out on a urine or blood sample to identify viruses, germs or bacteria that could single out an individual as having one or more of these 'conditions'. Likewise a person's DNA, or chromosomes, or genes, or EEG patterns cannot simply be examined for anomalies which could then turn a label into a diagnosis. However, a number of diverse ways have been tried to distinguish *normal* from *abnormal* (Wood & Richardson, 2002). There is the *statistical* approach to do with how common a behaviour or psychological function is. The more people who have it, the more *normal* it is; the fewer people, the more *abnormal*. An obvious problem is that someone with, say, a very low IQ, could be viewed as just as *abnormal* as someone with a very high IQ in terms of frequency of occurrence. Secondly, there is the *medical* approach. This way of doing things is sometimes known as reductionist or biological. It proposes that the presence or absence of disease is what should explain *normality/abnormality.* A problem here is that very few psychological issues are ever traceable to organic disease entities. Thirdly, there is the *personal distress* approach which focuses on how much distress, dissatisfaction and general unhappiness an issue has for the individual. If, for example, a person's self-harming is not bother-some, the level of professional concern should be low and the behaviour should not be considered *abnormal.* And finally, there is the *cultural* approach which takes the view that behaviour, or 'other psychological functioning', which conforms to or contravenes cultural, social, or historical norms, values and expectations should be classed as

normal or *abnormal*. The term 'other psychological functioning', of course, takes us beyond observable behaviour into areas such as thinking and feeling and *mind* itself.

Littleton, Toates & Braisby (2007), in their comparison of different approaches to learning in psychology, have written that *"...cognitive psychologists believe...it is possible to describe what is 'in the head' (i.e. what is called the mind)..."* (p.189). However, like *normal/abnormal,* the concept of *mind* can be difficult to grasp, especially in the 21st century when few empirical scientists would support the notion of dualism which originated from the ideas of French philosopher René Descartes. He argued for a strict body-mind separation. Descartes maintained that there is a clear and absolute distinction between the brain and the mind (Braisby, 2002; Toates, 2007). Psychologists nowadays would rightly be somewhat sceptical of this dichotomy, but most of us are perfectly comfortable using expressions like *losing our minds*, or, *not being in the right frame of mind*, or, *having a mind to do something else,* or, *being in two minds about someone*, or, *changing our minds*, or, *making up our minds,* and so on. We seem to be referring to something going on 'inside our heads', something to do with our thoughts, and perhaps even synonymous with thought or feelings which may be derived from thoughts; in other words, something *top-down* as opposed to *bottom-up*.

The notion of *top-down* and *bottom-up* processing has come from the psychology of perception (Gibson, 1950; Gregory, 1966; Niesser, 1976) and has never, to the best of my knowledge, been associated with the topic of self-harm. Edgar (2007) has pointed out how each process contributes to our understanding of the world, our ability to make sense of it and our meaning-making in general, while Brown (2013) gives these processes a key role in what he called *"explaining the unexplained"* (p.868) . *Bottom-up* information is what comes *up* towards the brain from our senses

(vision, hearing, smelling, tasting, and touching), and *top-down* information flows *down* from the brain. What is already in the brain as stored knowledge makes its way down, having influenced any *bottom-up* sensory data received.

Top-down and *bottom-up* processing can, I think, be usefully linked to the ideas of the behavioural psychologist Hans Eysenck (1967). Coming from a biological perspective Eysenck (1998) based his personality theory on assumptions about differences between introverts and extraverts which he thought were to do with an under/over-arousal of regions of the brain such as the ascending reticular activating system. Extraverts were thought to be cortically under-aroused and therefore sought stimulation. Introverts were considered to be over-aroused and tried to avoid environmental stimulus-seeking. Introverts preferred a quieter, calmer and generally more peaceful existence (Thomas, 2007).

The zoologist Desmond Morris (1967) also referred to what he called *"the stimulus struggle"* (Morris, 1969, p.158) by which he meant the tendency of human beings (and other animals) to seek an optimal amount and quality of stimulation. He has given many examples of animals kept in unnatural conditions in cages who will engage in self-harm as a consequence of over- or under-stimulation coming directly from the environment (*bottom-up)* or from a creature's brain (*top-down).* Morris talked about stimulation being too weak resulting in animals trying to get to their optimal level by creating unnecessary problems which then have to be solved; or, deliberately over-reacting to what would normally be unremarkable; or, inventing novel things to do; or, responding in inappropriate ways to what might be barely perceptible in other circumstances; or, artificially exaggerating particular events. By way of contrast, if stimulation is too strong, in order to get to an optimal level, an animal might attempt to reduce the stimulation by lowering responsiveness to

incoming signals, or by changing stimuli in some other way such as replacing them with alternative experiences.

Seeking to find an optimal level of stimulation does not seem to me to be far away from the idea of *experiential avoidance* (Clarke et al., 2012; Hayes et al., 1996; Kingston et al., 2010) or, as I prefer to call it, *experiential replacement.* These terms refer to how people try to avoid or replace distressing memories, thoughts, feelings, events or activities. It is a way of managing not only thoughts and behaviour but feelings as well, hence the close association with *emotion regulation*. The time may now be ripe for researchers and clinicians to look more closely at *experiential avoidance/replacement* and *emotion regulation* in relation to topics like self-harm, in both its culturally acceptable and unacceptable forms. This gap in the literature, I believe, is only now beginning to be partially filled.

The *stimulus struggle* idea of Morris (1969) is not unlike the *cortical arousal* of Eysenck (1967), the *experiential avoidance* of Clarke et al. (2012), the *bottom-up* and *top-down* processing of Neisser (1976), and, the physiological mechanism of *homeostasis* first described by Walter Cannon (1932) in the early 20th century. *Homeostasis* is a physiological term which literally means *"near to standing still"* (Toates, 2007, p.237). Various body mechanisms come into play to seek an equilibrium that allows the organism to operate optimally. This happens for temperature, thirst, hunger, sleep, sexual needs, sugar levels in the blood, and so on. The mechanisms are usually internal but have external components in the form of sweating, or by engaging in simple behaviours like taking on and off clothes. There appear to be quite narrow parameters within which the human body tries to remain. It operates in such a way as to make it possible, in a physiological sense, to comfortably deviate only slightly from a specific range of values. Moving from

physiology to psychology, there is also something called *risk homeostasis* (Edgar, 2007; Wilde, 1982) where it has been suggested that people seek to maintain a perceived level of risk by, say, driving fast cars, engaging in extreme sports, climbing dangerous mountains, or perhaps even self-harming in culturally acceptable or unacceptable ways.

Perceptual control theory developed by William T. Powers in the 1960s and 70s combined organic systems with social science (Powers, 1973). In essence he believed that human minds and behaviours were *"...signs of conflict between underlying layers of homeostatic control systems within the nervous system"* (Mansell, Tai & Carey, 2013, p.549). One of the central tenets of Power's theory is that behaviour is actually about the control of perception. People (and animals) do not actually control their behaviour as such. Instead they vary behaviour to control their perceptions which in turn will have an effect on behaviour. The human being is viewed as a *control system*. Specific internal mechanisms and basic physiological variables such as body temperature, hunger, thirst and sleep are only a part of this control system. When required, a person's behaviour is used to aid and abet these processes. An individual's physical and mental well-being is therefore determined, at least to an extent, by how successful he/she is at staying within unique optimal parameters. The regulation/control of perception is greatly assisted by behaviour and by cognitions (Abbott, 2013).

Control was a theme which featured in my pilot studies, literature searches, and in the transcripts of all participants in the main study. For example:

Martha – *"...I'm a very fit person. I've always been fit. I'm controlling about my food. I'm controlling about my exercise. I'm controlling about*...[pause]...*I'm quite a*

controlling person. I need everything in its place…Somebody has come in and re-arranged things. It's my control. I start to feel I want to hurt myself. I want to punch myself… And I get…really angry and aggressive (118-126)…*As I said before, I'm a kind of control person…" (159-160).*

Nancy – *"...I wouldn't like to say that if I had a really, really low period again that I wouldn't self-harm because I don't feel that I have the same level of control in that situation* (78-79)*...At other times it's been a kind of release of emotion, or it's been about gaining control, so it's been about different things at different times* (115-117)*...This is going to sound a little bit odd, but I think part of it is knowing that you can still do it, that you have still got that avenue open to you* (287-288)*...I don't really like being out of control… I've never been a big drinker and I've never taken any drugs. I really don't like that idea at all…I wouldn't know what I was doing. To me these aren't ways to gain any sort of control...They're not things that would be helpful..."* (323-327).

Mattie – *"...I find a lot of girls from the Asian community, underneath their layers and layers of salwar kameez and God knows what else, they have no control over anything. They go to school in a Western environment and they want to be Western girls, and they are so restricted, and they are so pressured, and it is the only thing that they have, you know,* [control of]*..."* (168-173).

Whether it is culturally acceptable or unacceptable self-harming, in my view, it makes no sense to call behaviour which damages the body simply by the name *self-harm.* Nor is it satisfactory to call it self-injury, self-mutilation or any of the dozens of other names which have been used (Ross & McKay, 1979). As Favazza (1996) has pointed out, it is mostly an act of self-help. It is *hurting to heal* (Hurting to Heal,

2013a; 2013b). People do it to make themselves feel better and to assert some kind of control. They cut themselves or burn themselves or punch themselves in order to create another kind of experience (experiential avoidance/replacement). It may be another kind of pain, an external pain which can be controlled more easily than an internal, emotional pain. The internal pain seems to be out of control. Some kind of homeostasis is being sought. The most appropriate name, in my opinion, is therefore *body self-harm* or *body self-harming* (BSH) to be contrasted with body self-care. It is not self-harming in a general way. It is obviously not body self-care either. It is *mind self-caring*, but caring for the mind by hurting the body.

There will be researchers and clinicians who may think that the expression BSH has weaknesses. It could be criticised, for example, for being too broad. However, this problem could be overcome simply by introducing innumerable variations to identify specific types of self-harming e.g. in the culturally unacceptable category (Western European culture) we could have BSH (cutting), BSH (overdosing), BSH (burning), BSH (punching), BSH (anorexia nervosa), BSH (bulimia), and so on. In the culturally acceptable category we could have BSH (alcohol), BSH (smoking), BSH (obesity), BSH (over-working), BSH (cosmetic surgery), BSH (piercing), and BSH (tattooing) etc. CUSHAS should then be changed to CUBSHAS (Culturally Unacceptable Body Self-harming ActivitieS) and CASHAS to CABSHAS (Culturally Acceptable Body Self-harming ActivitieS).

There would be no need to insist, as has been done by some experts in the field, that attempted suicide or suicide are, or are not, self-harm, which is one of a number of concerns with self-harm research identified by Warner & Spandler (2012). The expressions BSH (attempted suicide) and BSH (suicide) could be used with a fair degree of accuracy. It has always seemed rather strange to me that some of the

literature has either insisted on a complete separation of self-harm and suicide, or has treated them as one and the same thing. Many individuals with lived experience of self-harm continue to insist that their self-harming is anti-suicide. It is a coping mechanism which prevents them from killing themselves. However, those who separate self-harm and suicide entirely are left with the anomaly that previous self-harming is more common among people who commit suicide than others (Royal College of Psychiatrists, 2010; Walsh, 2012). Ryan et al. (1997), for example, estimated that about 18 times as many people will go on to kill themselves if they have previously engaged in CUBSHAS, and, NICE guidance (2004; 2011) has reported that those presenting themselves with BSH at A & E hospital departments in the UK are 100 times more likely to eventually end their own lives.

Many of the existing definitions of self-harming in the literature exclude attempted suicide and suicide. This cannot be correct. In a sense, suicide is the ultimate form of BSH since a person's life is lost. However, Martha saw a clear difference: *"...Self-harm to me is something you do to your body. When you try to take your life, that's you giving up. That's you accepted that that's it, the end…'I canny cope with life. I just don't want to be here anymore'. Whereas when I'm self-harming…it's to give me some emotion back..."* (175-178).

One example of a self-harm definition, among many, that excludes suicide is that of Babiker & Arnold (1997): *"...An act which involves deliberately inflicting pain and/or injury to one's own body but without suicidal intent"* (p.2). In contrast, an example, again among many, of a self-harm definition, that incorporates suicide is the one by Hewitt (2003) who wrote that self-harm includes behaviour *"...with motives ranging from coping and survival to attempts to seriously injure oneself or even kill oneself"* (p.1). However, with the change of nomenclature which I am suggesting, there is no

need to have the debate in the first place, just as there is no need to agonise over what is culturally acceptable body self-harm and what is not. Decisions on support and intervention can be taken on the basis of the levels of distress experienced by the individuals concerned.

The words *deliberate* and *non-accidental* have also caused me some difficulty in self-harm definitions. NICE (2011), for example, recommended dropping the word *deliberate*.The term *deliberate* self-harmer is unpopular among those with lived experience of self-harm because they feel that it over-simplifies BSH and implies more attention-seeking and manipulation than is warranted. There can be a whole range of causes and functions. Nancy was especially strong on this e.g. *"...At different times it's been for different things but maybe not at the same time... People felt that it was very, very hard to define self-harm, and very hard to specifically pin down why people were doing it…I think that for some people it maybe just has one function but for other people it can have more than one function…"* (113-114; 116; 120-122). And while the adjective *non-accidental* was not used in many descriptions, Platt (2013) could only accept the NICE (2004; 2011) definition that self-harm was *"…self-poisoning or self-injury irrespective of the apparent purpose of the act"* if the word *non-accidental* was inserted. In his view self-harm was *"non-accidental self-poisoning or self-injury irrespective of the apparent purpose of the act"* (personal communication, 1 March 2013).

Since I have provided a new name, *body self-harm* or *body self-harming* (BSH), it would now seem reasonable to formulate a new definition. In my view, the literature definitions do not take sufficient account of all the available data. Nor do they deal with short-term benefits versus long term deficits of hurting one's body, or the notion of *hurting to heal* which suggests that there is a trade-off whereby the body is hurt in

order to heal the mind (Hurting to Heal, 2013a; 2013b), or the stimulus struggle (Morris, 1969), or top-down versus bottom-up processing (Edgar, 2007), or arousal levels (Eysenck,1998), or homeostasis (Cannon, 1932), or experiential avoidance / replacement (Kingston et al., 2010) or behaviour as the control of perception (Abbott, 2013). In brief, my responses to the research questions are as follows:

1.*What meanings can be extracted from data on self-harm provided by individuals (a) who consider that they have never self-harmed; (b) who have mildly or moderately self-harmed; and, (c) who have seriously self-harmed?* The categories (a), (b), and (c) turned out to be rather spurious. No individuals were able to say convincingly that they never ever harmed their bodies. Most of us do not kill ourselves, though we might die more quickly than nature intended by not looking after our bodies properly. However, about 6000 people in the UK each year do wilfully end their lives (Samaritan, 2013). This is similar to the 12 in every 100,000 of the US population who kill themselves (Walsh, 2012). But all of us, whether in culturally acceptable or unacceptable ways, harm our bodies to some extent. It seems to me that our *minds* are frequently given priority. We hurt our bodies in the process of soothing our minds. How *'we think we feel'* is more important to us than how well our bodies are actually looked-after. The humanistic psychologist Abraham Maslow (1987) is re-nown for his hierarchy of needs. He started from basic physiological needs at the bottom such as food, drink and sleep, rising to safety needs, then the need for love and belonging, then esteem needs, and finally to the need for self-actualisation, to be all one is capable of being, at the top (Cohen, 2013). Perhaps he got the hierarchy completely the wrong way round. It may be that top-down needs are more important to us than bottom-up ones. For example, human beings have been said to be able to live for about 40 days without food, 10 days

without water, 7 minutes without air, but only a few seconds without hope. I think I now know what this means.

2.*Can personal and epistemological / functional reflexive analysis add value to a qualitative study of self-harm?* Throughout this thesis I have sought to be reflexive in my approach, and, in addition to writing in the first person, I have produced separate reflexive analysis sections. One of the distinguishing features of qualitative as opposed to quantitative work is that a researcher is expected to be as explicit as possible about what he/she has brought to the table in terms of values, relevant past experiences, and particular ontological, epistemological and methodological leanings. I have consistently sought to do this in a way which has, I believe, added value to this qualitative study.

3.*Do reflections on the process of being a student on a taught professional doctorate contribute to the overall credibility of this type of study on self-harm?* In addition to on-going and pervasive reflexive analysis being built into my work, I have tried to incorporate a series of reflections on the process of being a student on a taught professional doctorate. It did not feel like a culture shock when I took on the role of student after many years in other roles (e.g. part-time OU associate lecturer; head of education of a residential school; principal psychologist etc.). Instead, it felt like an exciting challenge, very much in line with my views on the value of lifelong learning and continuous professional development. The way I was allowed, and encouraged, to develop the DEdPsy assignments from 1 to 5 on one topic made it easier to chart the process and progress of the research. This provided yet another context for understanding how and why I arrived at my conclusions on self-harming.

4.*What is self-harm from a phenomenological and functional point of view?* By '*phenomenological point of view'* I was referring to the personal experiences of individuals and their perspectives on the world. I was hoping to sample my participants' psychic reality, subjectivity and meaning-making, rather than objective reality. And by '*functional point of view',* I meant the function the BSH had for each person. What was its purpose? What did it do for the individual? I interpreted data from brief incursions into the worlds of my participants as saying that, from a phenomenological stance, even if people had favourite ways of engaging in BSH, they tended to fall into using particular methods almost by accident. Some individuals could switch from one to another virtually at will. Others had gradually found some behaviours becoming a habit, even addictive. Some body self-harming behaviours were culturally acceptable and others were not. It was largely a feeling thing. Body self-harming individuals did not value their present state of mind (and feelings associated with that), and wanted a different experience. It was therefore easy to see how experiential avoidance/replacement could feature both as a self-medication hypothesis (Khantzian, 2013) and as part of a support and intervention package. As far as body self-harming functions were concerned, though BSH was multi-functional, it was carried out primarily because it was easier to deal with a self-created, self-controlled external pain than an out-of-control, internal, emotional pain. The attack on one's own body produced an external pain over which there was some control, while an internal emotional pain often felt as if it might take over, or even destroy, a person's life. The new name of BSH was required because the term *self-harm* was not meaningful as a description of behaviour that was essentially *self-caring* in relation to one's mind. My new definition has tried to take account of BSH being a balancing act. We all take part in the process of making sure that the needs

of our minds *and* the needs of our bodies are properly met. Mostly our minds take priority. Sometimes at the expense of our bodies. Short term benefits are prioritised over long-term deficits as in culturally acceptable tobacco smoking or in culturally unacceptable cutting. It makes no sense to me to talk about being a self-harmer or not being one. There is not a strict dichotomy, but rather a continuum from body self-care to BSH (chapter 1, section 1.313, diagram 2). The needs of the mind have overriding importance in determining where one is likely to be on this continuum. The new definition is therefore: *Body self-harm or body self-harming (BSH) is behaviour which occurs when individuals, intentionally or unintentionally, give precedence to their mental health over their physical health by the process of damaging their own bodies.*

5.*What implications might there be for support, intervention and staff training?* One of the overarching themes (referred to in chapter 3 section 3.2 Overview of themes; chapter 4 [this chapter] section 4.3 Overview of theme discussion; and, table 13 of Appendix Y) was called ‘Support & intervention’. There does not appear to me to be sufficient evidence to justify a different kind of support or intervention for individuals who engage in CUBSHAS from that which is available to those who engage in CABSHAS. And there is certainly no justification for the NHS, or anyone else for that matter, offering a less good service. Help should be provided on the basis of mutually perceived need, that is, what the client feels is required coupled with what clinicians believe is available and might be useful. This new conceptual framework will also have implications for staff training. More will be said later in the concluding chapter 5 (section 5.7) on support, intervention and staff training.

4.5 Final reflexive analysis

Reflexive analysis has already been covered in chapters 1 and 2 (sections 1.4 and 2.5). The section in chapter 1 dealt with what reflexivity was about and why it was so important in qualitative work. Demetriou (2011, as cited in Braun & Clarke, 2013), the daughter of a gay father, put it well in her work on the experiences of adult children of LGBT parents when she wrote: *"...it was difficult for me not to see the participants' stories through the lens of my own personal experience"* (p.27). While I had never previously considered myself to be someone who self-harmed, I was able to document numerous examples of behaviour from past years that I might now consider to have been self-harming. For example, going to extreme lengths to try to get a suntan to attract the opposite sex while ignoring the dangers of skin cancer; behaving recklessly while playing professional football and sustaining injuries which at the time appeared to be accidental but might have been a way of coping with anxiety; using a motor cycle to get to work on bitterly cold mornings when a warm comfortable car was available; and, insisting on eating every item of food on my dinner plate, as well as leftovers from other people's plates, even though I was already satiated, ostensibly to avoid waste. All of these behaviours now seem to me as if they could have been putting the care of my mind before that of my body, putting mental health before physical health.

Section 2.5 in the methods chapter focussed mostly on my reflexive, reflective and procedural log (the research journal). It covered the *'story'* of my research from the early DEdPsy assignments on self-harm to the research proposal. It included extracts of tutor feedback received on these assignments, notes of sessions with my academic supervisor (3 of which were recorded and transcribed), comments on meetings with my *practitioner consultants,* and sundry items regarding on-going

learning experiences on the topic of self-harm, annual student progress panel meeting reflections, and so on.

There is an almost inevitability about a researcher becoming steeped in the subject matter, especially when a project spans many years. As I read more about self-harm I noticed that I was becoming more critical and evaluative with respect to what I was reading. However, there were times when it felt as if I was seeing self-harm everywhere I looked: in tabloid and quality newsprint, in peer-reviewed journals, and in the lives of clients/patients with whom I was having contact in clinical practice. BSH seemed to be all around me. It was as if my world was being viewed through a *self-harm lens.* I had, of course, heard of viewing the world through a *cultural lens* (Bem, 1981; 1994). I am now not quite sure that the world can be viewed in any way other than through a cultural lens. Life is lived in societies, cultures and sub-cultures which impinge on our perception and thinking.

Just how different my own life was from that of some others was brought home to me on the 2nd of January 2013 while sitting in a Costa Coffee shop in Kilmarnock with my wife, two grown-up children, and two grandchildren (Jamieson, 2014a). It was mid-day. A young couple sat across from us, near enough for me to be able to observe them, but not sufficiently close to actually hear what they were saying. At one point the young man pulled up his shirt and revealed a tattoo above his right hip. It was leaking. He took a Costa Coffee napkin and carefully dabbed around the tattoo. A Christmas or New Year gift perhaps? I guessed he was not as taken aback by his behaviour as I was. I do not have any tattoos, not even a small, neat, aesthetically pleasing one discretely inscribed on a part of my body hidden from public view (see chapter 1, section 1.34). How times have changed!

Car journeys to and from the Open University in Milton Keynes (necessary as part of my duties as an associate lecturer and tutor) and similar but shorter journeys to and from Newcastle University during DEdPsy teaching days, or for supervision, were times for reflection on my research. Some of these reflections found their way into my reflexive, reflective and procedural log (Jamieson, 2014a). For example:-

(a) *'Tiredness can kill. Take a break'* was a motorway sign I encountered many times on my journeys. Of course, I knew what the words meant. Drivers were being advised to take lots of rest periods to prevent accidents. However, on reflection, tiredness itself has never killed anyone. Tiredness may make a person want to go to bed or fall asleep. Other things might kill us but not tiredness, at least not directly. Signs like this made me think of different levels of analysis in psychological research. Reductionism points to the lowest level of analysis as might be the case in a bio-psychological perspective. But there are many levels. My intention was to find the most appropriate one to answer the research questions I was posing. Realism, or even critical realism, did not quite capture my ontological, epistemological and methodological position, though Willig's (1999) attempt to take a critical realist approach to social constructionism was not too far away.

(b) Another message which temporarily confused me was a road sign on a stretch of the M74 motorway heading north, just before the England/Scotland border. It read: *'Edinburgh 94 miles, Glasgow 91 miles'.* But I knew from regularly travelling between Edinburgh and Glasgow that Scotland's two largest cities were about 50 miles apart. That road sign made them appear to be separated by only 3 miles (94 minus 91). How could this be? And, as if to reinforce the accuracy of the first sign, there was another one further into Scotland which read: *'Edinburgh 81 miles, Glasgow 78 miles'.* I may have chosen to do a qualitative rather than a quantitative project but I

could still work out that 81 minus 78 equalled 3. Eventually it dawned on me that one's perspective really is crucial. It depends, of course, on one's starting point. Commencing from either one of these signs and veering off north-west to Glasgow or north-east to Edinburgh, even though 50 miles separated the two cities, meant only an extra 3 miles to Edinburgh. Similarly, one's vantage point in psychology can dramatically affect how things appear to be. In relation to my self-harm research, I needed no further convincing that where I was starting from, my vantage points and perspectives, would inevitably impact on my findings.

(c) It is for good reason that I have called my work on self-harm a *research journey*. So many of the insertions in my log have been reflections on what took place during these *car journeys* between Scotland and England. As a final example, my journal notes reminded me that I would occasionally pass an Eddie Stobart distribution lorry. Sometimes I would stop at a service station for food and drink. At other times I would get stuck in traffic and gradually become quite expert at interpreting the advanced-warning signs across the carriageway which would say *'congestion'*, or, *'delays'*, or, *'long delays'*. However, I could not work out why I passed the Eddie Stobart lorry quite as often as I did, without ever noticing it pass me. Eventually I did work it out that there was more than one of these lorrys on the motorway, and while they looked identical, I was passing a different one each time. My *research journey* was somewhat like this. Sometimes it felt as if I was going backwards, or having to overcome the same obstacle again and again. These were, in fact, new obstacles, and often ones which were not really obstacles at all. By over-taking or overcoming them I was learning from experience and beginning to feel like a *real* researcher with a genuine contribution to make to the field of self-harm. As Eddie Stobart had many lorrys on the road, self-harm had many facets. I would eventually learn about lots of

them and be able to describe, analyse, compare and contrast, evaluate and interpret data until it was possible to make a small contribution to this area of study. By now I was able to fully empathise with Braun & Clarke (2013) who described the qualitative research process as *"...a recursive rather than a linear process*…[and one that]…*involves going sideways and backwards, as well as forwards, to reach the answers..."* (p.16).

4.6 Summary

This chapter 4 (Discussion) began with an introduction which set out my plans for discussing the analysis and findings of the main study. It looked at the findings in the context of existing research, and, an overview of these findings was examined by taking the overarching themes of (1) What self-harm is - CUSHAS & CASHAS; (2) Causes & functions of self-harm; (3) Support and intervention; and (4) Contradictions or dilemmas, and discussing them in the context of the subthemes, themes and supporting quotes which went some way towards answering the research questions. This was then followed by a presentation of the beginnings of a new conceptual framework for self-harm which utilised concepts such as *bottom-up* versus *top-down* processing, *stimulus control, homeostasis, emotion regulation, experiential avoidance/ replacement,* Eysenckian *arousal* ideas, and elements of the *perceptual control theory* of Powers. The new conceptual framework included producing another term for the phenomenon, namely, *body self-harm* or *body self-harming* (BSH) and a new definition which tried to take account of the self-help nature of BSH, and the need to balance *body* and *mind* elements. The chapter ended with some final comments on reflexive analysis to add to what had already been written in previous chapters. I made no apology for giving over as much time and space to reflexive

analysis / reflexivity. Whole books have been devoted to its overriding importance in qualitative research (Etherington, 2004; Finlay & Gough, 2003).

Chapter 5

Conclusions, and implications for support, intervention and staff training.

5.1 Introduction

This thesis embarked on a journey from the introductory chapter 1 on experiences of a professional part-time doctorate and attempting to answer the question 'what is self-harm?' to chapter 2 on method which looked at how comparing two published papers (taking a quantitative and qualitative approach respectively) enabled greater clarity to emerge about ontology, epistemology and methodology. This chapter also dealt with piloting work, the research questions, specific methods and procedures followed, and, the type of analysis employed. Chapter 3 covered the actual analysis and findings, and chapter 4 discussed the outcomes which included a new name for self-harm (BSH), a new definition, and the start of a new conceptual framework. Literature from many disciplines was used throughout the dissertation. Though reflexivity pervaded the entire write-up, reflexive analysis was the main focus in separate sections of chapters 1, 2 and 4. In "*big Q qualitative research"* (Braun & Clarke, 2013, p.4) as opposed to *small q* qualitative approaches (Kidder & Fine, 1987), reflexive analysis is meant to permeate the work from start to finish. Ethical issues were addressed specifically in chapter 2 section 2.4 though they too were an integral part of the study given the sensitive nature of the topic and the potential

vulnerability of some participants (Liamputtong, 2007). The final chapter 5 will now revisit the aims of the research, highlight evaluation and limitations, make further observations on method and analysis, and point out some implications of the study, including suggestions for support, intervention and staff training.

5.2 The aims of the research

By addressing the research questions using a qualitative methodology and a specially adapted form of thematic analysis, I was able to identify numerous subthemes, themes and overarching themes related to self-harm. The aims of the research were several-fold. First and foremost I was trying to find out what self-harm was while at the same time charting a qualitative path through a taught doctorate. The literature on self-harm was so diverse. Self-harm was called anything from self-mutilation to wrist-cutting syndrome to parasuicide. Eventually I settled on a new term for the phenomenon, namely, *body self-harm* or *body self-harming* (BSH).

To overcome possible criticisms that this new label might be viewed as too general, I pointed out that it can be made much more specific e.g. BSH (cutting), BSH (burning), BSH (punching), BSH (biting), BSH (gouging), BSH (overdosing), BSH (attempted suicide), BSH (anorexia/bulimia) etc., all of which belong in the culturally unacceptable group (CUBSHAS). Among the culturally acceptable group (CABSHAS) greater specificity could be obtained by using terms like BSH (alcohol), BSH (smoking), BSH (nail-biting), BSH (over-working), BSH (extreme sports), BSH (piercings), BSH (tattooing), BSH (cosmetic surgery), and so on. None of these labels need be used at all unless the behaviour is causing distress.

Previous definitions have almost been as numerous as the labels. I produced a new definition which seemed to me to capture more accurately what BSH was all about.

The new definition was: *BSH is behaviour which occurs when individuals, intentionally or unintentionally, give precedence to their mental health over their physical health by the process of damaging their own bodies.* Short-term gain is usually prioritised over the long-term position, though this is not always the case. For example, top sportsmen and women may repeatedly put their bodies through intense physical hardship in order to acquire a coveted prize that may be years away.

Secondly, I looked at the many causes of BSH. While the causes of CUBSHAS such as cutting or burning or punching oneself have been well documented in previous research, these causes have tended to be seen (wrongly in my view) as fundamentally different from the causes of CABSHAS. The latter are activities we all engage in from time to time. By exploring the views of those who engaged in either CUBSHAS or CABSHAS or both, I sought to tease out differences between the causes identified by those engaging mainly in one or the other. There did not appear to be many differences, save perhaps the emotional intensity and severity with which negative events were experienced by those in the former group. Events themselves are not necessarily neutral. They can range from severe child sexual abuse (e.g. Martha) to having no family forum to express emotions (e.g. Nancy) to romantic relationship break-ups (e.g Mattie; Ellie) to worry about exams and bullying (e.g. Kate). Subjectivity, meaning-making and one's interpretation of life events was obviously crucial. Chance too could play a part in how an individual attempted to cope e.g. one of my pilot participants (Lorna) was clearly suggesting that chance was a factor: *"…I was just sitting under the stairs at economics 'cause I didn't want to go to my class 'cause it was a writing class. I done that quite a lot - sat under the stairs. And it just so happened that a bit of my pen had snapped off. And then I just, don't know, I just started scratching and it felt a bit better…I was quite angry and I*

wasn't even aware that I was doing it until I had done it...". Also, a person's personality (Ó Súilleabháin, 2014) could have a part to play in the path taken for dealing with stressors. Ferguson (2013), for example, has suggested that in some cases personality is as good a predictor of early mortality as alcohol consumption, obesity, or social class. It seemed to me that multi-causal factors were the most likely scenario for BSH. While Favazza (1996) described one kind of BSH (the culturally unacceptable type) as *"acts of self-help",* I would describe all kinds of BSH as primarily acts of self-help. Perhaps part and parcel of what Kantzian (2013) called *the self-medication hypothesis.*

Another aim was to find out more about the functions which body self-harming served for individuals. While finding out causes was important, many causes originate in the distant past (e.g. child sexual abuse). Better support and intervention might arise from a greater focus on current functions which BSH serves. The functions of CUBSHAS have been well covered in the research literature, but, an assumption has been that these are distinctly different from the functions of CABSHAS. My small scale research study has challenged this assumption. There do not seem to be many *real* differences between the functions of CUBSHAS and CABSHAS. It therefore appears likely that we should be looking as much to *'normal'* psychology as to psychopathology and abnormal psychology for answers.

Other aims of the research were about trying to extract meaning from individual discussions with participants who had considerable knowledge of CUBSHAS (e.g. Martha, Nancy and Mattie); and, similar discussions with people whose knowledge of CUBSHAS was much less personal and direct (e.g. Sharrie, Ellie, and Kate). What struck me about the participants' subjectivity was that their *synoptic stories* seemed to be as similar as they were different. While some of the participants did at times

struggle with the idea that CUBSHAS and CABSHAS were more or less the same, none had much difficulty with the notion of BSH being on a continuum.

A final aim of the research was to see whether the work could shed any light on improving support, intervention and staff training. However, before this is looked at in more detail in a later section (section 5.6), some limitations of the present study will be considered.

5.3 Evaluation and limitations

My initial thoughts on reliability and validity conceptualised these concepts in much the same way as a quantitative researcher would. For example, I worried about the small scale nature of my project. There were only six participants. From a positivist perspective a small sample may indeed have been an issue, as would *replicability* and *generalisability*. However, since the study was qualitative and was concerned with exploring subjectivity and meaning rather than seeking objectivity and testing hypotheses, matters such as sample size, control, objectivity, replicability and generalisability were much less important. In fact, while writing chapters 3 and 4 there were times when I felt that six participants were too many. Having as many meant that I could not go into as much depth with any single one (Bowen, 2008; Clarke & Walker, 2013; Smith et al., 2009). Objectivity and the ability to generalise were sacrificed for an exploration of meaning-making and subjectivity. The strengths of quantitative work such as standardisation and relatively easy replication were therefore lost. But it is illogical to criticise an apple because it is not a pear.

Researcher *bias* may have been a contaminating issue given the kinds of relationships I had with the participants, and the way I chose to conduct the discussions and the analysis. However, it was argued earlier (chapter 4, section 4.1)

that *bias* or *error* are words more applicable to quantitative studies where efforts are made to eliminate *bias*. Many qualitative researchers have argued that the presence or absence of *bias* is not a valid way of critiquing qualitative research in the first place (Braun & Clarke, 2013; McLeod, 2001; Willig, 2009; Yardley, 2008). What some call *bias* can be viewed by others as a positive and essentially creative part of the study, especially when made explicit in reflexive analysis (Etherington, 2004; Finlay & Gough, 2003). As pointed out by Yardley (2008), rather than being detached experimenters, qualitative researchers are trying to *"...maximise the benefits of engaging actively with the participants…"* (p.237). In other words, being a participant-observer is not considered to be a source of contamination at all. Critical qualitative research tries to take into account broader social meanings, and interrogate data rather than simply accepting it at face-value. It delves into deeper meanings within data rather than accepting more obvious, superficial or surface suggestions of data (Braun & Clarke, 2013).

I have attempted to address some other possible limitations of this study. First of all, it may have been problematical to use only psychology undergraduates as participants. These undergraduates had all heard me speak on the subject of self-harm. They may therefore have been unduly influenced by my views and tried to tell me what they thought I wanted to hear, despite the fact that I repeatedly stressed that it was their views in which I was interested. However, I did draw participants from sources other than the Open University. I wanted to tap into the views of people from three groups: (i) those who considered themselves to have never ever self-harmed; (ii) those who had only mildly self-harmed or had done so in culturally acceptable ways; and, (iii) those who had seriously self-harmed, and in culturally unacceptable ways. This really meant that anyone could have met the criteria to be

part of the study. I therefore accepted anyone who expressed an interest in my research work, and took the first six volunteers.

It was a *purposive* sample (Patton, 2002) rather than just a *convenience* sample (Sandelowski, 1995), *purposive* in the sense that there was a good chance that all reasonably articulate participants would be able to produce some *"insight and in-depth understanding"* (Patton, 2002, p.230). I wanted to preserve the richness of data and to produce *'thick description'* (Geertz, 1973; Braun & Clarke, 2013, p.24). My intention was to tap into what complexities there might be in the topic of self-harm.

Like many researchers originally schooled in the quantitive paradigm, I had become accustomed to defining reliability and validity in particular ways. For example, the reliability of a test, or a piece of research, is to do with its accuracy and stability and how likely it is that a repeat measure would produce the same or similar results. Similarly, the validity of a test is about how well it measures what it is supposed to measure. A reading test should measure the ability to read, an IQ test should measure intelligence and so on. I could have addressed conventional views of reliability and validity: a) by inviting another researcher to blindly match quotes to a list of themes which I had already identified (inter-researcher reliability); b) by carrying out thematic analysis for a second time after a period of, say, a month away from the thesis (intra-researcher reliability); and, c) by asking participants to read over the findings in relation to their own data and subsequently provide a critique (Creswell, 2003). None of this was done for the following reasons.

I felt that importing notions of reliability and validity from a quantitative to a qualitative perspective would create more confusion than clarity. Braun & Clarke (2013) have

pointed out that something as apparently simple as *member checking* is fraught with difficulties. First, there is the difficulty of getting the participants to do it at all, as I soon discovered when I tried to keep my six participants (and other participants with whom I was not able to meet) involved by regular e-mailings about the work. Secondly, participants who do respond, and appear keen to critique the analysis, may very well have motives other than helping the researcher better understand the data. And, thirdly, participants may readily respond but be reluctant to disagree with the researcher's interpretations. In my work, *member checking* was therefore replaced with *member reflections* (Tracy, 2010) where I was not so much interested in participants validating my work as I was in keeping them contributing in whatever capacity they were comfortable. This meant regularly communicating to them that I was happy to have dialogue about findings, exchange questions and points of view, receive feedback, and generally collaborate at any level which appealed to them. All six participants received e-mail invitations to continue contact, as did over 30 other volunteers who were not video/audio recorded. However, on-going contact was somewhat disappointing. For example, I met Martha, by chance, in the town where I live and work. I took the opportunity personally to encourage her to remain in contact. So far she has not done so.

The terms 'reliability' and 'validity', of central importance in quantitative studies, are not, in my view, as useful in evaluating qualitative work. Lincoln & Guba (1985; 2013) have instead suggested terms like *transferability* as a better criterion. Transferability is demonstrated by providing *thick description* of *rich data* which is intended to make it easier and more acceptable for researchers to transfer the findings of one study into another context. Yardley (2008) has also identified a number of open-ended and flexible criteria for evaluating qualitative analysis. Among them were: *sensitivity to*

context, transparency, rigour and commitment, and coherence. Also, criteria have been suggested by Braun & Clarke (2013) that make up a triad of factors which they believe are apt for evaluating qualitative research: *coherence, resonating with readers,* and, *owning one's perspective*.

The limitations of my research into body self-harm should, I feel, be judged by the above criteria rather than by quantitive definitions of reliability and validity. However, of the various types of validity (congruent, concurrent, convergent, construct, ecological, external, predictive, discriminant, incremental, internal) which are primarily about whether research actually does what it claims to do, there is one which is very much relevant to qualitative working. *Ecological* validity in qualitative research is to do with how closely the meanings and interpretations are related to real life situations (Fine & Gordon, 1989; Goodman, 2008). And I have some concerns about this. With respect to my selection of supporting quotes for themes, and particularly my composition of synoptic stories using participants' own words, I was uncomfortable leaving out comments which I myself had made immediately prior to the words of a participant. There was a danger of depriving the reader of a proper *context* for each participant's remarks. Nevertheless, in the interests of brevity I felt this was necessary.

There is always a possibility in research of this kind that I, as sole researcher, would *not be able to see the wood for the trees*. Having two academic supervisors from the University of Newcastle was a great help in preventing this. Also, in order to further reduce the likelihood of blind spots, or becoming overwhelmed with data, I had asked Marie and Lorna (pilot participants) to provide additional supervision. They were invited to act as *practitioner-consultants* to the project and to comment on more

practice-based elements. I met with them on 5 occasions specifically to discuss my work. In turn they invited me to attend 3 conferences/training events on self-harm in which they were either trainers or key speakers. In one of these events I was also a contributor.

5.4 Further comment on method and analysis

It had been my intention to call participants *collaborators* or *co-researchers* to reflect that the project belonged to *'us'*. However, I underestimated how busy other peoples' lives were. While I was extremely grateful for participants' willingness to take part in this work, I found it difficult to secure a level of commitment that justified use of the term *collaborator* or *co-researcher.* All six participants left me in no doubt that, though they were happy to supply data, it was *my* research and I would be the one responsible for analysis and interpretation. Also, those who had agreed to take part but with whom I did not manage to meet individually proved difficult to motivate by e-mail. I would regularly send up-dates to all who had expressed an interest in being participants. Some responded, but most did not. Nevertheless, I would religiously record in the *Reflexive, reflective and procedural log* the few contributions which were sent to me.

While females generally outnumber males when it comes to BSH, particularly BSH (cutting), it was not my intention to deliberately select only females. The first pilot participant (Tommy) was male, and the second (Sheena), third (Marie) and fourth (Lorna) were female. By coincidence all six participants in the main study (Sharrie, Martha, Nancy, Mattie, Ellie, and Kate) were female. The literature, my clinical experience and the pilot work did not suggest that a participant's gender would significantly affect the data. However, had I realised at the time that none of my main

study participants was going to be male I may very well have taken steps to include males. Carrying out a similar study using some males would be worth pursuing in the future.

At the very beginning of the pilot work I put together a number of questions which formed the gist of a semi-structured interview. The trial with Tommy, an adolescent boy in a Children's Home, used a semi-structured interview which was not audio or video recorded. Likewise, my second trial with Sheena, a young woman in a low secure mental hospital, used a similar semi-structured interview which was not recorded apart from retrospective note-taking. Semi-structured interviewing felt stultifying and artificial. By the time I got to my third pilot participant (Marie) I was ready to try something else. I video-recorded the session with Marie and carried out a much looser, open, unstructured discussion, followed by transcription. With the fourth pilot participant (Lorna) I did the same. Soon after this, I began to video-record and transcribe my academic supervision sessions. These experiences were invaluable preparation for data collection in the main study which went relatively smoothly. However, having accumulated so much data, and experience, there might now be mileage in composing detailed semi-structured interview schedules for future in-depth work. Such interviews could further develop themes arising from the current study.

The procedures which I used in carrying out thematic analysis changed somewhat from initial piloting to final main study. No systematic analysis was used at all with Tommy and Sheena, the first two pilot participants. I merely tried to form an impression of what the data were telling me. With Marie and Lorna, the next two pilot participants, a deliberate attempt was made to thematically analyse the transcripts.

This formed an earlier DEdPsy assignment, and one tutor-marker wrote that *"…the data analysis was not easy to follow"* (Jamieson, 2014a, p.6). I therefore tried to learn from this in the main study. As well as being much more explicit about what I was doing while constructing themes from data provided by participants, I incorporated elements of other qualitative analytic techniques such as IPA and narrative analysis. In narrative analysis the story is the key unit, just as the theme is central in thematic analysis. Of course, one of the criteria of good thematic analysis is a coherent, interesting and believable story (Braun & Clarke, 2013). The author, John le Carré, was once quoted in *The Times* as saying that *"…'the cat sat on the mat' is not a story. But, 'the cat sat on the dog's mat' is the beginning of a story' "* (The Week, 18 May, 2013). My intention was not only to begin an interesting story on self-harm but also to produce a rigorous piece of systematic enquiry.

I produced what I called *synoptic stories* for the six participants, two for each participant. The stories were based on the overarching themes of *what self-harm is*, its *causes & functions*, *supports & interventions*, and, *contradictions or dilemmas*. The first synoptic story (for each participant) was produced in my words, and the second story was put together using quotations from the transcripts. One criticism I have of these second synoptic stories is that they were not sufficiently succinct. The original transcripts of 7,990 to 13,107 words were certainly reduced in size (see Appendix Y, Table 15), however, in future research I would like to see a further contraction with only minimal loss of richness and depth. After all, the essence of thematic analysis is to distil large amounts of raw data to a few core themes. While I succeeded in identifying four overarching themes, I felt that by producing such lengthy synoptic stories I was in danger of returning data to its initial form.

I had written (in chapter 2, section 2.6) that my intention was to graft elements of discourse analysis onto my analysis, just as I had incorporated parts of IPA and narrative analysis. However, it could be argued that by missing out quotes of my own comments and questions (appearing in the transcripts) from the synoptic stories I had done the opposite of discourse analysis, almost pretending that discourse had not taken place at all. One of the members of my DEdPsy progress panel in July 2013 had counselled against carrying out conversation analysis (which was his specialist area) unless I undertook training beforehand (Jamieson, 2014a, p.154). But I now think that a valid criticism of my work is that sufficient account has not been taken of the discourse/conversation which took place between me and each participant. This is another avenue worth exploring in future research.

In the kind of thematic analysis I did try to carry out, I could see similarities to what a college lecturer was trying to do while teaching her class biographical writing. She invited the students to use a maximum of six words to represent a good story. One of her students happened to be the writer, Ernest Hemingway. He wrote: *"For sale: baby shoes, never used".* Behind these words there is the potential for a poignant narrative. When I first heard of this teaching strategy, it reminded me that thematic analysis was a distillation of piles of raw data into a few fundamental features, in this case only six words. An entry in my *Reflexive, reflective & procedural log* (Jamieson, 2014a) indicated that I had shared the above with one of the many volunteers who had not made it into my main study group. She too had a fitting illustration of thematic analysis. She said: *"I used to belong to a small, exclusive religious sect called the Plymouth Brethern. There was a very devout spinster lady in the congregation who took an extremely high moral stand against just about everything, especially sexual infidelity. When she died, my friends and I thought of an epitaph:*

'Returned to God, unopened' " (p.35). Epitaphs too, it would appear, can be the layperson's thematic analysis.

I also wonder if sufficient time in my thesis has been devouted to discussing in enough detail the sub-themes, themes, and overarching themes which emerged from the analyses. 1st order, 2nd order and 3rd order codings, which roughly corresponded to subthemes, themes and overarching themes, were pregnant with meanings which could usefully have been explored further. First, the eight themes (addiction, coping, control, depression, emotion regulation, anti-suicide, suicide, and miscellaneous) which arose from the pilot work should have alerted me to the massive potential in this topic. They were an early sign that I could have formulated research questions around any one of them. The fact that I did not left my work open to the criticism that I had sacrificed depth for breadth. Secondly, though the main study threw up only four overarching themes, the number of themes from which these overarching themes were composed had grown from eight in the pilot work to at least 11 more by the time the main study was completed (purpose in life, pain, punishment, attention-seeking, attacking to be attacked, unattractive/attractive, communication, cry for help, dissociation/depersonalisation, someone (self) to look after, and manipulation). Perhaps greater breadth did allow me to attend to some fundamental issues such as providing a new name and a new definition. However, all of these themes were worthy of exploration in greater depth, and perhaps will be in future study.

Finally, while I have taken account of the principle of parsimony and Occam's Razor, I was not prepared to seek out simplicity for simplicity's sake. Study of the psychology of human beings throws up diverse issues such as identity and

personality, how we learn, sensation, attention and perception, systems of memory, video game violence, and, BSH to name but a few. Since psychology is defined as the systematic study of behaviour, experience and mental life, there are few areas outwith its ambit, and few uncomplicated answers to research questions in any of them. As pointed out by Ferguson (2014): *"If, as scholars, we truly wish to obtain sophisticated understanding of…influences on behaviour, we may need to accept that we will have to forgo big conclusions, frightening headlines, and moralistic pronouncements. As with much of human behaviour, things are much more complicated than that"* (p.327).

5.5 Potential implications of the study

Oscar Wilde was quoted in chapter 1 (section 1.31). He wrote in response to the much used expression *'the pure and simple truth'* that *'the truth is rarely pure and never simple'.* That things are not always what they seem is surely one implication of my research on body self-harm. Life can be complicated at times for all of us, and body self-harming (BSH) may be something we all do in some shape or form. We may have different reasons for doing it, have different functions for it, and sometimes not know what these reasons and functions are. We may even have different reasons and functions within the same BSH episode. With the benefit of hindsight, it is not surprising that one of the 19 themes was given the name *miscellaneous*. However, it was less predictable that one of the four overarching themes in the main study would be labelled *contradictions or dilemmas*. By this point in my research journey it might have been reasonable to expect fewer contradictions or dilemmas and a bit more clarity. Nevertheless, I did feel that there was enough clarity to help me wade through masses of different terms for self-harm and produce a new one which I called BSH (*body self-harm* or *body self-harming*). Also, having looked at the

numerous definitions of the phenomenon, and produced an alternative definition which sought to highlight the interaction of body and mind, I am now hopeful that the new name and definition will stimulate further research in the area. Future research may well take more account of the psychology of ordinary human beings and draw as much from normal psychology and typical human beings as it does from abnormal psychology and more atypical individuals. This could have implications for different approaches to support and intervention as well as altering key messages for staff training.

The point was made in earlier chapters of this thesis that I was dissatisfied with the support and intervention being offered to those needing help. For some children, young people and adults in distress nothing seemed to work very well. The next section will address this with a view to considering some new directions in which my research may now be pointing.

5.6 Support, intervention and staff training

One of my motivations for pursuing research in this area of study was to try to get a better understanding of what self-harm actually was, and subsequently find ways of working with people (who seriously self-harmed) which were more effective.

Specific strategies

I had tried a variety of practical self-harm behaviour management techniques including specific strategies such as: a) *the 5 4 3 2 1 technique* – asking those who engaged in BSH to name five things they could see at the moment, four things they could hear, three things they could touch/feel, two things they could taste/smell, and then to name at least one good thing about themselves, until the urge to self-harm dissipated; b) *the 15 minute rule* – inviting people to see how long they could resist

the temptation to self-harm; the idea was to avoid any self-injurious behaviour to the body for 15 minutes and then to gradually extend that time period; c) *putting elastoplasts or bandages on parts of the body the person wants to injure*, or marking susceptible areas of the body with red felt-tipped pen; d) *providing lists of telephone numbers to be contacted* such as the Samaritans (Samaritans, 2013) or the National Self-harm Network (www.nshn.co.uk); and, e) *harm minimization* – ranging from giving out first aid kits which people could use to dress their own wounds, to suggesting other ways of more safely causing pain to the body by, for example, wearing a rubber band round the wrist and *'pinging'* it against the skin, or, holding ice cubes tightly in a clenched fist (Jamieson & Haggerty, 2010). Nothing seemed to work well for everyone, and sometimes nothing seemed to work very well for anyone. Warner & Spandler (2012) have suggested that one of a number of problems with research work in this area is that it is too focussed on specific techniques rather than general practice principles.

Psychotherapeutic approaches

I was not expecting my research to find a panacea for all BSH. Nevertheless, there have emerged a number of pointers to potentially more fruitful ways of providing support and intervention. For example, time and time again the importance of relationships between individuals cropped up, perhaps not surprising given the centrality of positive relationships in all successful psychologist-client therapies (Arden & Linford, 2014; Page & de Haan, 2014). Poor relationships seemed to promote BSH and good relationships reduced it. Some examples of poor relationships and their effects:-

Sharrie: *"…She* [friend who cut] *did have a really difficult relationship with her dad...I don't think she had the kind of relationship with her dad that she wanted...She had a boyfriend at the time…but it was really one sided…He didny really give her anything back…"* (lines 177-182).

Martha: *"…I'd scrub myself clean after my dad hurt me and I'd feel dirty all the time. I'd scrub myself till I bled..."* (74-76)*. "…I still love my dad. My dad's my dad…I was quite lucky…He taught me all my sports…"* (192-194).

Nancy: *"…My parents both have mental health issues and I think in many ways they were not able to give emotionally to me…And I was bullied quite a lot in school… That kind of message that you're not good enough, you're not one of us, you're not allowed to join in...You get that message…"* (375-380).

Mattie: *"... Self-harming as far as relationships go I only ever meet complete bastards…I'm determined to stick with them even though they are only complete bastards…I've worked out that that's a form of self-harm...You sort of know this is a bad boy, don't play with this one. Well, then you do anyway…Is that a form of self-harm?...Well, I think it is..."* (115-121).

Ellie*: "…I had a friend, my first boyfriend…when we split up...he said to another one of our friends 'Ah, I'm going to kill myself…'…A week later he came into school and he'd been cutting his arms…"* (198-203).

Kate: *"…I've got one friend who's been a serious self-harmer for a while…She cut*[s] *herself…But she was bullied even worse than I was at primary school…"* (125-127).

By way of contrast, some examples of good relationships and their effects:-

Sharrie: *"...I enjoy spending time with my friends…Most of my friends now have got families* [children]*. So it can be very family orientated or I can also just go out with my friends and just relax, chat or whatever…"* (133-135).

Martha: *"...Now I wish people would get that into their heads, what children need is basic. It can be a mum. It can be a dad. As long as they've got that one person they can rely on…"* (428-430).

Nancy: *"…So I think now I'm in a stage where I feel it would be really nice if I don't do it* [cut] *again…I think that the emotional impact that it has on other people around me is such that I would really not want to…"* (70-72).

Mattie: [Talking about her daughter whom she believes will not 'cut' again] *"…She's now got the baby, and he's 13 months old…He's gorgeous…"* (306-310).

Ellie: *"…The forums on the internet and the idea of people who have self-harmed in the past talking to each other...I think it's very easy to say that's really negative, promoting it and things, but I think there is perhaps something to be said for the benefit of that…"* (384-387).

Kate: *"…Certainly for me, just having someone to talk to…And to have someone I can open up to about everything..."* (332-334).

Psychotherapeutic methods have not been without their critics over the years (Midlands Psychology Group, 2014). Some talking treatments have even been found to make matters worse (Moloney, 2013). Nevertheless, the *therapeutic alliance*, the relationship between worker and client, is undoubtedly powerful (Antoniou & Cooper, 2013). In brief, for a *therapeutic alliance* to be effective at least four factors should be present, irrespective of theoretical orientation of the therapist (Prever, 2015). First,

there is the ability of the therapist to transmit believable *hope-for-change* messages. Secondly, clients must be aware that there is *expertise* residing in the therapist. Thirdly, service-users should be provided with a *theoretical rationale* for their problems. And finally, the therapist must be able to demonstrate *accurate empathy*. These factors can, of course, be found to some extent in good relationships with non-therapists, friends and family.

Some individuals appear to have formed a habit of BSH, almost an addiction to it. Normally, for behaviour to become a habit, it requires to be practised. Habits usually take a long while to form. Solutions of any kind are therefore unlikely to appear overnight.

One example of a component of a number of therapies [including CBT (cognitive behaviour therapy), ACT (acceptance and commitment therapy), DBT (dialectical behaviour therapy)] which may have the potential to help people become more *body self-caring* (BSC) and less *body self-harming* (BSH) is *mindfulness.* This term is preferred by many psychologists to *meditation* (Bennett, 2014). Rather than simply a technique to be learned and applied, it is often considered to be a general orientation to life (William, Teasdale, Segal & Kabat-Zinn, 2007). However, though it is simple to carry out, it requires to be practised and to become a habit, one that may have to replace other habits to be successful. According to Christina Feldman (2004), it should not be looked upon as a 'quick fix'. She wrote that *'mindfulness is neither difficult nor complex; remembering to be mindful is the great challenge'* (Feldman, 2004, p.181).

Mindfulness involves paying attention to our actions, thoughts and emotions in a particular way. Key components of basic emotions (such as fear, disgust, anger,

anxiety, sadness and happiness) include beliefs, attitudes and thoughts as well as behaviours and body sensations. We all have emotions and need to manage or regulate them in some way. Emotions are *normal*. It is the intensity of these emotions which may be problematic. BSH would appear to me, from a practical and theoretical point of view, to be *normal*, though some types of BSH are culturally more acceptable than others. It is the CUBSHAS which have been presented as *abnormal*, and my research work, I believe, has begun to challenge this. Experiencing, say, sadness (depression) or anger, or any other emotion interpreted as unpleasant, is not *abnormal* in itself (Hayes et al., 2003). It is the severity and intensity of emotions and how we react to them, and to external events, which is central. Ordinary sadness, for example, can easily become *'malignant sadness'* (Wolpert, 1999), otherwise known as clinical depression, just as CABSHAS can become CUBSHAS and vice versa.

There is evidence to suggest that mindfulness, greater *awareness*, or, *consciousness,* or *'being in the here and now'* on a more frequent and regular basis has restorative power (Tolle, 2011). Humanistic psychologists have long been promoters of such a view (Rowan, 2001). Mindfulness is not so much an alternative to critical thinking as it is a way of attempting to make sure that individuals have the balance of thinking and sensing, top-down and bottom-up processing, operating optimally in their lives. Too much thinking and not enough sensing may lead to poor mental health. Fritz Perls, the originator of Gestalt therapy, stressed that it can be therapeutic to *"lose your mind and come to your senses".* It was Perls' motto (Stevens, 2007, p.210).

I wonder, however, if the opposite can also be true, namely, that some people engage in too much sensing and not enough thinking. Only recently has it been

highlighted that *mindfulness* may have its downside by making some people less stable (Booth, 2014; Rocha, 2014). Treating the body like a barometer and listening too intently to its messages may sometimes cause as many problems as it solves. I would therefore have some misgivings about assuming that everyone can benefit from *mindfulness*, especially those with a tendency to hypochondria. The comedian, Tony Hancock, was well known for having mental health problems, including various psychosomatic conditions. The Week (2014b) humourously quoted him as shouting in mock despair: *"Hypochondria is the only illness I don't have!"* (p.23).

Neverthless, proponents of mindfulness advise the cultivation of just *'being'*. Many of us, it has been suggested, dwell too much in the past, or worry too much about the future. Being more in the present, in the *here and now,* at least for short periods, and developing a greater awareness of ourselves through paying attention to the senses (vision, hearing, smelling, tasting and touching), one at a time, is advocated. Could it be that BSH, say BSH (cutting), is an attempt, albeit a poor attempt, to be more in the present and to be more aware and in control of what is entering the body via the senses? More bottom-up and less top-down processing, and therefore a shift in the balance?

Mindfulness has been used in a preventative way with all sorts of people, including children (Iyadurai, 2013). The idea is to purposely attend to one thing only. This one thing could be one's own breath, or the flame of a flickering candle, or the texture of a raisin, or a repetitive sound. Perception is reduced to being as near to the perception of a single item as possible. The focus is not on thoughts or thinking, but, instead, on sensing. It involves being non-judgmental and just accepting things as they are for the time being, following a route of non-resistance, and knowing the difference between what can be changed and what cannot. It is about accepting and

playing the hand that you have been dealt. What has become known as the alcoholics' prayer, or the serenity prayer, sits well with the concept of mindfulness: *"God, grant me - the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference"* (Niebuhr, 1932).

As succinctly put by William et al. (2007), *"…mindfulness is the awareness that arises from paying attention on purpose, in the present moment, non-judgmentally, to things as they are"* (p.54). Those committed to the psychological benefits of mindfulness argue that there are disadvantages to leaving too much to our unconscious, automatic, systems of operation. For example, the classic experiment by Simons & Levin (1998) illustrated well how limited, and limiting, our perceptual processing can be. They got a researcher-colleague to ask a passer-by for directions. The pair are interrupted by two people (in league with the researchers) carrying a door. The two people and door squeeze between the researcher and the member of the public, and, while doing so, the researcher and one of the door-carriers swap places. Less than half the real participants (33-47% in numerous repetitions of this experiment) actually notice the change despite the fact that the swap takes place between two individuals who differ in height (by about 5 cms), weight, clothing, and tone of voice (Edgar, 2007). I wonder if it is the more mindful people who actually do notice the researcher and confederate changing places?

I also wonder if people who engage in CUBSHAS are making a concerted attempt to move away from unpleasant thoughts? Are they trying to return to raw sensations, even if these sensations are painful? Or perhaps, in some cases, *because* they are painful? Losing unwelcome thoughts by heightening sensory experiences could be a way of going into mindfulness mode without actually realising it. The unbearable top-down experience of emotional pain is overtaken, at least temporarily, by the bottom-

up experience of physical pain. However, the role of physical pain appears to vary from person to person e.g. the National Self-Harm Network website recorded the comment: *"When I self-harm I don't feel any pain at all, just a release. It is not until after that I feel the pain…".* (NSHN, 2013). And Martha, one of my participants, remarked: *"…people would say: 'Is that no hurtin' you?' and I'd say: 'Nup', 'cause I'd cut myself off, I wanted to feel a bit of pain. It gave me emotion. I liked pain. And that might sound illogical…I didn't want to be mentally hurt..."* (101-104).

William et al (2007) wrote about mindfulness that *"...direct sensing of the body turns up the volume on the body's messages and turns down the volume on mental chatter"* (p.103). It may be that some people are engaging in, say, BSH(cutting) because the volume of mental chatter is too high and the stimulation from body sensations too low. Their behaviour may be an attempt to rectify the imbalance, a way to achieve equilibrium between top-down and bottom-up processing, a way into homeostasis.

Mindfulness has a lot to say about emotion regulation but in a slightly different way to, for example, *experiential avoidance/replacement*. Befriending your feelings rather than distraction is encouraged. Emotions are not the enemy. Intentionally holding something in awareness so that it can be named, faced up to, and worked with is the objective, rather than thought-blocking, or countering one emotion with another, or replacing one experience with another as in *experiential avoidance/replacement*.

Mindfulness has found its way into many therapeutic approaches. Psychological treatments such as mindfulness based stress reduction (MBSR), and, mindfulness based cognitive therapies (MBCT) are now in the armoury of many therapists (Goldin & Gross, 2010; Sipe & Eisendrath, 2012). For example, Hayes et al. (1993; 1996;

2003; 2006) have developed acceptance and commitment therapy (ACT) which has six core principles, many in tune with mindfulness, namely: (i) *Acceptance* of things as they are, particularly if they are not within your control to do much about in the first place. Harris (2006; 2009; 2013) has pointed out that control is sometimes not the solution and can be the problem. (ii) Identifying an individual's *basic values* and making changes in line with these values. (iii) *Committing* to the changes which will bring people nearer to aims and goals in tandem with their values. (iv) *Cognitive defusion* to do with learning that cognitions, thoughts, perceptions and memories are not fixed parts of a person but can be let go to float off like a feather in the wind. (v) *The observing self* which is about developing a transcendent sense of self that makes it possible to become aware that *you* are not thoughts, memories, images, feelings, sensations, or urges. They are a peripheral part of you that can be altered in an instant. (vi) And, finally, staying more *in contact with the present moment*.

ACT teaches ways of being mindful. By making extensive use of metaphor and a variety of other techniques, three categories of mindfulness skills can be taught. These are: 1. Accepting what is out of your personal control and which you cannot really do much about. 2. Defusion, mainly cognitive defusion, where you separate yourself from your thoughts/memories of past events, recognising that *they* and *you* are not quite the same. 3. Focusing on the here and now, attending to one thing at a time, and concentrating on only this moment. Many events are more or less neutral, it is our interpretation which is positive or negative. Thoughts are not *things* but are fleeting mental events that can be attended to or not. As Mark Twain once wrote: *"I have been through some terrible things in my life, some of which actually happened"* (The Week, 17 May, 2014c, p.23).

Freud popularised the notion of the unconscious (Freud, 1936) before it fell into disrepute at the hands of the behaviourists and the experimentalists. It seems to me that an *unconscious*, or, *pre-conscious* to be found just below the level of awareness, and certainly *consciousness* are coming back into vogue via Eastern *meditation* or the equivalent Western idea called *mindfulness.*

Mindfulness/meditation is playing its part in what many have called the third wave therapies originating from a behaviourist tradition. Behaviourism itself was a reaction against psychoanalysis on the one hand and introspectionism on the other. The arid nature of strict behaviourism with its emphasis on what was observable was soon to be replaced with cognitive behaviourism in the form of CBT. Cognitive behaviour therapy and associated procedures such as Albert Ellis's (2001) rational emotive behaviour therapy (REBT; Turner, 2014) and the cognitive therapy (CT) of Aaron Beck (Beck et al., 1987) were seen as the second wave. The third wave comprised the acceptance and commitment therapy (ACT) of Steven Hayes, Kirk Strosahl and colleagues (Hayes et al., 2003), and dialectical behaviour therapy (DBT) devised by Marsha Linehan (Linehan, 1993a; 1993b).

What is particularly interesting about DBT is that it has been used mainly with people for whom BSH has featured prominently among their presenting problems. One of the main reasons for choosing self-harm as the topic for my thesis was the lack of success I was having trying to help those who hurt their own bodies. I was intrigued therefore to find that Linehan (Dimeff & Linehan, 2001) developed DBT for similar reasons. She had been trying to apply the standard procedures of CBT to people with chronic suicidal behaviours and felt that she was failing miserably. Many of her clients had been diagnosed with borderline personality disorder (BPD), major symptoms of which are CUBSHAS. Additionally, those who commonly attract a BPD

diagnosis are people who have difficulty with impulsivity, self-regulation, and particularly emotion regulation.

DBT entails combining behavioural strategies and mindfulness techniques within an overall Hegelian (dialectical) view of the world, a view that puts emphasis on synthesising opposites. Instead of thinking in rigid, dichotomous, yes/no styles, DBT encourages dialectical thinking. The basic dialectic in DBT is the acceptance and validation of clients as they are on the one hand, and, promoting the changes necessary to become something different and better on the other. Among the many issues addressed are distress tolerance/intolerance, emotion regulation/ dysregulation, and interpersonal effectiveness/ineffectiveness. While DBT assumes that people are already doing their very best, its raison d'être is to help clients change some behaviours such as serious BSH (e.g. cutting or substance abuse) which might feel beneficial in the short-term but will be detrimental in the long-term. DBT usually takes the form of individual psychotherapy (e.g. to heighten awareness of strengths), group skills training (e.g. to practice new skills), individual telephone contact (e.g. to reinforce adaptive coping strategies), and, team support meetings for therapists (e.g. to keep them motivated given the stressful nature of the work). Unfortunately, not all clients who engaged in CUBSHAS with whom I have worked found DBT helpful. One mockingly told me that she had changed its name from *dialectical* behaviour therapy to *diabolical* behaviour therapy. Another Scottish client interpreted the abbreviation DBT to mean *Dinnae Boather Tryin'.* While the ultimate goal of DBT is *"to move the client from a life in hell to a life worth living as quickly and efficiently as possible"* (Dimeff & Linehan, 2001, p.11), it clearly does not work for everyone.

While nothing works for everyone (Jamieson & Haggerty, 2010), in my research I was struck by the similarities between people rather than their differences. It was the sameness between those carrying out CUBSHAS and those carrying out CABSHAS which caught my attention rather than what was different about them. Among my six participants, only Martha and Nancy hurt their own bodies in culturally unacceptable ways, yet all the others admitted hurting their bodies in culturally acceptable ways (binge drinking, smoking, over-eating, nail-biting). All human beings, it seems to me, are looking for many of the same basic things in life, perhaps in ways that can be determined by identifying individual values as suggested by Steven Hayes and colleagues (2003). There may therefore be routes to helping people deal with distress, gain more satisfaction, happiness and psychological well-being (PWB) to be found by studying typical human beings as by researching atypical ones.

Even the most horrendous experiences do not always result in psychological disabilities such as post-traumatic stress disorder (PTSD). To assume that more learning is to be got from researching abnormal psychology / psychopathology in preference to normal psychological functioning may be wrong. Joseph (2012a), for example, has taken an interesting stand on human adversity. He provided evidence to suggest that trauma has as much potential to make some people more resilient as it does to cripple them with mental ill-health. His basic position supported the well-know adage of the German philosopher Friedrich Nietzsche (1844-1900): *"What does not destroy me, makes me stronger".*

Instead of focussing on PTSD, Joseph turned his attention to post-traumatic growth (PTG). On interviewing survivors of the sinking of the Herald of Free Enterpise three years after the incident he found that 46% reported that their lives had deteriorated. However, 43% said that things had changed for the better. This led Joseph and

colleagues to pursue research on elements of psychological well-being (PWB) of which positive relationships were among the top six. He was adamant that what was important here was not just an affective state of subjective well-being (SWB) but PWB which "*reflects engagement with the existential challenges of life"* (Joseph et al., 2012, p.420). The six elements of PWB were: positive relationships, having a purpose in life, personal growth, acceptance of self, autonomy, and mastery of the environment (Ryff, 1989; Ryff & Singer, 1996; Northrop & Mahoney, 2014). All six were described by Joseph and colleagues in the process of constructing their scale to measure PTG. They wrote: *"Those high on autonomy are self-determining and able to resist social pressures to think and act in certain ways. Those high on environmental mastery have a sense of control and are able to make effective use of opportunities. Those high on personal growth have a feeling of continued development and are open to new experiences. Those high on positive relationships have warm satisfying trusting relationships with others and are capable of empathy, affection and intimacy. Those high on purpose in life have goals in life and a sense of directedness and hold beliefs that give life purpose. Those high on self-acceptance possess a positive attitude towards themselves and feel positive about their life"* (p.420). It is not difficult to see how BSH might be engaged in by someone with PWB at a low ebb. Improving PWB by addressing any or all of its six components could be a sensible way forward. Or, enhancing PWB by nudging people from one end of the BSH continuum where CUBSHAS are located, via CABSHAS (if necessary), to a more optimal body/mind balance may be an appropriate way to progress (see chapter 1, section 1.313 diagram 2).

It is not only studies of shipping disasters which have revealed quite startling findings of PTG (post-traumatic growth) rather than PTSD in some survivors (Dalgleish,

Joseph & Yule, 2000; Joseph, 2012b). Improvements have been revealed in quite diverse populations e.g. survivors of car accidents and plane crashes; rape and child abuse victims; people with serious medical conditions such as cancer, heart disease and multiple sclerosis; those finding themselves at the centre of natural disasters like typhoons, hurricanes and earthquakes; and, those involved in acrimonious relationship breakdowns such as divorce (Joseph, 2012a). Typical figures quoted for survivors self-reporting that they were better *after* their particular trauma than *before* have ranged from 30 – 70% (Linley & Joseph, 2004).

While the term PTSD is a very familiar one (DSM-5, 2013), PTG is less well known even though it was coined almost 20 years ago by Tedeschi & Calhoun (1996). However, it has now become part of the current Positive Psychology movement (Snyder & Lopez, 2009) but with less of an emphasis on personal happiness or SWB (subjective well-being) and more of an emphasis on PWB (psychological well-being). The philosophical origins of SWB are to be found in the hedonic approach to the *good life,* and those of PWB in the eudaimonic approach (Linley, Maltby, Wood, Osborne & Hurling, 2009; Wood & Joseph, 2010). SWB refers more to mood states and happiness, while PWB is concerned with existential things, the challenges of life, meaning and self-actualisation (Ryan & Deci, 2001).

One of the main messages from the eudaimonic PWB approach is, I feel, that trauma is not all bad and that post traumatic stress has the potential to be the engine room of PTG (Dekel, Ein-Dor & Solomon, 2012). Not that adverse experiences should be deliberately sought out, as might appear to be the case with CUBSHAS, however, the fact that they sometimes are sought out gives pause for thought.

Concerns about the lack of a proper understanding of the area of BSH and the need for more staff training have prompted Deb Martinson (see http//www.fortrefuge.com/SelfInjuryBillOfRights.html) to produce a Bill of Rights for people who engage in BSH (Walsh, 2012). Martinson pointed out in the preamble to her Self-harm Bill of Rights that, despite how common some self-harming behaviours are, CUBSHAS are still considered strange, freakish and outlandish. They elicit a stigma and prejudice among professionals and public that is seen in few other types of behaviour. Martinson's ten points are paraphrased below:

1. The right to caring, humane treatment of no lesser quality than what is offered to those presenting with physical disease, accidental injuries or who are the innocent victims of violent assault.

2. The right to participate fully in decision-making over whether or not it is appropriate to accept a placement in a mental hospital. Hospitalisation for BSH of any kind is rarely necessary.

3. The right to privacy over one's own body. Examination of the body of a person who has engaged in CUBSHAS should be carried out in a way that preserves dignity. Some of those who have been self-harming will have been sexually abused in childhood, or as adults, and therefore treatment of their bodies which is anything other than respectful is likely to be re-traumatising.

4. The right to have emotions associated with CUBSHAS validated. BSH does not come *out of the blue*. There are causes and functions. It is often a response to distressing feelings. These feelings should be accepted and recognised for what they are. While professional workers (medical and psychological) may not

understand all the circumstances surrounding the BSH, they can at least understand that clients are genuinely upset, and respect their right to be so.

5. The right to disclose only what they choose to disclose and to whom they choose to disclose it. Professionals should pass on information about BSH to third parties in general terms only. A person's permission should be obtained before specific details of the BSH are given to others, irrespective of whether they are CUBSHAS {e.g. BSH(cutting), BSH(burning), BSH(overdosing)}, or, CASHAS {e.g. BSH(alcohol), BSH (smoking), BSH(obesity)}. Confidentiality is as important in this area as in any other to do with a person's mental or physical health.

6. The right to choose what coping mechanisms they find most helpful. Nobody should be denied treatment because they refuse to sign a *no-harm behaviour contract*. To demand that people stop using a coping mechanism which works for them, at least in the short-term, is not helpful. Instead, the client and practitioner should work together on a plan of action if the urge to BSH becomes irresistible while treatment is on-going.

7. The right to have support and intervention provided by people who will not let their own feelings of shock or disgust interfere with the quality of work they are trying to do. Those who work with individuals who engage in CUBSHAS must harness any feelings of anxiety, fear or revulsion which they have. A therapeutic response of an equivalent high standard to someone presenting with CABSHAS should be aimed for. In order to do this properly, additional support and training may be required for frontline staff.

8. The right to have validated that the BSH was a way of coping. There are, no doubt, other ways of coping better. However, the choice made may have been a last

ditch attempt to avoid suicide. Exploring alternative, less self-destructive methods of coping should be encouraged (as in a harm-minimisation approach).

9. The right not to be automatically labelled as a dangerous person because of CUBSHAS. No one should be made to feel ashamed or guilty or be punished over what they have done. Neither should they be physically or chemically restrained, or locked up. Injuries or other damage requiring treatment as a result of CUBSHAS should be treated with the same respect as those arising from CABSHAS.

10. The right to have BSH seen as a way of communicating rather than manipulating. Self-harming has numerous functions. Many people hurt themselves because they feel unable to communicate their distress in a better way. While manipulation may play a part, it should not be the first consideration by providers of care and treatment.

The fact that a Bill of Rights, specifically for those who engage in CUBSHAS, is thought to be necessary at all, speaks volumes for the state of play in this whole field. Staff training must address such issues.

5.7 Concluding remarks

The main outcomes of my research included: a new name for the phenomenon, namely, *body self-harm* or *body self-harming* (BSH); a new definition e.g. *BSH is behaviour which occurs when individuals, intentionally or unintentionally, give precedence to their mental health over their physical health by the process of damaging their own bodies*; and, the beginnings of a new conceptual framework. This new framework sought to balance the interplay of mind and body, focussed on what could be learned from typical as well as atypical human beings, suggested that

there was a continuum of self-harming (CABSHAS and CUBSHAS) rather than a dichotomy between self-harmers and non-self-harmers, and pointed towards ways of providing support and intervention which were not significantly different from what would be provided for a whole range of psychological issues. Some of these strategies suggested stepping outside commonly accepted Western methods of intervention and making more use of Eastern meditation or mindfulness practices that have already been taken up to some extent by third wave therapies. The Freidrich Nietzsche maxim *'what doesn't destroy me makes me stronger'* was entertained as a possibility. Adverse circumstances can sometimes be a springboard to improved psychological well-being (PWB) rather than cause a deterioration of mental health. Given the right support, post traumatic growth (PTG) rather than post traumatic stress disorder (PTSD) can follow trauma.

The NHS has been severely criticised for the approach of some of its staff to individuals who seek help as a result of CUBSHAS (Law et al., 2009; Hadfield et al., 2009). Services in other countries (such as the USA) have also been criticised to the extent that attempts have been made to produce a Bill of Rights on behalf of individuals who self-harm in culturally unacceptable ways (see Walsh, 2012, pp.373-375). However, if there is any merit in the proposal in my thesis that CABSHAS are not qualitatively different from CUBSHAS, then doctors, nurses, psychologists and others should find it increasingly more palatable to work positively in this domain, and provide better and more humane care and treatment for all.

Suggestions have been made about developing potentially beneficial support and intervention not unlike what should be available to all who think they need help with any type of socio-psychological problem. A quality service should be there for everyone, irrespective of what kind of BSH is being carried out. Currently much more

remains to be done in the areas of self-harming theory, practice and policy. For example, Warner & Spandler (2012) have identified at least three problems with research on self-harm. First, they believed that there was a lack of clarity, or definitional ambiguity, about what was actually being researched; secondly, there was an over-emphasis on behaviour measures / outcomes targeting a complete cessation of all self-harming; and, thirdly, there was too much focus on specific treatment techniques at the expense of more general practice principles. The five key principles were: first, mental disorder, illness or distress should be more closely linked to trauma in the social world than to physical disease; secondly, greater recognition of the importance of specific meanings which a person attaches to his/her body self-harming behaviour should be given; thirdly, it should not be assumed that the goal must be for the person to stop the behaviour entirely; fourthly, the need to be service-user focused (person-centred); and, finally, additional support for workers with body self-harming clients should be provided. My own research, I feel, has lent support to these issues / problems associated with much research in this area as outlined by Warner and Spandler, and, to the value of prioritising these key principles.

To recap on some of the points about future research already made in section 5.5, a number of useful lines of enquiry could be pursued. Firstly, while I have previously argued in favour of having only a very small sample of six participant, it just so happens that all my participants, by chance, were female, and no one was below the age of 22 or above the age of 55. Carrying out a similar piece of work which included males, children and young people, and those in their 60s and above, might reveal additional valuable data. Engaging a wider variety of types of people from different cultural and subcultural groups in similar discussions about BSH may produce

further insights. Secondly, semi-structured interview schedules could be devised on the basis of each individual's initial transcript and used to more formally interview the participants. This may lead to investigation of other BSH matters which neither they nor I had thought of raising when we first met. Thirdly, it might prove worthwhile going back to the six participants, and/or the two pilot participants who were recorded (Marie and Lorna), and offering them the opportunity to watch the video of themselves or listen to the audio. They could then be encouraged to comment on any issues which caught their attention. Increased depth and greater clarity might then emerge. Fourthly, and finally, use could be made of a device like that invented by Matthias Mehl and James Pennebaker at the University of Arizona. They called it an Electronically Activated Recorder (EAR). It is *"…an observational ecological momentary assessment method…to obtain a sense of who people are and what they do by listening in on sound bites of their moment to moment social lives. Technically, the EAR is an audio recorder that periodically samples brief snippets of ambient sounds while participants go about their lives. Conceptually, it is an unobtrusive observation method that yields acoustic logs of people's daily experiences as they naturally unfold…"* (Sutton, 2014, p.223). Periods before, during and after BSH could be examined. People primarily engaging in CABSHAS and/or CUBSHAS could be enlisted for such a study. This kind of research would have the potential to bring us closer still to understanding what BSH is, its causes and functions, the meaning-making of participants, and how best to intervene if necessary. Some success has already been achieved with ecologically momentary assessment technology (Nock, Prinstein & Sterba, 2009). It has suggested that negative emotions (e.g. anger against the self) are more intense in people who engage in CUBSHAS than CABSHAS. Recommendations to pursue use of this kind of technology have already

been made in recent research by Victor & Klonsky (2014) on daily emotions experienced by those resorting to BSH of one sort or another.

At a BPS (Scottish Branch) Scientific Meeting in Edinburgh in February 2014 there was a presentation on post traumatic growth (PTG) by Stephen Joseph (Joseph, 2014; Joseph et al., 2012). His focus was PTG as opposed to post traumatic stress disorder (PTSD). He argued that PTG was as likely as PTSD after trauma. At the end of Professor Joseph's talk I tentatively pointed out to him during a plenary session that many of those engaging in CUBSHAS have said that they are *hurting to heal* (Hurting to Heal, 2013a; 2013b) and had no intention of taking their own lives. I asked if he thought that perhaps hurting one's own body could be a way of re-booting, re-setting, re-balancing, and re-establishing control of one's life by deliberately creating a different type of post traumatic stress? Was this an example of experiential avoidance/replacement? For some people could this be a way of initiating post traumatic growth? He replied: *"I don't know the answer...but I'm inspired by the question".* So am I.

5.8 Summary

I have sought in this thesis to describe a DEdPsy research journey utilizing the topic of BSH as a vehicle and travelling companion. The journey started with an outline of the various DEdPsy assignments and a literature search in the introductory chapter to try to answer the question *'What is self-harm?'* Not only were there no satisfactory definitions, neither was there a single label for self-harming behaviour that was acceptable to all researchers, clinicians and clients. The thesis was peppered with direct quotes about self-harming from a number of sources including participants from the published research of others, clients (Cs) with whom I had been working

over the years, four pilot participants, six participants recruited for my main study, and other individuals with whom I was able to keep in contact by e-mail but unable to work with face-to-face.

Chapter 2 took the journey into deciding on the most appropriate methodology for the main study. This was done by comparing a quantitative paper (Nock & Prinstein, 2004) with a qualitative paper (Oldershaw et al, 2008) on self-harming. Interestingly, for essentially the same phenomenon, the first pair of researchers called it *self-mutilative behaviour* (USA) and the other group called it *self-harm* (UK). However, at this stage, rather than looking at alternative labels, the exercise was being used to look at the differences between quantitative and qualitative research paradigms and to examine respective ontologies, epistemologies and methodologies with a view to selecting a methodology which might best answer the kinds of research questions of interest to me. I was later to discover after being invited to review *Successful Qualitative Research* by Braun & Clarke (2013) for the journal Qualitative Methods in Psychology Bulletin (Jamieson, 2014b) that Professors Braun and Clarke would also illustrate similarities and differences in quantitative/qualitative approaches using the same strategy. The theoretical framework for my research tended to be somewhere between critical realism and social constructionism (Willig, 1999).

The pilot studies were also referred to in chapter 2 where developments from semi-structured interviewing to unstructured, individual discussions were experimented with, initially via interviews on self-harming with a young male in a Children's Home and an adult female in a low secure mental hospital; then, separate recorded and transcribed discussions were carried out with a worker with extensive experience of dealing with those who self-harmed, and a young woman who had seriously self-harmed since her early teenage years. Transcription and analyses of 18 video/slide

productions on self-harm obtained from www.youtube.com was also part of the pilot work, as well as the recording, transcribing and thematic analysis of a number of sessions with my academic supervisor. Why thematic analysis was chosen as the preferred way of analysing the data was explored, research questions were identified, and the method and procedures for the main study outlined. This was followed by chapter 3 on 'analysis and findings' that concentrated on subthemes, themes and overarching themes from which synoptic stories were produced. Chapter 4 was a discussion of these findings. It included an overview of theme discussion, the beginnings of a new conceptual framework with a new name (*body self-harm* or *body self-harming; BSH)* and a new definition, as well as further commentary on reflexivity.

The final chapter 5 began by reminding the reader of the contents of each of the previous chapters before repeating the aims of the research which were basically to answer the research questions. These answers were provided by drawing on my clinical experience as a psychologist over several decades, careful study of a selection of the existing multi-disciplinary literature on self-harm, thematic analysis of recorded and transcribed discussions with six participants in the main study, and contributions from other participants who were not as deeply involved but who were willing to stay in touch by e-mail.

As well as providing some evaluation of the study and identifying a number of its limitations, chapter 5 also made some observations on the research method used, and critically commented on the analysis. For example, thematic analysis was adapted to incorporate aspects of some other qualitative techniques like IPA and narrative analysis. *Synoptic stories* were produced from overarching themes and joined-up data extracts. The new name for self-harm, the new definition and the

beginnings of the new conceptual framework emerged from the subthemes, themes, overarching themes and synoptic stories.

Finally, pointers were given to some potentially exciting future research and implications of the study regarding support, intervention and staff training. Support / intervention I thought should be based more on the psychology of typical than atypical human beings and more closely aligned with *normal* than abnormal psychology. Concluding remarks included a Bill of Rights for people who hurt their own bodies, and suggestions about possible failings of past research in this area. An invitation was given to reconsider some key practice principles, and, a plea for the NHS to provide an equally good service for all those engaging in BSH, irrespective of whether the self-harming took the form of CUBSHAS or CABSHAS.

References

Abbott, B. B. (2013). *A Synopsis of William T. Powers' Perceptual Control Theory.* Retrieved August 31, 2013, from http://users.ipfw.edu/abbott/pct / pct.html

Alexander, H. B. (1967). *The World's Rim: Great mysteries of the North American Indians.* Lincoln: University of Nebraska Press.

Anderson, R. & Braud, W. (2011). *Transforming self and others through research: Transpersonal research methods and skills for the human sciences and humanities.* Albany, New York: Suny Press.

Anderson, S. (2008). The Urge to End it All. *New York Times, July 6.*

Anderson, M., & Sansone, R. A. (2003). Tattooing as a means of acute affect regulation. *Clinical Psychology and Psychotherapy, 10*, 316-318.

Antoniou, P. & Cooper, M. (2013). Psychological treatments for eating disorders: What is the importance of the quality of the therapeutic alliance for outcomes? *Couselling Psychology Review, 28*(4), 34-46.

APA (2010). *Publication manual of the American Psychological Association* (6th ed.) Washington, DC: American Psychological Association.

Arden, J. & Linford, L. (2014). Brain wave: The demise of pax medica and the emergence of brain-based therapy. *New Therapist, July / August,* 8-19.

Arksey, H. & Knight, P. (1999). Interviewing for Social Scientists. London: Sage.

Arnold, L. (1995). *Women and Self-injury - a survey of 76 women*. Bristol: Bristol Crisis Service for Women, PO box 654 BS99 1XH.

Arnold, L. (2004). *For friends and family: a guide for supporters of women and girls who self-injure*. Bristol: Bristol Crisis Service for Women, PO box 654 BS99 1XH.

Arnold, L. (2007). *Understanding self-injury*. Bristol: Bristol Crisis Service for Women, PO box 654 BS99 1XH.

Asch, S. S. (1971). Wrist scratching as a symptom of anhedonia: a pre-

depressive state. *Psychoanalytic Quarterly, 40*, 603-613.

Attride-Stirling, J. (2001). Thematic networks: An analytic tool for qualitative research. *Qualitative Research, 1*(3), 385-405.

Babiker, G. & Arnold, L. (1997). *The Language of Injury: comprehending self-mutilation.* Leicester: BPS Books.

Barnes, J., Caddick, N., Clarke, N. J., Cromby, J. McDermott, H., Willis, M. E. H. & Wiltshire, G. (2014). Methodological pluralism in qualitative research: Reflections on a meta-study. *Qualitative Methods in Psychology Bulletin, 17,* 35-41.

Bateson, P. (2014). Men at Play. *Cambridge Alumni Magazine, 71,* 35-37.

Bateson, P. & Martin, P. (2013). *Play, Playfulness, Creativity and Innovation.* Cambridge, UK: Cambridge University Press.

Beck, A. T., Rush, A. J., Shaw, B. F. & Emery, G. (1987). *Cognitive Therapy of Depression.* New York: Guilford Press.

Becker, H. (1963). Outsiders: Studies in the Sociology of Deviance. Free Press.

Bennett, P. L. (2014). Spirituality, religious belief and mindfulness. *Transpersonal Psychology Review, 16*(1), 26-29.

Bem, S. (1981). Gender schema theory: A cognitive account of sex-typing. *Psychological Review, 88,* 354-364.

Bem, S. (1994). *The Lenses of Gender.* London & New York: Yale University Press.

Bennum, I. (1984). Psychological models of self-mutilation. *Suicide and life threatening behaviour, 14*, 166-186.

Bennum, I., & Phil, M. (1983). Depression and hostility in self-mutilation. *Suicide and life threatening behaviour, 14*, 71-84.

Bingham, W. & Moore, B. (1959). *How to Interview.* New York: Harper International.

Bishop, D. (2014). The clinical reality of neurodevelopmental disorders. *The BPS Research Digest, Issue 263.*

Blackmore, S. (2014). A public and private trip to understand the mind. *The Psychologist, 27*(9), 700-701.

Block, S., & Singh, B. (1997). *Understanding Troubled Minds*. Melbourne: Melbourne University Press.

Bong, S. A. (2002). Debunking myths in qualitative data analysis. *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research, 3.* Retrieved on October 13, 2013, from http://www.qualitative-research.net/index.php/fqs/article/view/849/1845.

Booth, R. (2014). Mindfulness therapy comes at a high price for some, say experts. *The Guardian, Monday 25 August.*

Bourdieu, P. (1992). *Invitation to a Reflexive Sociology.* University of Chicago Press.

Bowen, G. A. (2008). Naturalistic enquiry and the saturation concept: a research note. *Qualitative Research, 8*(1), 137-152.

Boyatzis, R. E. (1998). *Transforming Qualitative Information: thematic analysis and code development.* London: Sage.

BPS (2006). *Code of Ethics and Conduct.* Leicester: British Psychological Society.

BPS (2009). *Code of Ethics and Conduct.* Leicester: British Psychological Society.

BPS News (2013). DSM-5 Petition. *The Psychologist, 26*(5), 323.

Braisby, N. (2002). Consciousness. In T. Cooper & I. Roth (Eds.), *Challenging Psychological Issues* (pp.169-216). Milton Keynes: Open University Press.

Braud, W. & Anderson, R. (1998). *Transpersonal research methods for the social sciences: Honouring human experience.* London: Sage.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3,* 77-101.

Braun, V. & Clarke, V. (2013). *Successful Qualitative Research: a practical guide for beginners.* London: Sage.

Brodsky, B. S., Cloitre, M., & Dulit, R. A. (1995). Relationship of dissociation to self-mutilation and childhood abuse in borderline personality disorder. *American Journal of Psychiatry, 152*, 1788-1792.

Brooker, C., Repper, J., Beverley, C., Ferriter, M., & Brewer, N. (2002). *Mental health services and prisoners: a review*. Sheffield: Mental Health Task Force.

Brown, R. J. (2013). Explaining the unexplained. *The Psychologist, 26*(12), 868-872.

Burr, V. (1995). *An Introduction to Social Constructionism.*Oxford: Routledge.

Cannon, W. B. (1932). *The Wisdom of the Body.* New York: Norton.

Caplan, P. (2013). Diagnosing DSM nausea. *New Therapist, July/August,* 35-36.

Carson, D. & Lewis, J. M. (1971). Ocular auto-enucleation while under the influence of drugs: a case report. *Adolescence, 6, 23*, 397-403.

Caspi, A., Houts, R. M., Belsky, D. W., Goldman-Mellor, S. J., Harrington, H., Israel, S., Meier, M. H., Ramrakha, S., Shalev, I., Poulton, R. & Moffitt T. E. (2014). The p Factor: One general psychopathology factor in the structure of psychiatric disorders? *Clinical Psychological Science, 2*(2), 119-137.

Ceci, S. J. (2014). One on one…with Stephen J. Ceci. *The Psychologist, 27*(4), 296.

Chamberlain, K. (2000). Methodolatory and qualitative health research. *Journal of Health Psychology, 5,* 285-296.

Chamberlain, K. (2012). Do you really need a methodology? *Qualitative Methods in Psychology Bulletin, 13,* 59-63.

Chandler, A. (2010). *Pain Incarnate: a narrative exploration of self-injury and embodiment.* Unpublished Phd in Sociology, University of Edinburgh.

Chandler, A. (2012). Self-injury as Embodied Emotion Work: Managing Rationality, Emotion and Bodies. *Sociology, 46*(3), 442-457.

Chandler, A. (2013a). Inviting pain? Pain, dualism and embodiment in narratives of self-injury. *Sociology of Health & Illness, 35*(5), 716-730.

Chandler, A. (2013b). *The lived experience of self-injury: contradictory stories*

from research. Powerpoint presentation at Hurting to Heal Launch Conference, March 1, University of Edinburgh.

Chandler, A. (2014). Managing the myths of self-harm. *Children in Scotland, 158,* 16.

Chandler, A., Myers, F. & Platt, S. (2011). The Construction of Self-Injury in the Clinical Literature: A Sociological Explanation. *Suicide & Life-Threatening Behaviour, 41*(1), 98-109.

Chaney, S. (2013). 'An emotional but ill-ruled machine'. *The Psychologist, 26*(11), 842-843.

Chase, A. (2003). *Harvard and the Unabomber: The education of an American terrorist.* New York: W.W. Norton & Co.

Chesney, E., Goodwin, G. M. & Fazel, S. (2014). Risks of all-cause and suicide mortality in mental disorders: a meta review. *World Psychiatry, 13*(2), 153-160.

Christianson, M., Lalos, A., Westman, G., & Johansson, E. E. (2007). 'Eyes Wide Shut' sexuality and risk in HIV-positive youth in Sweden: A qualitative study. *Scandinavian Journal of Public Health, 35,* 55-61.

Clarke, K. & Walker, N. (2013). Gettting off the starting blocks: An interpretative phenomenological analysis (IPA) of a physical activity referral scheme non-completer. *Qualitative Methods in Psychology Bulletin, 15,* 6-13.

Clarke, L., & Whittaker, M. (1998). Self mutilation: culture, context and nursing responses. *Journal of Clinical Nursing, 7*, 129-137.

Clarke, S., Kingston, J., Wilson, K. G., Bolderston, H. & Remington, B. (2012). Acceptance and Commitment Therapy for a Heterogenous Group of Treatment-Resistant Clients: A Treatment Development Study. *Cognitive and Behavioural Practice, 19* (4), 560-572.

Clarke, V. & Braun, V. (2013). Teaching thematic analysis. *The Psychologist, 26*(2), 120-123.

Cochran, W. G. (2007). *Sampling Techniques* (3rd edition). New York: John

Wylie & Sons.

Cohen, E. (2013). Abraham Maslow's Taoistic Science: Experimental methods and experiential modes. *Transpersonal Psychology Review, 15* (2), 3-14.

Colom, R., Jung, R. E. & Haier, R. J. (2006). Distributed brain sites for the 'g' factor of intelligence. *NeuroImage, 3,* 1359-1365.

Comtois, K. (2002). A review of interventions to reduce the prevalence of parasuicide. *Psychiatric Services, 53*, 1138-1144.

Cooper, T., & Roth, I. (Eds.). (2007). *Challenging Psychological Issues*. Milton Keynes: The Open University.

Creswell, J.W. (2003). *Research Design: Qualitative, Quantitative and Mixed Methods Approaches.* London: Sage.

Crossley, M. L. (2009). Breastfeeding as a moral imperative: an autoethnographic study. *Feminism & Psychology, 19,* 71-87.

Crouch, W., & Wright, J. (2004). Deliberate self harm at an adolescent unit: a qualitative investigation. *Clinical Child Psychology and Psychiatry, 9*, 185-204.

Crowe, M., & Bunclark, J. (2000). Repeated self injury and its management. *International Review of Psychiatry, 12*, 48-53.

Csipke, E. & Horne, O. (2008). Understanding Self-Harm. SANE.

Cullen, C. (2013). One on one...with Chris Cullen. *The Psychologist, 26*(10), 776.

Daldin, H. (1990). Self-mutilating behaviour in adolescence with comments on suicidal risk. *Bulletin of the Anna Freud Centre, 13*, 279-293.

Dalgleish, T., Joseph, S. & Yule, W. (2000). The Herald of Free Enterprise disaster. Lessons from the first 6 years. *Behaviour Modification, 24*(5), 673-699.

Dekel, S., Ein-Dor, T. & Solomon, Z. (2012). Post traumatic growth and post traumatic distress: A longitudinal study. *Psychological Trauma: Theory, Research, Practice and Policy, 4,* 94-101.

Demetriou, E. (2011). *Instead of dad coming out of the closet, I suppose we all jumped in with him: A qualitative analysis of the experiences of adult children*

of lesbian, gay and trans parents. Dissertation. University of the West of England.

Dimeff, L. & Linehan, M. M. (2001). Dialectical behaviour therapy in a nutshell. *The California Psychologist, 34,* 10-13.

Doctor, S. (1981). The symptom of delicate self-cutting in adolescent females: a developmental view. In S.C. Feinstein, J.G. Looney, A. Z. Schwarzberg & A. D. Sorosky (Eds.), *Adolescent Psychiatry vol. 9* (pp 443-460). Chicago: University of Chicago Press.

DoH (2011). *Improving the physical health and well-being of people with mental health problems: Reducing the gaps in premature mortality and healthy life expectancy.* London: Department of Health.

DSE212 Course-team. (2007). *Exploring Psychological Research Methods*. Milton Keynes: The Open University.

DSM – IV (1994). *Diagnostic and Statistical Manual of Mental Disorders,* Virginia: American Psychiatric Association.

DSM – 5 (2013). *Diagnostic and Statistical Manual of Mental Disorders,* Virginia: American Psychiatric Association.

Edgar, G. (2007). Perception and attention. In D. Meill, A. Phoenix & K. Thomas (Eds.) *Mapping Psychology Book 1 Chapters 6-9* (pp.1-56). Milton Keynes: The Open University.

Elichaoff, F., Rodriguez, D. & Murphy, A. (2014). More than just a method: Doctoral students' perspectives on the place of qualitatively driven mixed methods. *Qualitative Methods in Psychology Bulletin, 17, 17-21.*

Elliott, J. G. & Grigorenko, E. L. (2014). The end of dyslexia? *The Psychologist, 27*(8), 576-580.

Elsbree, L. (1982). *The Rituals of Life: Patterns in Narrative.* Port Washington, NY: Kennikat Press.

Etherington, K. (2004). *Becoming a reflexive researcher: Using our selves in research.* London: Jessica Kingsley Publishers.

Eysenck, H. J. (1967). *The Biological Basis of Personality.* Springfield, IL: Thomas.

Eysenck, H. J. (1992). *Decline and Fall of the Freudian Empire.* London: Penguin Books.

Eysenck, M. W. (1998). Personality. In Eysenck, M. (Ed.) *Psychology: An Integrated Approach.* London: Longman.

Favazza, A. (1996). *Bodies under seige: self-mutilation and body modification in culture and psychiatry*. Baltimore: The John Hopkins University Press.

Favazza, A. R. (1989). Why patients mutilate themselves. *Hospital and Community Psychiatry, 40*, 137-245.

Favazza, A. R., & Conterio, K. (1989). Female habitual self-mutilators. *Acta Psychiatrica Scandinavica, 79*, 283-289.

Feldman, C. (2004). *Meditation: Plain and Simple*. London: Harper Collins.

Feldman, M. (1988). The challenge of self-mutilation: a review. *Comprehensive Psychiatry, 29*(3), 252-269.

Ferguson, C. J. (2014). Is video game violence bad? *The Psychologist, 27*(5), 324-327.

Ferguson, E. (2013). Personality is of central concern to understand health: Towards a theoretical model for health psychology. *Health Psychology Review, 7,* 32-70.

Fielding, N. G. & Lee, R. M. (1991). *Using computers in qualitative research.* London: Sage.

Fine, M. & Gordon, S. M. (1989). Feminist transformations of / despite psychology. In M. Crawford & M. Gentry (Eds.), *Gender and thought: Psychological perspectives* (pp. 146-174). New York: Springer-Verlag.

Finlay, L. & Gough, B. (Eds) (2003). *Reflexivity: A practical guide for researchers in health and social sciences.* Oxford: Blackwell Science.

Firestone, R. W., & Seiden, R. H. (1990). Suicide and the continuum of self destructive behaviour. *Journal of American College Health, 38*, 207-213.

First, M. B., Pincus, H. A., Allen, F., & Widiger, T. A. (Eds.) (2000). Diagnostic Criteria from DSM-IV-TR. Arlington, VA: American Psychiatric Association.

Fletcher, J. (1966). *Situation Ethics: The New Morality*. Philadelphia: Westminster Press.

Frank, A. (2010). *Letting stories breathe: A socio-narratology.* Chicago: University of Chicago Press.

Freud, S. (1936). *The Ego and the Mechanisms of Defence,* London: Hogarth Press.

Freud, S. (2003). *Dreams and Occultism*. In A. Phillips (Ed.). Sigmund Freud: an outline of psychoanalysis (pp26-51). London: Penguin. (Original work published in 1940).

Frost, N. (2011). *Qualitative Research Methods in Psychology: combining core approaches.* Maidenhead: McGraw Hill.

Frost, N. & Shaw, R. (2014). Editorial: The place of qualitative methods in mixed methods research. *Qualitative Methods in Psychology Bulletin, 17,* 1-3.

Furnivall, J., Connelly, G., Hudson, B., & McCann, G. (2008). Looked after children and young people: we can and must do better - training materials DVD-rom. Edinburgh: The Scottish Government Crown copyright.

Geertz, C. (1973). *The interpretation of cultures: Selected essays.* New York: Basic Books.

Gergen, K. (1999). *An Invitation to Social Construction.* London: Sage.

Gergen, K. J. (2013). The rugged return of qualitative inquiry in American psychology. *Qualitative Methods in Psychology Bulletin, 15,* 38-40.

Gergen, K. J. & Gergen, M. (1986). Narrative form and the construction of psychological science. In T. Sarbin (ed.) *Narrative Psychology: The Storied Nature of Human Conduct.* New York: Praeger.

Gibson, J. J. (1950). *The Perception of the Visual World.* Boston: Houghton Mifflin.

Goldin, P. R. & Gross, J. J. (2010). Effects of mindfulness-based stress reduction

(MBSR) on social anxiety disorder. *Emotion, 10*(1), 83-91.

Goodlad, K. (2013). Reflections of using online discussion forums as a data collection tool. *Qualitative Methods in Psychology Bulletin, 15,* 33-36.

Goodley, D., Lawthom, R., Tindall, C., Tobbell, J. & Wetherell, M. (2003). *Understanding People: qualitative methods.* DSE212 Methods Booklet 4, Milton Keynes: The Open University.

Goodman, S. (2008). The generalizability of discursive research. *Qualitative Research in Psychology, 5,* 265-275.

Green, L. (2008). *Seeking the As and Bs. Moving from description to critical evaluation in DSE212 assignments: a toolkit for students and tutors.* Milton Keynes: a project funded by the Open University PILS/CETL.

Greenspan, G., & Samuel, S. (1989). Self-cutting after rape. *American Journal of Psychiatry, 146*, 789-790.

Gregory, R. L. (1966). *Eye and Brain.* London: Weidenfield and Nicholson.

Grossman, R. & Siever, L. (2001). *Impulsive self-injurious behavior.* In Simeon, D. & Hollander, H. (Eds.) Self-injurious behaviors: assessment and treatment. Washington: American Psychiatric Publishing Inc.

Guest, G., MacQueen, K. M. & Namey, E. E. (2012). *Applied Thematic Analysis.* Thousand Oaks, CA: Sage.

Guillemin, M.. & Gillam, L. (2004). Ethics, reflexivity, and 'ethically important moments' in research. *Qualitative Inquiry, 10*(2), 261-280.

Guthrie, E., Kapur, N., & Mackway-Jones, K. (2001). Randomised controlled trial of brief psychological intervention after deliberate self-poisoning. *British Medical Journal, 323*, 135-137.

Haddad, M. (2012). *The perfect storm: Economic stagnation, the rising cost of living, public spending cuts, and the impact on UK poverty.* Oxford: Oxfam Briefing Report.

Hadfield, J., Brown, D., Pembroke, L. & Hayward, M. (2009). Analysis of Accident and Emergency Doctors' Responses to Treating People who Self-harm. *Qualitative Health Research, 19,* 755-765.

Haines, J., Williams, C. L., Brain, K. L., & Wilson, G. V. (1995). The psychophysiology of self-mutilation. *Journal of Abnormal Psychology, 104*, 471-489.

Hall, S. (2013). The "godfather of multiculturalism". *The Week, 22 February, Issue 959, p 43* [Obituaries].

Hammersley, M. (2011). *Methodology, who needs it?* London: Sage.

Hands-On-Scotland (2009). *Responding helpfully and safely to a child or young person who is self-harming.* Retrieved 24 March 2011 from http://www.handsonscotland.co.uk/topics/selfharm/general.html

Handy, C. (1985). Understanding Organisations. Middlesex: Penguin Books.

Happé, F. (2014). A creative, interpersonal, social scientist: Editor Jon Sutton meets Professor Francesca Happé to talk about autism, DSM-5, women in science and more. *The Psychologist, 27*(10), 762-765.

Harper, D. & Thompson, A. R. (2011). *Qualitative Research Methods in Mental Health and Psychotherapy: a guide for students and practitioners.* Oxford: Wiley-Blackwell.

Harris, J. (2000). Self-harm: Cutting the bad out of me. *Qualitative Health Research, 10,* 164-173.

Harris, R. (2006). Embracing your demons: An overview of Acceptance and Commitment Therapy. *Psychotherapy in Australia, 12*(4), 2-8.

Harris, R. (2009). Mindfulness without meditation. *Healthcare Counselling & Psychotherapy Journal,* October*,* 21-24*.*

Harris, R. (2013). *Acceptance and Therapy.* Retrieved May 13, 2014, from http://www.actmindfully.com.au/acceptance_&_commitment_therapy

Hartman, D. (1996). Cutting among young people in adolescent units. *Therapeutic communities, 17*, 5-17.

Hawton, K., Arensman, E., Townsend, E. & Traskman-Bendz, L. (1998). Deliberate self-harm: systematic review of the efficacy of psychosocial and pharmacological treatments in preventing repetition. *British Medical Journal 31*, 441-447.

Hayes, S. C., Wilson, K., Gifford, E., Follette, V. & Strosahl, K. (1996). Experiential avoidance and behavioural disorders: a functional dimensional approach to diagnosis and treatment. *Journal of Consulting and Clinical Psychology, 64,* 1152-1168.

Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and Commitment Therapy: model, processes and outcomes. *Behaviour Research and Therapy, 44,* 1-28.

Hayes, S.C., Strosahl, K.D., & Wilson, K.G. (2003) *Acceptance and Commitment Therapy: an experiential approach to behaviour change*. New York. Guilford Press.

Hayes, S.C. & Wilson, K.G. (1993). Some applied implications of a contemporary behaviour-analytic account of verbal events. *The Behaviour Analyst, 16,* 283-301.

HCPC (2008). *Standards of conduct, performance and ethics.* Health and Care Professions Council.

Hefferon, K. & Gil-Rodriquez, E. (2011). Interpretative phenomenological analysis. *The Psychologist, 24*(10), 756-759.

Herlitz, C. & Ramstedt, K. (2005). Assessment of sexual behaviour, sexual attitudes, and sexual risk in Sweden (1989-2003). *Archives of sexual behaviour, 34,* 219-229.

Hewitt, A. (2003). Young people who self-harm. *National Children's Bureau Highlight* 201.

Hiles, D. & Cermák, I. (2008). Narrative Psychology, In C. Willig & W. Stainton-Rogers (Eds.) *The Sage Book of Qualitative Research in Psychology.* London: Sage.

Holloway, I. & Wheeler, S. (2010).*Qualitative research in nursing and health care* (3rd edn.). Chichester: Wiley-Blackwell.

Howitt, D. (2010). *Introduction to Qualitative Methods in Psychology.* Harlow: Pearson Education Ltd.

Hoyt, C. L., Burnette, J. L. & Auster-Gussman, L. (2014). "Obesity is a disease": Examining the self-regulatory impact of this public health message. *Psychological Science, 25*(4), 997-1002.

Hurting to Heal (2013a). *Dvd on self-harm.* Available from www.harmlesspsychotherapy.com [Re-launched as www.mindswell.org.uk on 1 April, 2014.

Hurting to Heal (2013b). Powerpoint presentation at Hurting to Heal Launch Conference, March 1, University of Edinburgh.

ICD-10 (1992). *Classification of Mental and Behavioural Disorders: clinical description and diagnostic guidelines.* Geneva. World Health Organisation.

ICD-11 (2017). *Classification of Mental and Behavioural Disorders: clinical description and diagnostic guidelines.* Geneva. World Health Organisation.

Iyadurai, S. (2013). Mindfulness meditation with children: A universal preventative approach? *Debate, 148,* 22-27.

James, A. (2013a). Learning about ethics. (BPS annual conference report). *The Psychologist, 26*(6), 410.

James, A. (2013b). Protection or exclusion. (BPS annual conference report). *The Psychologist, 26*(6), 411.

James, A. (2013c). Mixed experiences of mixed methodology. (BPS annual conference report). *The Psychologist, 26*(6), 410.

Jamieson, J. (1978). What is an interview? *Community Care,* 8 February, 18-19.

Jamieson, J. (1981). A lump in my throat. *Bulletin of the British Psychological Society, 34*, 276-277.

Jamieson, J. (1985). The cry for help. *The Times Educational Supplement, February 8.*

Jamieson, J. (1995). Be good enough to beware of experts. *The Times Educational supplement, December 29.*

Jamieson, J. (2009). *What is Self-harm?* Unpublished assignment 1 for DEdPsy, University of Newcastle.

Jamieson, J. (2010). *A comparison of a quantitative and qualitative paper on self-harm.* Unpublished assignment 2 for DEdPsy. University of Newcastle.

Jamieson, J. (2011a). *Insights into self-harm: a comparison of information gleaned from (a) a selective literature review, (b) thematic analysis of 18 video/slide presentations from www.youtube.com (c) thematic analysis of an unstructured, open interview of an experienced worker with self-harm, and (d) thematic analysis of an unstructured, open interview of a known self-harmer.* Unpublished assignment 3 for DEdPsy University of Newcastle.

Jamieson, J. (2011b). *Thesis proposal – From self-care to self-harm, from self-harm to self-care: crossing the bridges.* Unpublished assignment 4 for DEdPsy University of Newcastle.

Jamieson, J. (2014a). *Reflexive, reflective, and procedural log.* Unpublished Research Journal, DEdPsy, University of Newcastle.

Jamieson, J. (2014b). Successful Qualitative Research: a practical guide for beginners, Virginia Braun & Victoria Clarke, Sage (2013) [Book Reviews], *Qualitative Methods in Psychology Bulletin, 18,* 39-41.

Jamieson, J., & Haggerty, D. (2010). No panacea for self-harming. *The Times Educational Supplement Scotland*, July 23.

Janesick, V. (1994). The dance of qualitative research design: Metaphor, methodolatory, and meaning. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed., pp 209-219). Thousand Oaks, CA: Sage.

Jefferson, G. (2004). Glossary of transcript symbols with an introduction. In G. H. Lerner (Ed.), *Conversation analysis: Studies from the first generations (pp. 13-31),* Philadelphia: John Benjamins.

Joffe, H. (2011). Thematic Analysis. In D. Harper & A. R. Thompson (Eds.) *Qualitative methods in mental health and psychotherapy: a guide for students and practitioners* (pp.209-224). Chichester: Wyley.

Joffe, H. & Yardley, L. (2004). Content and thematic analysis. In D. F. Marks & L. Yardley (Eds.) *Research methods for clinical and health psychology* (pp.56-68). London: Sage.

Johnstone, L. (1997). Self-injury and the psychiatric response. *Feminism and Psychology, 7*, 421-426.

Joseph, S. (2012a). *What doesn't kill us: A guide to overcoming adversity and moving forward.* London: Piatkus Little Brown

Joseph, S. (2012b). What doesn't kill us…*The Psychologist, 25*(11), 816-819.

Joseph, S. (2014). *Post Traumatic Growth.* Presentation at BPS (Scottish Branch) scientific meeting. February 14, 2014.

Joseph, S., Maltby, J., Wood, A. M., Stockton, H., Hunt, N. & Regel, S. (2012). The Psychological Well-Being – Post-Traumatic Changes Questionnaire (PWB-PTCQ): Reliability and Validity. *Psychological Trauma: Theory, Research, Practice and Policy, 4*(4), 420-428.

Josselin, D. (2014). *Pluralistic research and professional development: a trainee's experience.* Retrieved February, 10, 2014, from http://npqr.word.press.com/

Josselin, D. & Willig, C. (2014). Layering the wounded self: Using a pluralistic qualitative approach to explore meaning-making around self-injury. *Qualitative Methods in Psychology Bulletin, 17*, 23-33.

Khantzian, E. J. (2013). Modifying the medication: The dynamics of addiction and its treatment. *New Therapist, 87,* 5-9.

Kazdin, A. E. (2003). *Research design in clinical psychology (4th edition)*. Boston: Yale University Press.

Keleman, S. (1985). *Emotional Anatomy: The Structure of Experience*. Berkeley: Center Press.

Kennedy, H., Landor, M. & Todd, L. (2011). *Video Interaction Guidance: A relationship based intervention to promote attunement, empathy and well-being.* London: Jessica Kingsley.

Kidder, L. H. & Fine, M. (1987). Qualitative and quantitative methods: when stories converge. *New Directions for Program Evaluation, 35,* 57-75.

King, N., Finlay, L., Ashworth, P., Smith, J., Langdridge, D. & Butt, T. (2008). Can't really trust that so what can I trust? A polyvocal qualitative analysis of the psychology of mistrust. *Qualitative Research in Psychology, 5,* 80-102.

King, N. & Horrocks, C. (2010). *Interviews in Qualitative Research.* London: Sage Publications Ltd.

Kingston, J., Clarke, S., & Remington, B. (2010). Experiential Avoidance and Problem Behaviour: A Mediational Analysis. *Behaviour Modification, 34*(2), 145-163.

Kirmayer, L. J. (2006). Beyond the 'new cross-cultural psychiatry': cultural biology, discursive psychology and the ironies of globalization. *Transcultural Psychiatry, 43,* 126-144.

Klonsky, E. D. (2007). The functions of deliberate self-injury: a review of the evidence. *Clinical Psychology Review, 27*, 226-239.

Klonsky, E. D. & Glenn, C. R. (2008). Resisting urges to self-injure. *Behavioural and Cognitive Psychotherapy,* 36, 211-220.

Kolb, D. A. (1984). *Experiential Learning: experience as the source of learning and development.* Englewood Cliffs, N.J: Prentice Hall.

Kolb, D. A. & Fry, R. (1975). *Towards an applied theory of experiential learning.* In C. Cooper (ed.) Theories of Group Process. London: John Wiley.

Konopasek, Z. (2008). Making thinking visible with Atlas.ti: computer assisted qualitative analysis as textual practices. *Forum Qualitative Sozialforschung: Qualitative Social Research, 9.* Retrieved on October 13, 2013, from http://www.qualitative-research.net/index.php/fqs.article/view/420/911.

Landor, M. (2014a). What is Video Interaction Guidance (VIG)? What is Video Enhanced Reflective Practice (VERP)? *Educational Psychology in Scotland,*

15(1), 9.

Landor, M. (2014b). Video enhanced reflective practice (VERP): Lessons from Sweden – personal account of a study trip. *Educational Psychology in Scotland, 15*(1), 30-33.

Langdridge, D. (2007). *Phenomenological psychology: Theory, research and method.* Harlow, UK: Pearson Education Ltd.

Langdridge, D. & Hagger-Johnson, G. (2009). *Introduction to Research Methods and Data Analysis in Psychology.* New Jersey: Prentice Hall.

Law, G., Rostill-Brookes, H. & Goodman, D. (2009). Public stigma in health and non-healthcare students: Attributions, emotions and willingness to help with adolescent self-harm. *International Journal of Nursing Studies, 46,* 108-119.

Lemert, E. (1951). *Social pathology: A systematic approach to the study of sociopathic behaviour.* New York: McGraw-Hill.

Liamputtong, P. (2007). *Researching the Vulnerable.* London: Sage.

LifeSigns (2013). *Everything was 'great', and I was self-injuring.* Retrieved February 22, 2013, from http:/blog.lifesigns.org.uk/2012/everything-was-great-and-i-was-self-injuring/

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry*. Newbury Park: Sage.

Lincoln, Y. S., & Guba, E. G. (2013). *The Constructivist Credo.* Calefornia: Left Coast Press.

Linehan, M. M. (1993a). *Cognitive Behavioural Therapy of Borderline Personalilty Disorder.* New York: Guilford Press.

Linehan, M. M. (1993b). *Skills Training Manual for Treating Borderline Personalilty Disorder.* New York: Guilford Press.

Linley, P. A. & Joseph, S. (2004). Positive change processes following trauma and adversity: A review of the empirical literature. *Journal of Traumatic Stress, 17,* 11-22.

Linley, P. A., Maltby, J., Wood, A. M., Osborne, G., & Hurling, R. (2009). Measuring happiness: The higher order factor structure of subjective and

psychological well-being measures. *Personality and Individual Differences, 47,* 878-884.

Littleton, K., Toates, F. & Braisby, N. (2007). Three approaches to learning. In D. Miell, A. Phoenix & K. Thomas (Eds.) *Mapping Psychology* (pp. 167-224). Milton Keynes: The Open University Press.

Lloyd, E. E. (1998). Self-mutilation in a community sample of adolescents (doctoral dissertation, Louisiana State University). *Dissertation Abstracts International, 58*, 5127.

Lumsden, V. (2013). Colours of the kaleidoscope: Reflections on the process of carrying out a D.Clin.Psy IPA research study. *Qualitative Methods in Psychology Bulletin, 15,* 15-22.

Lu, C. J. & Shulman, S. W. (2008). Rigor and flexibility in computer-based qualitative research: Introducing the coding analysis toolkit. *International Journal of Multiple Research Approaches, 2,* 105-117.

Mackay, N., & Barrowclough, C. (2005). Accident and emergency staff's perceptions of deliberate self-harm: Attributions, emotions and willingness to help. *British Journal of Clinical Psychology, 44*, 255-267.

MacKay, T. & Malcolm, L. (2014). Guest Editorial: Child abuse and protection – the need for practice-based evidence in educational psychology. *Educational & Child Psychology, 31*(3), 5-8.

MacMillan, K. (2005). More than just coding? Evaluating CAQDAS in a discourse analysis of news texts. *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research, 6.* Retrieved on October 13, 2013, from http://www.qualitative-research.net/index.php/fqs/article/view/28.

MacMillan, K. & Koenig, T. (2004). The wow factor: preconceptions and expectations for data analysis software in qualitative research. *Social Science Computer Review, 22,* 179-186.

Maisel, R., Epston, D., & Borden, A. (2004). *Biting the Hand that Starves You: inspiring resistance to anorexia / bulimia.* New York: W.W. Norton & Co.

Mangnall, J., & Yurkovich, E. (2008). A Literature Review of Deliberate Self-Harm. *Perspectives in Psychiatric Care, 44*(3), 175-184.

Mansell, W., Tai, S. J. & Carey, T. A. (2013). William T. Powers (1926-2013): obituary. *The Psychologist, 26*(8), 549.

Marshall, H. & Yazdani, A. (1999). Locating culture in accounting for self-harm amonst Asian young women. *Journal of Community Applied Social Psychology, 9*(6), 413-433.

Martin, A. J. (2014). Academic buoyancy and academic outcome: Towards a further understanding of students with attention-deficit/hyperactivity disorder (ADHD), students without ADHD, and academic buoyancy itself. *British Journal of Educational Psychology, 84*(1), 86-107.

Maslow, A. H. (1987). *Motivation and Personality.* (3rd edn.) New York: Harper & Row.

Mason, J. (2006). *Six strategies for mixing methods and linking data in social science research.* ESRC, National Centre for Research Methods.

Maybin, J. (2001). Language, struggle and voice: the Bakhtin / Volosinov writings. In M. Wetherill, S. Taylor & S. Yates (Eds.), *Discourse Theory and Practice*. London: Sage / The Open University.

McAllister, M. (2003). Multiple meanings of self harm: A critical review. *International Journal of Mental Health Nursing, 12*, 177-185.

McLellan, V. (1998). *Wise Words and Quotes.* Illinois: Tyndale House Publishers.

McLeod, J. (2001). *Qualitative research in counselling and psychotherapy.* London: Sage.

Melzer, D., Fryers, T. & Jenkins, R. (2004). *Social inequalities and the distribution of common mental health disorders. Maudsley Monographs.* Hove: Psychology Press.

Mertens, D. M. (2005). *Research and evaluation in education and psychology: Integrating diversity with quantitative, qualitative, and mixed-methods* [2nd ed.]. Thousand Oaks, CA: Sage.

Messer, J. M., & Fremouw, W. J. (2008). A critical review of explanatory models for self-mutilating behaviors in adolescents. *Clinical Psychology Review 28*(1), 162-178.

Midlands Psychology Group (2014). Charting 'the mind and body economic'. *The Psychologist, 27*(4), 232-235.

Milgram, S. (1974). *Obedience to Authority.* London: Tavistock.

Miller, F., & Bashkin, E. A. (1974). Depersonalization and self mutilation. *Psychoanalytic Quarterly, 43*, 638-649.

Milne, A. A. (1973). *Winnie-The-Pooh.* London: Methuen.

Moloney, P. (2013). *The therapy industry: The irresistible rise of the talking cure, and why it doesn't work.* London: Pluto.

Morris, D. (1967). *The Naked Ape.* Great Britain: Jonathan Cape Ltd.

Morris, D. (1969). *The Human Zoo.* Great Britain: Jonathan Cape Ltd.

Morse, J. M. & Field, P. A. (2002). *Nursing Research: The application of qualitative approaches* (2nd Ed.). Cheltenham: Nelson Thornes.

Naranjo, M. (2008). Penumbra skills based training in managing self harm and suicide. Penumbra, Scotland.

National Self-Harm Network (2013). Retrieved September 12, 2013, from http://www.nshn.co.uk/resources.html

Newton, C. & Bale, C. (2012). A qualitative analysis of perceptions of self-harm in members of the general public. *Journal of Public Mental Health, 11*(3), 106-116.

NICE (2004). *Self harm: short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care.* National Clinical Guidelines Number 16.

NICE (2011). *Self-harm: longer term management.* National Clinical Guidelines Number 133.

Niebuhr, R. (1932). *Moral Man and Immoral Society: A study in ethics and politics.* (2nd Ed.) Louisville, Kentucky: Westminster John Knox Press.

Niesser, U. (1976). *Cognition and Reality.* San Francisco, CA: Freeman.

Nock, M. K. (2010). Self-injury. *Annual Review of Clinical Psychology, 6,* 339-363.

Nock, M. K. (2012). Future directions for the study of suicide and self-injury. *Journal of Clinical Child & Adolescent Psychology, 41*(2), 255-259.

Nock, M. K., & Prinstein, M. J. (2004). A functional approach to the assessment of self-mutilative behaviour. *Journal of Consulting and Clinical Psychology, 72*, 885-890.

Nock, M. K., & Prinstein, M. J. (2005). Contextual features and behavioural functions of self-mutilation among adolescents. *Journal of Abnormal Psychology, 114*, 140-146.

Nock, M. K., Prinstein, M. J. & Sterba, S. K. (2009). Revealing the form and function of self-injurious thoughts and behaviours: A real-time ecological assessment study among adolescents and young adults. *Journal of Abnormal Psychology, 118*(4), 816-827.

Northrop, S. & Mahoney, A. (2014). In love with psychology. *The Psychologist, 27*(4), 263.

O'Connor, R. C., Rasmussen, S., Miles, J. & Hawton, K. (2009a). Self-harm in adolescents: self-report survey in schools in Scotland. *British Journal of Psychiatry,* 194, 68-72.

O'Connor, R. C., Rasmussen, S. & Hawton, K. (2009b). Predicting deliberate self-harm in adolescents: a six month prospective study. *Suicide and Life-Threatening Behavior*, *39*, 364–*375.*

Oldershaw, A., Richards, C., Simic, M., & Schmidt, U. (2008). Parents' perspectives on adolescent self-harm: qualitative study. *The British Journal of Psychiatry, 193*, 140-144.

Onwuegbuzie, A. J. & Leech, N. L. (2005). The role of sampling in qualitative research. *Academic Exchange Quarterly, 9,* 280-284.

Ó Súilleabháin, P. (2014). Personality – at the heart of health. *The Psychologist, 27*(4), 256-257.

Page, N. & de Haan, E. (2014). Does executive coaching work? *The Psychologist, 27*(8), 582-586.

Parfitt, A. (2005). On aggression turned against the self. *Psychoanalytic Psychotherapy, 19*, 160-173.

Parker, I. (2005). *Qualitative Psychology: Introducing radical research.* Maidenhead, UK: Open University Press.

Parker, R. (2010). *Critical realism: some basics.* Unpublished paper for DEdPsy students, University of Newcastle.

Patent, V. (2010). *Reflection on DSE232 (Applying Psychology): a short guide.* Milton Keynes: The Open University.

Patton, M. Q. (1990). *Qualitative Evaluation and Research Methods* (2nd Ed.). London: Sage.

Patton, M. Q. (2002). *Qualitative Evaluation and Research Methods* (3rd Ed.). Thousand Oaks, CA: Sage.

Pettersson, E., Anckarsäter, H., Gillberg, C. & Lichtenstein, P. (2013). Different neurodevelopmental symptoms have a common genetic etiology. *Journal of Child Psychology and Psychiatry and allied disciplines, 54*(12), 1356-65.

Phoenix, A. & Thomas, K. (2007). Psychology in the 21st Century. In D. Miell, A. Phoenix & K. Thomas (Eds.). *Mapping Psychology (2nd Edn.),* (pp.1-42), Milton Keynes: The Open University Press.

Platt, S., McLean, J., & McCollam, A. (2006). *Evaluation of the first phase of Choose Life: the national strategy and action plan to prevent suicide in Scotland.* Scottish Executive Social Research.

Poland, B. D. (2002). Transcription Quality. In J. F. Gubrium & J. A. Holstein (Eds.) *Handbook of Interview Research: context and method* (pp. 629-649) *.* London: Sage.

Powers, W. T. (1973). *Behavior: The Control of Perception*. Chicago: Aldine.

Preston, S. (2014). Together we can beat this. *Children in Scotland, 185,* 10-11.

Prever, M. (2015). The Therapeutic Alliance and the Counselling Process. In S. Pattison, M. Robson & A. Beynon (Eds.) *The Handbook of Counselling Children and Young People* (pp.170-182). London: Sage.

Rawlinson, G. (2013). Are we competent to recognise our own incompetence? (Letters). *The Psychologist, 26*(7), 470.

Reicher, S. (2000). Against methodolatory: some comments on Elliott, Fischer and Rennie. *British Journal of Clinical Psychology, 39,* 1-6.

Responding to Self-Harm in Scotland (2010). Consultation paper produced by the National Self-Harm Working Group formed in August 2009. Retrieved 9 October 2010 from http://www.bps.org.uk/publications/consultation-papers

Rice, C. (2009). Imagining the other? Ethical challenges of researching and writing women's embodied lives. *Feminism & Psychology, 19,* 245-266.

Ricketts, J. (2011). Research review: Reading comprehension in developmental disorders of language and communication. *Journal of Child Psychology & Psychiatry, 52*(11), 1111-1123.

Rinpoche, G. (1975). *The Tibetan Book of the Dead.* Berkeley: Shambala.

Ritchie, J., Spencer, L. & O'Connor, W. (2003) Carrying Out Qualitative Analysis. In J. Ritchie & J. Lewis (Eds.) *Qualitative Research Practice: A Guide For Social Science Students and Researchers,* pp 218-262. London: Sage Publications Ltd.

Robinson, O. (2014). Re-examining the epistemological foundations of quantitative psychology: Pluralism, not positivism. *Qualitative Methods in Psychology Bulletin, 17,* 5-9.

Rocha, T. (2014). The dark night of the soul. *The Atlantic, June 2014. Retrieved August 27, 2014, from http://www.theatlantic.com/health/print/2014/06/thdark-knight-of-the-souls/372766/*

Ross, R. R., & McKay, H. B. (1979). *Self-Mutilation*. Massachusetts, Toronto: Lexington Books.

Ross, S. & Heath, N. (2002) A study of the frequency of self-mutilation in a

community sample of adolescents*. Journal of Youth and Adolescence, 31,* 67-77.

Ross, S., & Heath, N. L. (2003). Two models of adolescent self-mutilation. *Suicide and Life Threatening Behaviour, 33*, 277-287.

Rowan, J. (2001). *Ordinary Ecstasy: The Dialectics of Humanistic Psychology* (3rd edn) London: Brunner-Routledge.

Royal College of Psychiatrist (2010). *Self-harm, Suicide and Risk: Helping people who self-harm.* Final report of a working group. College Report CR158, London, RCP.

Ryan, J., Clemmett, S., & Snelson, A. (1997). Role of a psychiatric liaison nurse in an A and E department. *Accident and Emergency Nursing, 5*, 152-155.

Ryan, R. M. & Deci, E. L. (2001). On happiness and human potentials: A review of research on hedonic and eudaimonic well-being. *Annual Review of Psychology, 52,* 141-146.

Ryff, C. D. (1989). Happiness is everything, or is it – exploration on the meaning of psychological well-being. *Journal of Personality and Social Psychology, 57,* 1069-1081.

Ryff, C. D. & Singer, B. H. (1996). Psychological well-being: Meaning, measurement, and implications for psychotherapy research. *Psychotherapy and Psychosomatics, 65,* 14-23.

Sacks, H. & Jefferson, G. (1995). *Lectures on Conversation* (Vols 1 & 2). Oxford: Blackwell.

Samaritans (2013). *Samaritans' Newsletter*, Spring / Summer, 2013.

Sandelowski, M. (1995). Sample size in qualitative research. *Research in Nursing and Health, 18,* 179-183.

Scanlon, C., & Adlam, J. (2009). Why do you treat me this way? Reciprocal violence and the mythology of deliberate self-harm. In A. Motz (ed.).

Managing Self-Harm: Psychological Perspectives (pp 55-81) East Sussex: Routledge.

Schiller, G. (1972). *Iconography of Christian Art, vol. 2, The Passion of Jesus Christ.* Greenich CT: New York Graphic Society.

Schon, D. (1983). *The Reflective Practitioner.* Basic Books.

Scotland's Future (2013). *Scotland's Future: Your Guide to an Independent Scotland.* Edinburgh: A Scottish Government Publication.

SDC & RUHBC (2005). *Written on the body: a review of literature on self-cutting.* Scottish Development Centre for Mental Health & Research Unit in Health, Behaviour and Change, University of Edinburgh.

Shaw, C., & Shaw, T. (2007a). Working with self-harm: basic and advanced self-harm awareness training: www.harm-ed.co.uk.

Shaw, C. & Shaw, T. (2007b). A dialogue of hope and survival. In H. Spandler & S. Warner (Eds.), *Beyond Fear and Control: working with young people who self-harm* (pp 25-36). Ross-on-Wye: PCCS Books.

Shaw, R.L. (2010). Embedding reflexivity within experiential qualitative psychology. *Qualitative Research in Psychology, 7*(3), 233-243.

Shaw, S. (2002). Shifting conversations on girls' and women's self injury. *Feminism and Psychology, 12*, 192-219.

Simeon, D., Stanley, B., Frances, A., Mann, J. J., Winchel, R., & Stanley, M. (1992). Self-mutilation in personality disorders: psychological and biological correlates. *American Journal of Psychiatry, 149*, 221-227.

Simons, D. J. & Levin, D.T. (1998). Failure to detect changes to people during real-world interaction. *Psychonomic Bulletin and Review, 5*(4), 644-649.

Simpson, C. A., & Porter, G. L. (1981). Self mutilation in children and adolescents. *Bulletin of the Menninger Clinic, 45*, 429-436.

Sinclair, J. & Green, J. (2005). Understanding resolution of deliberate self-harm: qualitative interview study of patients' experiences. *British Medical Journal, May 14, 2005.*

Singer, D. & Hunter, M. (1999). The experience of premature menopause: a thematic discourse analysis. *Journal of Reproductive and Infant Psychology,* 17, 63-81.

Sipe, W. E. & Eisendrath, S. J. (2012). Mindfulness-based cognitive therapy: theory and practice. *Canadian Journal of Psychiatry, 57*(2), 63-69.

Smith, B. (2013). What is Narrative Analysis? In V. Braun & V. Clarke, *Successful Qualitative Research: a practical guide for beginners* (pp. 197-198). London: Sage.

Smith, J. A. (1995). Semi-structured interviewing and qualitative analysis. In J. A. Smith, R. Harre & L. van Langenhove (Eds.), *Rethinking methods in psychology* (pp.9-26). London: Sage.

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review, 5*(1), 9-27.

Smith, J. A., Flowers, P. & Larkin, M. (2009). *Interpretative phenomenological Analysis: Theory, method and research.* London: Sage.

Snyder, C. R. & Lopez, S. J. (Eds.) (2009). *Oxford Handbook of Positive Psychology.* Oxford: Oxford University Press.

Soloff, P., Lis, J., & Kelly, T. (1994). Self mutilation and suicidal behaviour in borderline personality disorder. *Journal of Personality Disorders, 8*, 257-267.

Spandler, H. & Warner, S. (Eds.). (2007). *Beyond Fear and Control: working with young people who self-harm.* Ross-on-Wye: PCCS Books.

Sparkes, A. & Smith, B. (2008). Narrative constructionist inquiry. In J. Holstein & J. Gubrium (Eds.), *Handbook of constructionist research* (pp. 295-314). London: Guilford Publications.

Spearman, C. (1904). 'General Intelligence': Objectively determined and measured. *The American Journal of Psychology, 15*(2), 201-292.

Stanley, B., Gameroff, M. J., Michalsen, V., & Mann, J. J. (2001). Are suicide attempters who self-mutilate a unique population? *American Journal of Psychiatry, 158*, 427-432.

Stevens, R. (2007). Person psychology: psychoanalytic and humanistic perspectives. In D. Miell, A Phoenix & K. Thomas (Eds.), *Mapping Psychology* (pp. 171-226). Milton Keynes: Open University Press.

Stihler, C. (2013). *March Newsletter: tobacco products directive to be reviewed.* Parliamentary Office 25 Church Street, Inverkeithing, Fife, UK.

Stirn, A., & Hinz, A. (2008). Tattoos, body piercing and self injury: is there a connection? Investigations on a core group of participants practising body modification. *Psychotherapy Research, 18*(3), 326-333.

Stoppard, J. (2002). Navigating the hazards of orthodoxy: Introducing a graduate course on qualitative methods into the psychology curriculum. *Canadian Psychology, 43,* 143-153.

Strong, M. (1999). *A Bright Red Scream: self-mutilation and the language of pain.* New York: Viking.

Sutton, J. (2007). *Healing the Hurt Within: Understand Self-Injury and Self-Harm, and Heal the Emotional Wounds* (revised and updated 3rd edit.). Oxford: How To Books.

Sutton, J. (2013). The emotions of ethics. (BPS annual conference report). *The Psychologist, 26*(6), 409.

Sutton, J. (2014). A new game plan for psychological science. [News]. *The Psychologist, 27*(4), 222-223.

Suyemoto, K. L. (1998). The functions of self-mutilation. *Clinical Psychology Review, 18*, 531-554.

Suyemoto, K. L., & MacDonald, M. L. (1995). Self cutting in female adolescents. *Psychotherapy, 32*, 162-177.

Swales, M. (2005). *Pain and Deliberate Self-harm.* The Welcome Trust.

Talking Self-harm (2012). *Talking Taboos: report on perceptions and misconceptions of the general population on self-harm.* London: Young Minds & Cello Group plc.

Tanguay, I. (2013). A review of Qualitative Inquiry in Everyday life: Working with

Everyday Life Materials by S. Brinkmann. *Qualitative Methods in Psychology Bulletin, 16,* 46-49.

Taylor, D., & Cameron, P. (1998). Deliberate self-inflicted trauma: population demographics, the nature of injury and a comparison with patients who overdose. *Australia and New Zealand Journal of Public Health, 22*, 120-125.

Taylor, G. W. & Ussher, J. M. (2001). Making sense of S&M: a discourse analytic account. *Sexualities, 4*(3), 293-314.

Tedeschi, R. G. & Calhoun, L. G. (1996). The post traumatic growth inventory measuring the positive legacy of trauma. *Journal of Traumatic Stress, 9,* 455-471.

Tesch, R. (1990). *Qualitative Research: analysis types and software tools.* London: Falmer Press.

The Psychologist (2013). News: Norman Kreitman. *The Psychologist, 26* (3), 171.

The Week (2013). Wit & Wisdom. *The Week, 18 May, Issue* 920, 22.

The Week (2014a). Wit & Wisdom. *The Week, 25 October, Issue* 994, 25.

The Week (2014b). Wit & Wisdom. *The Week, 17 May, Issue* 971, 23.

The Week (2014c). Wit & Wisdom. *The Week, 17 May, Issue* 971, 23.

The Week (2014d). Wit & Wisdom. *The Week, 1 November, Issue* 995, 25.

Thomas, K. (2007). The individual differences approach to personality. In D. Miell, A. Phoenix & K. Thomas (Eds.) *Mapping Psychology* (pp. 291-347). Milton Keynes: The Open University Press.

Thomas, L. F. (2014). Conversational science for qualitative and quantitative investigators: A personal journey. *Qualitative Methods in Psychology Bulletin, 17,* 42-48.

Thorne, S. (2011). Towards methodological emancipation in applied health research. *Qualitative Health Research, 21*(4), 443-453.

Toates, F. (2007). Biological processes and psychological explanation. In D. Miell, A. Phoenix & K. Thomas (Eds.) *Mapping Psychology* (pp. 225-289).

Milton Keynes: The Open University Press.

Todd, L. (2011). *DEdPsy Thesis Proposal Guidelines.* Newcastle: The University of Newcastle.

Tolle, E. (2011). *The Power of Now: a guide to spiritual enlightenment.* London: Hodder & Stoughton.

Townsend, M. (2000). *Psychiatric Mental Health Nursing: concepts of care* (3rd ed.). Philadelphia: FA Davis.

Tracy, S. J. (2010). Qualitative quality: Eight 'big-tent' criteria for excellent qualitative research. *Qualitative Inquiry, 16,* 837-851.

Truth Hurts (2006). *Report of the National Inquiry into Self-harm among Young People.* London: Mental Health Foundation.

Tuckett, A. G. (2005). Applying thematic analysis theory to practice: A researcher's experience. *Contemporary Nurse, 19*, 75-87.

Turner, M. J. (2014). Smarter thinking in sport: Use of rational emotive behaviour therapy (REBT) with athletes. *The Psychologist, 27*(8), 596-599.

Turp, M. (2001). *Psychosomatic Health: The Body and the Word*. London: Palgrave.

Turp, M. (2003). *Hidden Self-harm*. London: Jessica Kingsley.

Turp, M. (2007). Self-harm by omission: A question of skin containment. *Psychodynamic Practice: Individual, Group and Organisation, 13*(3), 229-244.

Van der Kolk, B. A., Perry, J. C., & Herman, J. L. (1991). Childhood origins of self-destructive behaviour. *American Journal of Psychiatry, 148*, 1665-1671.

Van der Sande, R., Van Rooijen, L., Buskens, E., Allart, E., Hawton, K., Van der Graff, Y., et al. (1997). Intensive in-patient and community intervention versus routine care after attempted suicide: a randomised controlled intervention study. *British Journal of Psychiatry, 171*, 35-41.

Victor, S. E. & Klonsky, D. E. (2014). Daily emotion in non-suicidal self-injury. *Journal of Clinical Psychology, 70*(4), 364-375.

Vivekanada, K. (2000).Integrating models for understanding self-injury.

Psychotherapy in Australia, 7, 18-25.

Walsh, B. W. (2012).*Treating Self-Injury: a practical guide.* New York: The Guilford Press.

Walsh, B., & Rosen, P. (1988). *Self-Mutilation: Theory, Research and Treatment* New York: Guilford Press.

Warner, S. & Spandler, H. (2012). New strategies for practice-based evidence: A focus on self-harm. *Qualitative Research in Psychology, 9*(1), 13-26.

Webb, L. (2002). Deliberate self-harm in adolescence: a systematic review of psychological and psychosocial factors. *Journal of Advanced Nursing, 38*, 235-244.

Weber, M. (2002). Triggers for self abuse: a qualitative study. *Archives of Psychiatric Nursing, 16*, 118-124.

Welldon, E. V. (1988). *Mother, Madonna, Whore: The Idealisation and Denigration of Motherhood*. New York: Guilford.

Wetherell, M. (2001). Debates in discourse research. In M. Wetherell, S. Taylor & S. J. Yates (eds.), *Discourse Theory and Practice: A Reader.* London: Sage.

White, C. P. (2014). A heavy stigma. *Life & Work: The Magazine of the Church of Scotland, July,* 44.

White, R. (2013). The globalisation of mental illness. *The Psychologist, 26*(3), 182-185.

Whitlock, J. L., Eckenrode, J. E. & Silverman, D. (2006). The epidemiology of self-injurious behavior in a college population. *Pediatrics, 177,* 1939-1948.

Whitlock, J., Muehlenkamp, J., Purington, A., Eckenrode, J., Barriera, J., Abrams, G. B., Marchell, T., Kress, K., Girard, K., Chin, C., & Knox, K. (2011). Non-suicidal self-injury in a college population: general trends and sex differences. *Journal of American College Health, 59*(8), 191-198.

Whitlock, J. L., Powers, J. L., & Eckenrode, J. (2006). The Virtual Cutting Edge: The Internet and Adolescent Self-Injury. *Developmental Psychology, 42*(3), 1-11.

Wickens, C. (2011). The investigation of power in written texts through the use of multiple textual frames. *International Journal of Qualitative Studies in Education, 24*(2), 151-164.

Wiggins, S. & Potter, J. (2008). Discursive Psychology. In C. Willig & W. Staiton-Rogers (eds.) *The Sage Handbook of Qualitative Research in Psychology.* London: Sage.

Wilkinson, R. & Pickett, K. (2009). *The spirit level: Why more equal societies almost always do better.* London: Penguin.

Wilkinson, S. (1988). The role of reflexivity in feminist psychology. *Women's Studies International Forum, 11,* 493-502.

William, M., Teasdale, J., Segal, Z. & Kabat-Zinn, J. (2007). *The Mindful Way Through Depression: freeing yourself from chronic unhappiness.* New York: Guilford Press.

Willig, C. (1999). Beyond appearances: a critical realist approach to social constructionism. In D. J. Nightingale & J. Cromby (Eds.), *Social Constructionist Psychology: a critical analysis of theory and practice (pp 37-51).* Milton Keynes: The Open University.

Willig, C. (2008). *Introducing Qualitative Research in Psychology* (2nd ed.). Maidenhead: Open University Press.

Winchel, R. M., & Stanley, M. (1991). Self-injurious behaviour: a review of the behaviour and biology of self-mutilation. *American Journal of Psychiatry, 148*, 306-317.

Windfurh, K., While, D., Hunt, I., Turnbull, P., Lowe, R., Burns, J., et al. (2008). Suicide in juveniles and adolescents in the United Kingdom. *Journal of Child Psychology and Psychiatry, 49*(11), 1155-1165.

Wing, L., Gould, J. & Gillberg, C. (2011). Autistic Spectrum Disorders in the DSM-V: Better or worse than DSM-IV? *Research in Developmental Disabilities, 32*(2), 768-773.

Wilde, G. J. S. (1982). The theory of risk homeostasis: implications for safety and health. *Risk Analysis, 2*(4), 209-225.

Wise, M. (1989). Adult self-injury as a survival response in victim-survivors of childhood abuse. *Journal of Chemical Dependency Treatment 3*(1), 185-201.

Wolpert, L. (1999). *Malignant Sadness: The Anatomy of Depression.* London: Faber & Faber.

Wood, A. M. & Joseph, S. (2010). The absence of positive psychological (eudaimonic) well-being as a risk factor for depression: a ten year cohort study. *Journal of Affective Disorders, 122,* 213-217.

Wood, C. & Richardson, A. (2002). Normal development? The case of dyslexia. In T. Cooper & I. Roth (Eds). *Challenging Psychological Issues.* Milton Keynes: The Open University.

Woods, J. (1988). Layers of meaning in self-cutting. *Journal of Child Psychotherapy, 14*, 51-60.

World Suicide Report (2014). *Preventing suicide: a global imperative.* Geneva, Switzerland: WHO.

Yardley, L. (2008). Demonstrating validity in qualitative psychology. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (2nd ed., pp. 235-251). London: Sage.

Zila, L. M., & Kesilica, M. S. (2001). Understanding and counselling self-mutilation in female adolescents and young adults. *Journal of Counselling and Development, 79*, 46-52.

Zimbardo, P., McDermott, M., Jansz, J., & Metaal, N. (1995). *Psychology: A European Text.* London: Harper Collins.

Zwicker, J. G., Harris, S. R. & Klassen, A. F. (2013). Quality of life domains affected in children with developmental coordination disorder: A systematic review. *Child: Care Health and Development, 39*(4), 562-580.

Appendices (U-Z; 1-23; A-B)

Appendices (U-Z)

Appendix U – Procedure regarding thematic analysis of transcripts of all six main study participants

Procedure for thematic analysis of Martha's transcript as an example

The abbreviated 1st order codes, (written down the left hand side margin of each page of the transcript), were collected together on the back of page 1 of the transcript. They were numbered in the order in which they appeared and meanings attached to each one. (See Appendix W, Abbreviated 1st order codes for Martha).

The full thematic analysis process was written in the middle of the back of page 1 of the transcript, along with symbols which would indicate how 1st order coding would be translated into 2nd order coding e.g. x = take out; ✓= keep in; ↑↓ = amalgamate / change / re-label; ? = don't know. The thematic analysis process was: recording of open, unstructured discussion → transcription → highlighting or underlining everything of interest (familiarisation) → 1st order coding (mainly descriptive codes or labels put on relevant comments which may relate to the research questions) → 2nd order coding (more interpretative coding which involved taking out, or keeping in, or amalgamating the previous codes) → 3rd order coding (thematic coding which identified possible themes or patterns from which a synoptic story could be constructed (utilising supporting data extracts / quotes). In essence I was moving the analysis gradually from subthemes to themes to overarching themes, and then finally to synoptic stories in order not to lose sight of the original data from which the overarching themes were developed.

The bottom half of the back of page 1 of the transcript consisted of a three column table outlining the analytical process and the results of moving from 1st to 2nd to 3rd order coding. (See Appendix Y List of Tables. Table 2 Coding Table for Martha).

Next, the 3rd order codes (overarching themes) were written down the right hand side margin of each page of the transcript alongside the raw data, some of which would be used in the synoptic stories. And, finally, on the back of page 2 of Martha's transcript, the themes were re-assembled into two **synoptic stories.** As the researcher, I compiled the first synoptic story in which I noted the lines in the transcript from which my story was derived. These lines were identified in two ways, firstly, by simply looking across from the theme written down the right hand margin of the transcript, and, secondly, by using the 'Microsoft Word Find Function' to locate particular terms on the transcript securely computer-stored in a .docx file. The other synoptic story consisted of the participant's own words which were put together utilising the data extracts identified by these lines.

[Procedures for thematic analysis of Sharrie, Nancy, Mattie, Ellie and Kate transcripts were essentially the same. See Appendix Y List of tables for Table 1 Coding for Sharrie, Table 2 Coding for Martha, Table 3 Coding for Nancy, Table 4 Coding for Mattie, Table 5 Coding for Ellie, and Table 6 Coding for Kate.]

Appendix W – **List of Abbreviations for 1st Order Codes (Sharrie, Martha, Nancy, Mattie, Ellie and Kate)**

Abbreviated 1st order codes for Sharrie (Excerpt only)

1. Rat/Quest – rating scale / questionnaire.
2. Exerc – exercising; too much exercise; too little exercise; weight in relation to exercising.
3. Weight – on the importance of a person's weight.
4. Pain – reference to physical pain of any kind.
5. Cut – mention of cutting the body.
6. What SH – what is self-harm; identification of self-harm; descriptions of self-harm.
7. SH func – the functions of self-harm; known functions; surmised functions.
8. Alc – alcohol; drinking; the role of alcohol in the person's life.
9. Smok – smoking; tobacco and its use.
10. Burn – burning referred to as a way of self-harming.
11. Coping – coping mechanisms.
12. Release – a way of de-stressing oneself.
13. CASHAS – culturally acceptable self-harming activities.
14. CUSHAS – culturally unacceptable self-harming activities.
15. Drugs – drugs; legal and illicit drugs; use of medicine prescribed by the GP; medicine bought at a pharmacy.
16. Emot Reg – emotion regulation and the feel-good factor.
17. Eat – eating; food; person's weight in relation to eating.
18. Work – working; employment and unemployment; studying at school, college or university.
19. Sleep – sleeping; not sleeping; lack of sleep; benefits of sleep; problems associated with poor sleep.
20. Friends – friends and friendship; benefits and deficits of relationships with friends.
21. Partners – intimate romantic partners; pros and cons of relationship with partner.
22. Stress – stress and the part it has to play in people's behaviour.
23. Balance – a balance of activities in life; a balance of self-care and self-harm; work and leisure balance.
24. Families – pros and cons of the family in relation to self-harm.
25. Bullying – bullying and its relationship to self-harm.
26. Other SH – self-harm known to have been carried out by others.
27. Dad – the role of fathers in the self-harm of their children.
28. Cry for help – cry for help as a function of self-harming.
29. Attention-seeking – attention-seeking as a function for self-harming.
30. Cause SH – the causes of self-harm; known causes; surmised causes.
31. Supp SH – support or intervention for self-harming; what works and what does not work; what is known to work and what is surmised might work.
32. Secret / not secret – self-harm as public vs self-harm as private.

33. Freq SH – the frequency of self-harming and how that may be related to severity…….FULL RANGE OF ABBREVIATIONS GOES FROM ITEM 1 – 50……

Abbreviated 1st order codes for Martha (Excerpt only)

1. SH what or SH defn – what is self-harm?
2. Worth – esteem; self-worth; self-image.
3. Dissoc – dissociation; apparent separation of person from the body.
4. Emot Reg – emotion regulation.
5. Trauma – traumatic events of some kind. ……FULL RANGE OF ABBREVIATIONS GOES FROM ITEM 1 – 35……

Abbreviated 1st order codes for Nancy (Excerpt only)

1. Rapport or closure – establishing a relationship with the participant and ending the meeting.
2. Ethics – living up to ethical guidelines in research.
3. SH rat – the self-harm / self-care rating scale / questionnaire.
4. Superv – supervision of research.
5. Choice – choices available to participants……FULL RANGE OF ABBREVIATIONS GOES FROM ITEM 1 – 48……

Abbreviated 1st order codes for Mattie (Excerpt only)

1. Rapp – rapport building.
2. Overweight – issues to do with being fat or overweight.
3. Over-eating – issues to do with eating too much.
4. Smoking – cigarette smoking.
5. Alc – drinking alcohol. ……..FULL RANGE OF ABBREVIATIONS GOES FROM ITEM 1 – 41…….

Abbreviated 1st order codes for Ellie (Excerpt only)

1. Rat scale/quest – rating scale questionnaire.
2. Supp/interv – support / intervention.
3. Weight loss – losing excessive amounts of weight.
4. Eating – eating to put on weight; uncomfortable eating vs comfort eating.
5. SH manipulation – manipulating others to get own way using self-harm….. ……..FULL RANGE OF ABBREVIATIONS GOES FROM ITEM 1 – 45……

Abbreviated 1st order codes for Kate (Excerpt only)

1. Rat / quest – rating scale questionnaire.

2. Bullying – victims and bullies and self-harming.
3. Over-weight – being over-sized; large body shape.
4. Relationships – friends; friendship formation and dissolution.
5. School – the primary & secondary school experience and self-harm.

……FULL RANGE OF ABBREVIATIONS GOES FROM ITEM 1 – 50….

Appendix X - **List of diagrams** (inserted into thesis, sections 1.2 & 1.313)

Appendix Y - **List of tables**

1st order coding (mainly descriptive; containing sub-themes.)	2nd order coding (more interpretative; clustering of sub-themes; themes.)	3rd order coding (clustering of themes; overarching themes.)
1.Rat/Quest x 2.Exerc ✓ 3.Weight ✓ 4.Pain✓ 5.Cut✓ 6.What SH ✓ 7.SH func ✓ 8.Alc ✓ 9.Smok ✓ 10.Burn✓ 11.Coping✓ 12.Release✓ 13.CASHAS ✓ 14.CUSHAS ✓ 15.Drugs ✓ 16.Emot Reg 17.Eat ✓ 18.Work x	24,25,30;22;27,35,38,39,42,50↑↓ Families;Bullying; **Cause** SH;Stress;Dad;Mental health;Daft;Underlying problem;Emot abuse;Abuse. 7,23,36,37,47,11,12;16;28,29;43↓↑ SH **func;**Balance; SH Phenom; Comm SH; SH Control;release;Coping;Emot reg; Cry for help; Attention-seeking;Symbolic; 6,33,34,45,46↓↑ **What** SH;Freq SH; Stable/unst;When SH;	Causes & functions of self-harm – [2] What self-harm is. CUSHAS & CASHAS – [1]

19.Sleep ✓ 20.Friends ✓ 21.Partners✓ 22.Stress✓ 23.Balance ✓ 24.Families ✓ 25.Bullying ✓ 26.Other SH ✓ 27.Dad✓ 28.Cry for help✓ 29.Attention-seeking✓ 30.Cause SH ✓ 31.Supp SH ✓ 32.Secret/not secret✓ 33.Freq SH ✓ 34.Stable/unst ✓ 35.Mental health✓ 36.SH Phenom ✓ 37.Comm SH ✓ 38.Daft✓ 39.Underlying problem✓ 40.Frustration✓ 41.Mum✓ 42.Emot abuse✓ 43.Symbolic✓ 44.SH suicide ✓ 45.When SH ✓ 46.Where SH ✓ 47.SH control ✓ 48.ShortT/longT ✓ 49.Overdose✓ 50.Abuse✓	Where SH; 8,9,13,2↑↓ Alc; Smok;**CASHAS;**Exercise. 14,26,5,10,49↑↓ **CUSHAS;**Other SH;Cut;Burn;Overdose. 19,24,31,41↓↑ Sleep;Families; **Supp** SH;Mum; 2,15,17,19,20,21,24, 44,48,32,37. Various codes which showed up **Contradictions/ Dilemmas –** Exerc; Drugs;Eat;Sleep;Friends;Partners;Families; SHsuicide;Short/longT; Secret/not secret; Comm SH.	Support & intervention – [3] Contradictions / dilemmas – [4]

Table 2 Coding Table for Martha

1st order coding (mainly descriptive; containing sub-themes.)	2nd order coding (more interpretative; clustering of sub-themes; themes.)	3rd order coding (clustering of themes; overarching themes.)
1.SH what or SH defn✓ 2.Worth ✓ 3.Dissoc ✓ 4.Emot Reg ✓ 5.Trauma ✓ …… …….. (excerpt only)	2,3,5,8,9,17,19,21,22, 23,26,33,34↑↓ Worth; dissoc; trauma; abusex or sexab; abuse; anger; obscom; mentally ill; parents or mum or dad; physab; SH shame; addict; **Cause** SH. …… …… ……	Causes & functions of self- harm – [2] …… ……

Table 3 Coding Table for Nancy

1st order coding (mainly descriptive; containing sub-themes.)	2nd order coding (more interpretative; clustering of sub-themes; themes.)	3rd order coding (clustering of themes; overarching themes.)
1.Rapport or closure x 2.Ethics x 3.SH rat x 4.Superv x 5.Choice x .... (excerpt only)	↑↓ 15,10,17,18,19,22,44,42,45,35. **SH why**; SH others; SH anger; Bad person; Punishment; Multi-**causal**; Depression; Parents or mum; Brothers or sisters; Self-esteem. …… ……	Causes & functions of self- harm – [2] …… ……

Table 4 Coding Table for Mattie

1st order coding (mainly descriptive; containing sub-themes.)	2nd order coding (more interpretative; clustering of sub-themes; themes.)	3rd order coding (clustering of themes; overarching themes.)
1.Rapp x		

2.Overweight ✓ 3.Over-eating ✓ 4.Smoking ✓ 5.Alc ✓ …….. …….. (excerpt only)	↑↓ 7,11,14,15,26,28,30,33,34. **SH cause**; cause/reason; stress; relationships; SH parent/parenting; SH& physical illness; depression; parenting; parent's views…….. ……	Causes & functions of self-harm – [2] …… ……

Table 5 Coding Table for Ellie

1st order coding (mainly descriptive; containing sub-themes.)	2nd order coding (more interpretative; clustering of sub-themes; themes.)	3rd order coding (clustering of themes; overarching themes.)
1.Rat scale / quest x 2.RQ x 3.Supp/inter✓ 4.Weight loss ✓ 5.Eating ✓ 6.SH manipulation✓ 7.SH (why?) ✓ 8.Parents ✓ 9.Health ✓ 10.Body image ✓ 11.Not SH ✓ 12.Self-caring ✓..... .. (excerpt only)	↑↓ 6,7,9,10,15,16,17,18,19,21,22,25,26,27,29,30,31, 36, 37,39,40,42,44,45. SH manipulation**; SH why;** health; body image; obsession; relationships; teacher/ employment /school; school/pupils; SH cutting; SH self-destructive; experiential replacement / avoidance; SH suicide; SH attention; SH pain; SH communication; SH cry for help; SH emot reg; SH unconscious; SH depressed; SH tension release; celebrities; personality; control; internet; blood. (**SH func).** …… ……	Causes & functions of self-harm – [2] …… ……

Table 6 Coding Table for Kate

1st order coding (mainly descriptive; containing sub-themes.)	2nd order coding (more interpretative; clustering of sub-themes; themes.)	3rd order coding (clustering of themes; overarching themes.)
1.Rat/quest x		

2.Bullying ✓ 3.Over-weight ✓ 4.Relationships ✓ 5.School ✓ 6.Supp/interv ✓ 7.Talking ✓ 8.Confidence ✓ 9.CASHAS ✓ ……. (excerpt only)	↑↓2,4,5,11,12,13,14,15,16,17,25,26,28,31,33,36 37, 39,40,47,48. Bullying; relationships; school; SH unconscious; addiction; stress relief; emot reg; pain; SH (not relief); eating; **SH causes/func /why;** habits; SH stress; coping; modelling others; SH control; gay/sexuality/cutting; SH emot distress;……. ……..	Causes & functions of self-harm – [2] …… ……

Table 7 Construction of subthemes (some examples)

Subthemes	How subthemes were constructed (e.g. items appearing many times in at least one transcript and related to the research questions).
Tension relief / release (14 times in Sharrie) Dissociation (17 times in Martha) Self-esteem & self-worth (14 times in Nancy) Over-eating (8 times in Mattie) Attention-seeking (4 times in Ellie) Nail-biting (14 times in Kate)	A subtheme in thematic analysis was defined by Braun & Clarke (2013) as a code which *"captures and develops one notable specific aspect of one theme...[and]...shares the central organising concept of that theme"* (p.337). I constructed subthemes on the basis of how prominent they were in at least one of the 6 transcripts. This prominence was likely to have been shown in a number of ways e.g. (a) being returned to by the participant at different points in the transcript; and/or, (b) being referred to many times in the same part of the discussion. In essence subthemes were constructed by clustering of similar 1st order codes and the frequency of appearance of specific items in single transcripts.

Table 8 Construction of themes (some examples)

Themes	How themes were constructed (e.g. items appearing across 4 or more transcripts and related to the RQs).

Alcohol/drinking Sharrie/Martha/Nancy/Mattie/Ellie/Kate Drugs/addiction Sharrie/Martha/Nancy/Kate Smoking Sharrie/Nancy/Mattie/Ellie/Kate Cutting Sharrie/Mattie/Ellie/Kate Coping Sharrie/Martha/Nancy/Kate Over-eating/weight Sharrie/Martha/Mattie/Ellie/Kate Pain Sharrie/Martha/Nancy/Mattie/Ellie/Kate Emotion regulation Sharrie/Martha/Nancy/Ellie/Kate Dad/mum/siblings/relationships Sharrie/Martha/Nancy/Mattie/Ellie/Kate Physical/sexual/emotional abuse Sharrie/Martha/Mattie/Kate Control/power Sharrie/Martha/Nancy/Mattie/Ellie/Kate Suicide/anti-suicide/overdose Sharrie/Martha/Nancy/Mattie/Ellie/Kate Secret/non-secret communication Sharrie/Nancy/Mattie/Ellie/Kate Physical & mental health/ill-health Sharrie/Martha/Ellie/Kate	A theme in thematic analysis was defined by Braun & Clarke (2013) as *"patterned meaning across a dataset that captures something important about the data in relation to the research question..."* (p.337). I constructed themes on the basis of their prominence in at least 4 of the 6 transcripts. They were essentially the result of clustering of subthemes e.g. 'alcohol/drinking' was referred to by all 6 participants, 'smoking' by 5 out of 6 participants, and 'pain' by 5 out of 6 participants, and so on.

Table 9 Construction of overarching themes

Overarching themes	How overarching themes were constructed (e.g. items appearing in all 6 transcripts and related to the research questions).
(1) What self-harm is. CUSHAS & CASHAS	According to Braun & Clarke (2013) an overarching theme

(2) Causes and functions of self-harm (3) Support & intervention (4) Contradictions or dilemmas	is *"...used to organise and structure a thematic analysis...[and]... captures an idea encapsulated in a number of themes"* (p.333). I constructed overarching themes by clustering themes which appeared to have similar or related meanings. They were formed initially from thematic analysis of the Sharrie transcript, and subsequently allowed to influence the formation of overarching themes from the other 5 transcripts.

Table 10 Table of subthemes, themes & overarching themes (some examples)

Subthemes (e.g.1st order codes; clusters of 1st order codes; items of relevance to research questions): some examples	Themes (e.g. 2nd order codes; clusters of subthemes): some examples	Overarching themes (e.g. 3rd order codes; clusters of themes).
Tension relief / release Dissociation Self-esteem & self-worth Over-eating Attention-seeking Nail-biting	Alcohol/drinking Drugs/addiction Smoking Cutting Coping Over-eating/weight Pain Emotion regulation Dad/mum/siblings/relationships Physical/sexual/emotional abuse Control/power Suicide/anti-suicide/overdose Secret/non-secret communication Physical & mental health/ill-health	(1) What self-harm is: CUSHAS & CASHAS (2) Causes & functions (3) Support & intervention (4) Dilemmas or contradictions

Table 11 Overarching theme (1) - What self-harm is: CUSHAS & CASHAS

Participants	What self-harm is: CUSHAS (some examples)	What self-harm is: CASHAS (some examples)

Sharrie	"*...My gut instinct was probably the stereotype of self-harm...cutting ... release...".* (lines 42-43)	*"...after thinking about...that stereotype, no that stereotype doesn't affect me. I don't do that. But then thinking about it, I'm smoking, I drink. I don't drink that often, but when I do, it's probably what would be called binge drinking. So I drink more than I should. So that's harming..."* (lines 44-47).
Martha	*"...I'd scrub myself clean after my dad hurt me and I'd feel dirty all the time. I'd scrub myself till I bled...That started with me when I was about 9 but it came to a head when I was about 14..."* (74-75).	*"...My self-harm was extremism... I used to exercise to the extreme and I would be shaking and falling on the floor...I'd starve myself to see how much I could live on..."* (72-74).
Nancy	*"...Generally I would cut myself, so that's the main thing that I would do…I suppose I would tell myself that if I used just my finger nails or something like that, then it's less of a big deal..."* (81-83).	*"…I think that now I've got a sort of broader definition of what self-harm is and…when I was younger I used to fast and things and I think it's probably kind of connected. But I didn't sort of try to physically hurt myself till I was a bit older [age 19]..." (87-90).*
Mattie	*"...We have serious issues with self-harming in school... About 4 or 5 girls a year will sidle up and say, 'Can I talk to you, Miss?', and you think, 'Right this is either anorexia or self-harm* [cutting]*, isn't it?'...I don't know if it's all part of the same package..."* (158, 160-162).	*"...One of my issues as you see is overweight...My weight goes up and down in this 4 stone band... My wardrobe goes from size 16 to size 22...I've done that pretty much all my life, and I would say that over-eating, which is a form of self-harm in my opinion, is becoming culturally unacceptable in a way that it used to be okay..."* (27-32).
Ellie	*"...if you went out to the pub and said you had a hard day at work…went home and cut …people would be really shocked and upset and worried about you..."* (288-290).	*"...I probably see myself in the non-self-harmer [category] edging slightly towards, you know, maybe I don't look after myself enough..."* (270-271).
Kate	*"...I've got one friend who's been a serious self-harmer for a while…She cut herself… but she was bullied even worse than I was at Primary school. Ehmm, and she became a self-harmer..."*	*"...nail-biting...I'm a really bad nail-biter...I've tried so many times to stop and I can't do it...I don't remember not doing it...It gets worse when I'm worrying about something...[JJ: So is that something you would categorise*

	(126-127).	*as self-harming?] ... Ehmm, to a certain extent. I guess it's painful sometimes but I still do it..."* (47-51, 54-63).

Table 12 Overarching theme (2) – Causes and functions of self-harm

Participant	Causes of self-harm (some examples)	Functions of self-harm (some examples)
Sharrie	*"...she'd pick up bits of glass and I wouldny say cut herself but kind of scratched herself ...I don't think she* [friend] *had the kind of relationship with her dad that she wanted...She had a boyfriend at the time... but it was really one-sided on her part. He didny really give her anything back..."* (lines 176, 179-180, 182-184).	*"...it could possibly have been a kind of cry for help...I always just put it down to...a bit of attention-seeking, and just being a bit 'cookie'..."* (lines 178-179, 189-190).
Martha	*"...he* [dad] *tried to rape me...and I just flipped, and I don't remember anything. I just conked out the brain. I just shut off...Inside I was just screaming and screaming and screaming ..."* (78-81).	*"...I'd get my arm ripped open with this wire. And people would say: 'Is that no hurtin' you?' and I'd say 'Nup', 'cause I'd cut myself off. I wanted to feel a bit of pain. It gave me emotion. I liked pain. And that might sound illogical. It made me feel I was alive 'cause I felt like I was dead. So I cut myself to feel alive. I didn't want to be hurt mentally. You could hurt my body but you couldn't get in here* [pointing to head]*...*(101-105).
Nancy	*"...I think for...individuals it* [self-harm] *can be for different reasons at different times..."* (259).	*"...It* [self-harming] *was partly a way to kind of express that I felt frustrated and upset and angry and I thought if I did this then people would maybe notice and they would ask me about it. So I think it was a kind of attempt to communicate how I felt..."* (91-93).

Mattie	*"...I'm not surprised that she* [daughter] *feels really rubbish about herself. So I think it* [cause of cutting] *was feelings of self-hatred..."* (236-237).	*"...Towards the end of my marriage I was nearly 18 stone, and…that is BIG...Well, when your belly comes down it covers all your genitals and you end up with an apron and it effectively goes: 'Look no way'...It's a way to make yourself not sexual, I think..."* (42-47).
Ellie	*"...My first boyfriend...we were about 13 or 14...when we split up, which at the time was all traumatic and awful...A week later he came into the school and he'd been cutting his arms..."* (198-203).	*"...He* [boyfriend] *was just doing it for attention...not like* [friend's mum] *who's a real self-harmer..."* (220-221).
Kate	*"...I've got one friend who's been a serious self-harmer for a while...She cut herself ...But she was bullied even worse than I was at primary school..."* (126-127).	[JJ: ...D'you see a link between cutting, drugs, and alcohol in relation to your friend or are they separate…?] *"...I think there's some continuity ...There was still a need to have some release from whatever she needs a release from..."* (174-178).

Table 13 Overarching theme (3) – Support and intervention

Participants	Support and intervention (some examples)
Sharrie	*"...At the time I can remember being quite dismissive of it* [friend's cutting] *and going, kind of, 'Don't be so stupid. What are you doing that for? Get a grip'..."* (lines 176-178). *"...It maybe was just silly teenage stuff...I never asked about it and I never thought she would want to discuss it..."* (198-200). *"...I just remember thinking 'That's so silly'...I think probably I was too young at the time to understand what she was doing...It feels strange that I never actually did more about it at the time...At the time I really did dismiss it and put it down to being daft..."*(204-209).
Martha	*"...I've been around social workers all my life. The nicest one I ever had was Mr Highbodgiball. He was a black man who'd come to Irvine. I was about 15. He listened. He didn't judge me. He was nice...It's funny, I always remember that man for listening to me. He made a big difference in my life 'cause he listened to me. He smiled..."* (500-506).
Nancy	*"...I lived in Germany for a while and a therapist there actually showed an interest in trying to help me work out why I might be*

	doing it [cutting]...*I went to Germany after uni to work for a while... Maybe it was just the fact that someone showed an interest that helped me to sit down and examine it...I think I would find it very difficult to talk to a friend about it because people's emotions are very involved…and ultimately very 'Look just don't do that'…I think it's very difficult to stop if you don't know why you're doing it in the first place. So to be able to talk to someone who is impartial, and is accepting of where you are at, and this is what you are doing, but how can I help you to unpick that, and unravel that, so that it makes sense to you? And that seems to me to be the primary aim rather than just, 'Let's get you not to do this'. And I felt that was quite a helpful approach..."* (163-178).
Mattie	*"...For 'G'* [daughter], *THE...NHS...HAS...DONE...NOTHING* [said slowly and deliberately] *except bad tempered nurses patching her up inadequately…She's had a lot of treatment, and its all been private...Where she's worked she's had private health insurance. And that was the only way to get any effective treatment. Treatment for self-harm when you've been sectioned, and she was briefly sectioned once, is just being put in a locked ward with no access to anything...She went to...a lovely place called the Cardinal Clinic in Windsor…It really, really helped her*...[It was] *her psychiatrist, Shyvonne, that she built up a really good, trusting relationship with. She still sees her even though she's no longer under the Cardinal Clinic but she pays privately to see Shyvonne…Just the fact that she's got this relationship that she can absolutely trust..."* (356-368).
Ellie	*"...The forums on the internet and the idea of people who have self-harmed in the past talking to each other. I think it's very easy to say that's really negative, promoting it and things. But I think there is perhaps something to be said for the benefit of that. You're talking to someone who understands a bit of what that's like as opposed to somebody...perhaps a psychiatrist...You maybe need somebody who's almost at your level..."* (384-392).
Kate	*"...I've found that, especially with my partner...I can talk to him… We were friends before we got together, and…from the day we started talking he's always been very open and, I've felt, very nonjudgmental towards me. And so I've kind of opened up to him. So I pretty much talk to him about everything now...absolutely anything that's worrying me, that's made me angry, or whatever... And…it's kind of dealt with and then I can move on from it...He's a shoulder to cry on…That kind of sorts it for me. I don't need another outlet too much anymore..."* (197-205).

Table 14 Overarching theme (4) – Contradictions or dilemmas

Participants	Contradictions or dilemmas (some examples)

Sharrie	*"...If you are cutting yourself to have a 5 minute break fae the daily grind, or, are you cutting yourself to deal with some other big issue, you know, like abuse, mental health problems, or that kind of thing? I think if there's an underlying problem causing the self-harm then that needs to be addressed...Probably not so much in relation to smoking, but drinking, that's probably how a lot of alcoholics start. It's probably a coping mechanism which escalates. So I think kinda stereotypical self-harmers, kinda alcoholics, drug addicts kinda thing, if there's an underlying issue that they're trying to deal with, I think it should be treated...Not necessarily stitching them up, and then you go and do it again.. .And that's not to say that they all have an underlying issue...It's still more acceptable to smoke than it is to cut yourself, self-harm, in that sense. But it really depends on the extent of the self-harm, who's doing the more damage..."* (lines 453-467).
Martha	*"...I've got pain in my body. I've got neurological pain. There's nothing they can do for it. I've got a broken neck...I get all the pain that goes with it. So I have pain, constant pain from my chest down. But I quite like that pain because it tells me where my body is, doesn't it? If I've got pains in my legs, I know where my legs are. It's only when another pain comes along, then I'll take a paracetamol or a drug. I'll not take anything for the other pain because my brain can cope with that pain...It's horrendous pain... It's that burning, like rods going through your legs, but I can cope with that. I can accept that pain. And this sounds really odd, it's quite an enjoyable pain. I feel like I'm here...I don't need to hurt myself anymore 'cause the pain is there constantly..."* (131-142).
Nancy	*"...It* [self-harming] *was partly a way to kind of express that I felt frustrated and upset and angry and I thought if I did this then people would maybe notice and they would ask me about it so I think it was a kind of attempt to communicate how I felt*...[JJ:..So for you self-harm was...a kind of communication thing, you wanted people to notice...?]*…I don't think so actually. Well, I think partly it's changed over time what it's been about...I think…it's definitely not about wanting people to notice...I think it's maybe been a way of, I don't know, if there can be such a thing, communicating with yourself, if that makes sense..."* (91- 100).
Mattie	*"...I don't do alcohol at all...I mean, I had a G and T last night and I'll have a half a glass of wine with my Sunday lunch and that's it... I could go from one end of the month to another without one drop of alcohol and it wouldn't bother me in the slightest...However, if I'm going out on the lash I can down a considerable amount to the point where I can't stand...It's like, 'I'm going drinking', so I would really drink, but 99 days out of 100 I would have no alcohol at all…"* (95-101). *"...I would say that overeating, which is a form of self-harm in my opinion, is becoming culturally unacceptable in a way that it used to be okay. Smoking and drinking too much were bad but overeating was okay, but it's now...been demonised..."* (31-34). *"...The feeling I got from what she* [daughter] *said to me was that*

	the nurses treated it like an attack on their profession...But if that was someone who'd drunk themselves to a heart attack or liver disease, they wouldn't see that as an attack on their profession... And nobody ever wants self-harm to be culturally acceptable, but you've almost got to get to the point where it's not acceptable but it's understandable and it's not necessarily blameworthy...So, it's a little bit of re-categorisation..." (417-426).
Ellie	*"...People talked about it* [self-harm] *when I was a teenager and things but I've never really known anybody, well, who's had a real life experience of it...*(167-168). *"...I had a friend, my first boyfriend actually…Well, we weren't boyfriend and girlfriend actually. We were about 13 or 14 and… when we split up, which at the time was all traumatic and awful, but I'm sure it wasn't actually, he said to another one of our friends: 'Ah, I'm going to kill myself. This is really awful'. Which at the time was really upsetting...A week later he came into school and he'd been cutting his arms..."* (197-204). *"...I drink but I think moderately...I wouldn't consider myself to be a self-harmer at all...If I go to a pub, I'd probably have maybe 2 or 3 glasses of wine...I probably do drink more if I go to a club or something like that but that's not very often. That probably would be classified as binge drinking but I wouldn't consider myself to be a binge drinker...I don't do it very much but I suppose that doesn't matter...I think it is possible to be drinking till, even if it's unconsciously, you're harming yourself. But I think there are lots of reasons for drinking and I think one of them is, almost like that tension thing, you're letting out steam. I suppose a culturally acceptable way of letting out steam…I've just said that it's not self-harm but maybe I've just talked myself round in a circle..."* (272-292).
Kate	*"…I'm a really bad nail-biter...And it's something I've tried so many times to stop and I can't do it...It's not something I seem to be able to do very much about. I have tried. As soon as something stresses me out, it doesn't seem important any more so I just go back to it..."* (47-49; 59-61). *"...Trying to nudge them* [self-harmers] *from something that's really dangerous, like the cutting which can be very dangerous… towards something that's less dangerous, you know, instead of just trying to get them to stop. I think that's a good way to go…I'm one to talk 'cause I bite my nails but I don't really have the desire to stop and so I don't. But then...I don't think I'm causing myself any particular danger...You find people with…anorexia. You find people who do understand that by eating so little they're doing serious damage to their physical body but mentally they're happy with that. And so they don't feel they need to change...I think… there's also very much a, 'Oh, but that's not me. It's dangerous to everybody else but it's not dangerous to me'. A bit like the smokers…Smoking causes cancer but it won't happen to me. That sort of perception. I wonder if the same can be applied to other forms of self-harm where…it might be dangerous for*

	everybody else but for me it's…okay 'cause it makes me happy, or, it makes me feel better..." (401-419).

Table 15 Comparison of transcript & synoptic story word-lengths

Participant	Words in transcript	Words in participant's own synoptic story
Sharrie	8857	1247
Martha	13107	1811
Nancy	12410	1329 (+2756 in Appendix A)
Mattie	7990	1316 (+1648 in Appendix B)
Ellie	8479	1342
Kate	8551	1514

Appendix Z - **List of Photographs** (inserted into thesis, section 1.34)

Photograph 1: Tattoos – too many?

Photograph 2: Piercings – over-the-top?

Photograph 3: Tattoos and piercings – acceptable or unacceptable? In whose culture?

Appendices 1 - 23

Appendix 1
Pilot Study Information Sheet
SCHOOL OF EDUCATION, COMMUNICATION AND LANGUAGE SCIENCES

The research on self-harm I am undertaking is a component of the work which is required in part fulfilment of the DEdPsy (Doctorate in Educational Psychology) at Newcastle University.
The title of my pilot study is: **"Insights into Self-harm: a comparison of information gleaned from (a) a selective literature review, (b) thematic analysis of an unstructured, open interview of an experienced worker with self-harm, and (c) thematic analysis of an unstructured, open interview of a known self-harmer".**
My intention is to firstly interview an experienced worker with those who self-harm, and then to interview someone who views himself / herself to be, or to have been at one time, a self-harmer. The interview will take place in a venue of your choosing and you may have someone with you to provide support if you wish. The session is likely to last less than an hour. The questions asked will generally be open-ended and you will be invited to give your opinion on what self-harm is, why people do it, who does it, how it is carried out and how individuals who self-harm can be best supported.
There will be no pressure on you to answer any questions that you are not comfortable talking about. An attempt will be made to encourage you to talk about any knowledge or experience of self-harm that you have and may be interested in discussing.
If you are prepared to participate, I will provide you with a consent form to sign that will be our agreement that: a) you have been informed about the research and why it is taking place; b) you understand that your participation in the research is voluntary; c) you know that you can withdraw from the research at any time; d) you are aware that your data will be anonymous; and, e) you have been informed that you will be provided with a debrief after taking part.
I will be pleased to provide a copy of the final assignment to you when it is completed. My contact details are:
John H. Jamieson 22 Moorfield Avenue Kilmarnock KA1 1TS
Tel. 01563 534065 Mobile 07753425836
E-mail addresses: johnhjamieson@tiscali.co.uk j.h.jamieson@newcastle.ac.uk

Appendix 2
Pilot Study Consent Form

SCHOOL OF EDUCATION, COMMUNICATION AND LANGUAGE SCIENCES

Consent to participate

I have been asked to participate in this research on self-harm and give my free consent by signing this form.

I have been informed about the research and why it is taking place.
I understand that my participation in this research is voluntary.
I understand that I can withdraw from the research at any time.
I understand that my data will be anonymous.
I understand that I will be provided with a de-brief after taking part.

Signature _____
Date _____

Appendix 3
A sample transcript of video/slide presentation retrieved on 1 February 2011 from http://www.youtube.com/watch?v = p55akpogFJs (part of pilot study)
Self Harm: Stuart's story by TheSite.org (6 mins. 31 secs.)
"I first started self-harming when I was 19…I just came back from a camp in America. Someone I was very close to in the camp got raped. I came back to England. I was in my gap year…I came back to an empty house. I'd always kind of suffered from depression and this really triggered a really depressive episode and my mind started spiralling out of control and I felt really lost. I didn't know what to do so one day I lashed out and smashed a mirror and cut myself and just…The pain really helped me focus and cleared up what was going on in my head. So self-harm became my way of coping with the turbulence and the turmoil that was going on for me…The point where I felt most vulnerable and isolated was…mostly at night. During the day I could distract myself and I became the master of distraction. It was whenever I stopped, whenever I had a moment to sit down and there was no one there, and it was night time, that was when my problems, my demons, really came back…That's when I felt most vulnerable and that's when I'd fall back into my pattern of self-harming…When I started university I quickly got involved in a relationship. She was awesome. She was really, really understanding…I went and saw a GP…She (GP) said that I was a really intelligent person and why was I doing this. I really started a process of self-loathing because of that…I felt completely lost and that's

why I continued to self-harm…Strange as it may sound, that was my way of taking care of myself. The way I see it was, lots of little cuts saved me from one big cut. How is that not an act of love? It ultimately saved my life…My problems got worse and got to the point where I became suicidally depressed and I was in a serious rut and seriously contemplating ending my life. I didn't want to live my life any more…I went on a cycling trip…My muscles stretching. I was getting from this physical exercise what I was getting from my self-harm…I've continued this exercise therapy. I've done a trip from John O'Groats to Lands End. I've got a punch bag. I really recommend that to anyone. You can get all your frustration and anger out…I know that if I physically feel fit, I mentally feel better as well…Make sure you are eating well and basically taking care of yourself and not hiding away from the world…".

Appendix 4

Thematic Analysis of 18 www. youtube.com contributions retrieved on Jan. & Feb. 2011 (part of pilot study)

1st order coding (mainly descriptive)	2nd order coding (more interpretative; code amalgamation etc)	3rd order coding (further interpretation; themes)
In the end it becomes a problem on its own. It's an addiction (1). Self-harm is an addictive behaviour…Once you start it's hard to stop. It will be part of your life for -ever (2). It is an addiction. Believe me once you start it's very hard to stop. At the moment I was cutting I felt that nothing else really mattered. I just felt so free. The more I cut, the deeper I cut, the more I wanted to cut…Right now I am recovering from self-injury and it is the hardest thing I have ever had to do (3). When you can stop you don't want to…and when you can't there's nothing more you want to do…Don't let it grab a hold of you. You'll end up like me…I wish I could stop. I want to stop (4)…… …… (Excerpt only)	Self-harm appeared to have become an ADDICTION with many of the characteristics of alcoholism, drug addiction etc. Inability to stop even if the person wanted to. An inner craving. Physiological need to see the blood flowing and so on.	1. ADDICTION

(1) Retrieved on Jan. & Feb. 2011 from http://www.youtube.com/watch?v = s6FSWEOHJCk&feature = fvst

(2) Retrieved on Jan. & Feb. 2011 from http://www.youtube.com/watch?v = uWJTDGlSWC8

(3) Retrieved on Jan. & Feb. 2011 from http://www.youtube.com/watch?v = fLodqVTWG_o

(4) Retrieved on Jan. & Feb. 2011 from http://www.youtube.com/watch?v = kcwjwZghlGO
(5) Retrieved on Jan. & Feb. 2011 from http://www.youtube.com/watch?v = dHyXczBualc
(6) Retrieved on Jan. & Feb. 2011 from http://www.youtube.com/watch?v = GBmoYHXrgyE
(7) Retrieved on Jan. & Feb. 2011 from http://www.youtube.com/watch?v = BDh8osabH3E
(8) Retrieved on Jan. & Feb. 2011 from http://www.youtube.com/watch?v = PFXmmoZepe4
(9) Retrieved on Jan. & Feb. 2011 from http://www.youtube.com/watch?v = hIbhWtrgv-I
(10) Retrieved on Jan. & Feb. 2011 from http://www.youtube.com/watch?v = IBJXvVzqZ9E
(11) Retrieved on Jan. & Feb. 2011 from http://www.youtube.com/watch?v = p55akpogFJs
(12) Retrieved on Jan. & Feb. 2011 from http://www.youtube.com/watch?v = RCkNjLW3214
(13) Retrieved on Jan. & Feb. 2011 from http://www.youtube.com/watch?v = KlG7uWXYIWQ
(14) Retrieved on Jan. & Feb. 2011 from http://www.youtube.com/watch?v = tsf0qYdAkDs
(15) Retrieved on Jan. & Feb. 2011 from http://www.youtube.com/watch?v = OVg6VaAYrtE
(16) Retrieved on Jan. & Feb. 2011 from http://www.youtube.com/watch?v = 9_ICNfFksRw
(17) Retrieved on Jan. & Feb. 2011 from http://www.youtube.com/watch?v = Dao3eSZCRoU
(18) Retrieved on Jan. & Feb. 2011 from http://www.youtube.com/watch?v = Cr534pW6wC48feature=fvst

Appendix 5

Transcribed discussion with experienced self-harm worker – Marie (part of pilot study) – Excerpt only i.e. lines 1-13 and lines 281-302.
(Total length of recording [sound & vision] = 39 minutes)
J = John Jamieson
M = Marie

J What were you going to say when I so rudely interrupted you?1
M What I was going to say is that one of my interests is the challenges that2 professionals face. We know through 'Truth Hurts' and other reports that asking3 people to sign a contract to stop, doesn't work. People need time to reduce it just like4 smoking. For a lot of people you have to do it there and then and that's it – cold5 turkey - but for a lot of people, perhaps older people, they have relied on it for6 maybe years. So for someone to say, that's it you have to stop, otherwise you cannot7 engage in therapy, for them the anxiety gets in the way of the therapeutic8 intervention.9
J So, contracts don't work?10
M In a lot of people they don't. They say 'this is what I have done for so many11 years, how can I just stop?' Also, there are emotional relationships with the12 implements.13
……
……
……
……
……
…….
M That's something that also has been…I mean, self-harm has been in human281 history up until the present. Why now is it flaring up? As humankind, nobody else282 apart from the youth of 2010 has used self-harm to cope with emotions? (Said with283 sarcasm in her voice). Why now?284
J Are you suggesting that historically it has always been there?285
M Has it? I don't know? I have no idea. There are no records. There is flagellation in286 the Catholic church for example. There have been accepted ways of enduring pain287 like tribes in the heart of Africa they have rituals of endurance and stuff like that288

which were accepted socially. Maybe we have removed that. Who knows? It's quite289
interesting, isn't it?290
J Certainly in some primitive tribes piercing goes on. In fact not only in primitive291
tribes but in this country people pierce their ears and their noses.292
M And their toes…293
J And in your view does that get to a certain point where it is self-harm whereas294
before that point it is not self-harm, it is perhaps a decorative, acceptable thing?295
M I just don't know. These are questions that I just don't know.296
J So after 10 years working in the field there are lots of things you still don't know297
the answer to.298
M Yes, obviously (laughing).299
J That's a nice humble attitude to have. It's not common to all professionals.300
M Thank you (smiling and laughing).301
J I'm grateful to you. Thank you.302….FULL TRANSCRIPT GOES FROM LINE 1 – 302…

Appendix 6

Thematic Analysis of transcript of discussion with experienced self-harm worker (Marie; part of pilot study)

1st order coding (mainly descriptive)	2nd order coding (more interpretative; amalgamation of 1st order codes etc.)	3rd order coding (further interpretation; themes)
People need time to reduce it just like smoking (line 4-5). For a lot of people you have to do it there and then and that's it – cold turkey (line 5-6). It is an addictive behaviour (line 39). It has been sustained for so long that anything triggers it (line 153). I worked with somebody who had been married for 30 odd years to a GP and he never knew that she self-harmed (line 246-247)…….. …….. (excerpt only)	Self-harm appeared to have become an ADDICTION with many of the characteristics of alcoholism, drug addiction etc. Smoking Cold-turkey Sustained for so long	1. ADDICTION

Appendix 7

Transcribed discussion with participant known to seriously self-harm (part of pilot study – Lorna) – Excerpt only i.e. lines 1-25 and lines 271-287.
(Total length of recording [sound & vision] = 34 minutes)
J = John Jamieson L = Lorna
(Also present: a friend of L, and Marie. Venue: L's home).

J What I'm looking for, L, is for your expertise, your knowledge from an insider's1
point of view. So could you maybe just start and tell me when you started.2

L When I started self-harming was in high school.3
J What age would you be?4
L About 14. 5
J About 14? And what age are you now? Or is it not appropriate to ask a lady her6 age?7
L No, I'm 25 now. 8
J And have you been free of self-harm for a while? Or is it still part of your life.9
L I've been free of it. Well, I was free of it for a good couple of years 'cause I found10 my way of coping with it. I mean it took me years to find that. My way was if I felt11 like cutting or I was suicidal I would go and get my nephew 'cause I knew I wouldn't12 cut myself if I was with him. That was my way of stopping myself. But before I had13 anything like that I was cutting quite a lot actually. And there was people like Marie14 who helped me 'cause I wasn't hurting myself to kill myself. I wasn't cutting myself15 'cause I wanted to die. At school, I know now but I didn't know back then. I couldn't16 understand why I was doing it back then. But now I've got older and I've found out17 just recently that I'm dyslexic. It made a lot of sense. Maybe that's why I was doing it18 at school to try and get the help that I needed. Like trying to show them that I was19 struggling. I wasn't getting any learning support or anything like that. And my20 guidance teacher, she was the one that first saw the scratches. She just gave me21 Speak Easy and never informed my mum about it. So my mum had no idea about22 my self-harming. And then I ended up being kicked out of school and all there's to it.23 And then I got abused when I was 16 which made me start drinking heavy and that's24 when the cutting got worse. And just kept getting worse from there.25

……

……

J Are the people that you know who have self-harmed, have they self-harmed for the271 same reasons that you have?272
L No. Different. I think everybody has got their own reasons for it.273
J What kinds of reasons do they have?274
L It might be, like, they are not getting on with family. Family not understanding them.275 It could be a fall-out with a boyfriend…It's like just stupid things.276
Marie [self-harm worker] They're not stupid.277
L No, they're not stupid. Just simple things, everyday things.278
[Some general chat took place about football and the fortunes of Scotland in comparison279 to the current world champions, Spain; the self-harm worker, Marie, was280 Spanish].281
J Can I just say that I'm grateful for all the time you have spent talking to me about282 self-harm. It may be that because this is just the start of a bigger piece of work I am283 doing on self-harm, it may be that I would like to see you again at some point in the284 future. But I don't want to impose myself on you if you think that you don't want to285 talk to that strange guy.286
L No, you have been alright but I was pretty nervous before you came.287

Appendix 8

Thematic Analysis of transcript of discussion with the participant known to seriously self-harm (Lorna; part of pilot study)

1st order coding (mainly descriptive)	2nd order coding (more interpretative; amalgamation of 1st order codes etc.)	3rd order coding (themes)
People think because I have	Self-harm appeared to have	1. ADDICTION

not self-harmed for a while that I don't have the thoughts and that every day. I fight with these thoughts every single day (line 78-80) …… …… (excerpt only)	become an ADDICTION with many of the characteristics of alcoholism, drug addiction etc. Fighting against self-harm daily	

Appendix 9

Thematic Analysis of selective literature review (during pilot study)

1st order coding (mainly descriptive)	2nd order coding (more interpretative; amalgamation of 1st order themes; renaming etc)	3rd order coding (themes)
Grossman & Siever (2001) and Walsh (2012) use the term *'addiction hypothesis'* owing to the apparently addictive properties that self-harm seems to have for many individuals.	Self-harm appeared to have become an ADDICTION with many of the characteristics of alcoholism, drug addiction etc.	1. ADDICTION
One definition of self-harm is that it is *'a purposeful, if morbid, act of self-help'* (Favazza & Conterio, 1989).	Self-harm seemed to be a general COPING mechanism that was more effective than other more conventional means.	2. General COPING mechanism
Hawton and his colleagues found that the top motive selected by young people for both self-cutting and self-poisoning was to *'escape from a terrible state of mind'* (Hawton, Rodham & Evans, 2006). Adults who self-harm have been diagnosed with anything from clinical depression to Munchausen Syndrome (Van der Kolk, Perry, & Herman, 1991).	Self-harm was a response to melancholy, unhappiness, and DEPRESSION.	4. DEPRESSION
The desire to manage unbearable emotional pain is frequently present (O'Connor, Rasmussen & Hawton, 2009). Some self-harmers say that they feel less tense and more at peace after self-harming (Klonsky, 2007; Csipke & Horne, 2008).	Self-harm was a response to many of the basic emotions such as Fear, Disgust, Anger, and Sadness. It was about EMOTION REGULATION.	5. EMOTION REGULATION

For some people who self-harmed it seemed to be mainly a matter of control. There were so few things in their lives that they could control, apart from the self-harm. They alone decide, not anyone else, when they cut, where they cut and how deep, and indeed if they cut at all, or chose to use some other method (Hands-On-Scotland, 2009).	Self-harm was about exerting more CONTROL over one's life which was seen to be out-of-control. It was about changing the locus of control.	3. CONTROL
The first documented example of tattooing as a form of self-harm was that of a 19 year old who was voluntarily hospitalised with suicidal thoughts (Anderson & Sansone, 2003). Those who are treated for self-harm at hospital A&E departments in the UK are 100 times more likely than others to eventually kill themselves (NICE, 2004).	Self-harm was ATTEMPTED SUICIDE. It may have been a half-hearted or a very serious suicide attempt but it was still an attempt to end life and the pain that resulted from life.	7. SUICIDE
Emotional distress does not necessarily drive people to self-harm in order to commit suicide. It is most certainly not always a means to end life and can even be a gesture towards survival rather than death (Swales, 2005).	Self-harm was quite the opposite of suicide. It was ANTI-SUICIDE. The self-harmer was engaged in it to make life more bearable and to stave off suicidal feelings.	6. ANTI-SUICIDE
A single self-harmer may have different motives on different occasions (Royal College of Psychiatrist, 2010). Some textbooks use the term self-harm and BPD interchangeably, linking them very closely, giving the impression that any adult who self-harms must also have BPD (Townsend, 2000). The medical model points towards physical treatments and associated explanations when it might be better	Different motives on different occasions. Interchangeable BPD and self-harm. Medical models vs psychological / sociological models. Sex and sexuality. Punishment. Dissociation / depersonalisation. Rite of passage into a group. Behavioural / learning theory.	8. Miscellaneous

looking towards psychology and sociology for the insights that these disciplines can offer (Johnstone, 1997). Cutting is linked to sexuality. It can be for sexual gratification, or to punish oneself for imagined sexual transgressions, or to establish some kind of control over sexual urges (Messer & Fremouw, 2008). Depersonalisation refers to people who self-harm feeling that a kind of separation of their minds and bodies has taken place (Miller & Bashkin, 1974). Using qualitative approaches such as Interpretative Phenomenological Analysis (IPA), interview transcripts from adolescents have been coded and the most prominent theme has been *'being accepted into the group'* (Crouch & Wright 2004). A few studies have implicated problematic neurotransmitter activity in the central nervous system, or unusual physiological responses to self-harming in relation to how tension is reduced (Haines, Williams, Brain, & Wilson, 1995; Stanley et al., 2001; Winchel & Stanley, 1991). Some quite sophisticated attempts at using learning theory can be found in the literature e.g. the functional approach to self-harm among adolescents has looked at how antecedents and consequences maintain particular types of behaviour such as self-harm (Nock & Prinstein, 2004, 2005)		

Appendix 10 Information sheet for main study participants

Information sheet for participants
SCHOOL OF EDUCATION, COMMUNICATION AND LANGUAGE SCIENCES

The research on self-harm which I am undertaking is a component of the work that is required in part fulfilment of the DEdPsy (Doctorate in Educational Psychology) at Newcastle University.
My intention is to individually interview (have a conversation with) a number of people, including yourself, about self-harm. The meeting will take place in a venue of your choosing and you may have someone with you to provide support if you wish. The session is likely to last about an hour and will be audio and/or video recorded, and later transcribed. Your preference for audio and/or video recording will be respected. A copy of the written transcript will be available for you to peruse if you wish. The recording and transcription will be kept under secure conditions and destroyed when all the work is completed. Your data will be identified by a pseudonym. The questions asked will generally be open-ended and you will be invited to give your opinion on what self-harm is, why people do it, who does it, how it is carried out and how individuals who self-harm can best be supported.
There will be no pressure on you to answer any questions that you are not comfortable talking about. An attempt will be made to encourage you to talk about any knowledge or experience of self-harm that you have, or may be interested in discussing. In order to encourage co-researcher status with all participants, in addition to asking me any question before, during or after the session, you may interview me on the subject of self-harm and I will attempt to answer all your questions as fully and honestly as I can. This interview may also be recorded at your request and sent to you later.
If you are prepared to participate, I will provide you with a consent form to sign that will be our agreement that: a) you have been informed about the research and why it is taking place; b) you understand that your participation in the research is voluntary; c) you know that you can withdraw from the research at any time without giving a reason; d) you are aware that your data will be anonymous [and that confidentiality would only be breached in exceptional circumstances where it would be in the public interest to do so, such as when a serious crime had been committed, or was about to be committed, or a child was likely to be put in danger of significant harm]; and e) you have been informed that you will be provided with a full debrief after taking part.
When I have completed a thematic analysis of your transcript I will provide you with a copy if you would like that. This will give you the chance to make any corrections or comments on my analysis if you wish.
I will be pleased to provide a copy of the final thesis/dissertation to you when it is completed. My contact details are:
John H. Jamieson 22 Moorfield Avenue Kilmarnock KA1 1TS
Tel. 01563 534065 Mobile 07753425836
E-mail addresses: johnhjamieson@tiscali.co.uk j.h.jamieson@newcastle.ac.uk
j.h.jamieson@open.ac.uk

[Contact details of main supervisor: Liz Todd, Professor of Educational Inclusion, School of Education, Communication, and Language Sciences, Room 2.62, King George VI Building, Newcastle University, Newcastle upon Tyne, NE1 7RU. E-mail: liz.todd@newcastle.ac.uk].

Appendix 11 Consent form for main study participants

Consent form
SCHOOL OF EDUCATION, COMMUNICATION AND LANGUAGE SCIENCES

Consent to participate

I have been asked to participate in this research on self-harm and give my free consent by signing this form.

I have been informed about the research and why it is taking place.
I understand that my participation in this research is voluntary.
I understand that I can withdraw from the research at any time without giving a reason.
I understand that my data will be anonymous.
I understand that I will be provided with a verbal and written debrief after taking part, in addition to being able to ask questions/make points before, during and after the session.
I understand that I will also have the opportunity to interview the researcher and have this session recorded and sent to me by e-mail.
I understand that a written transcript of the conversation will be made available to me if I wish.
I understand that I can request a thematic analysis of the session in which I was the participant and have the opportunity to comment on the analysis.
.

Signature _____
Date _____

[Contact details of main supervisor: Liz Todd, Professor of Educational Inclusion, School of Education, Communication, and Language Sciences, Room 2.62, King George VI Building, Newcastle University, Newcastle upon Tyne, NE1 7RU. E-mail: liz.todd@newcastle.ac.uk].

Appendix 12 Debriefing sheet for main study participants

Participant Debriefing Document
SCHOOL OF EDUCATION, COMMUNICATION AND LANGUAGE SCIENCES

End of Project Debriefing

In addition to the Consent Form and Participant Information Sheet which you were provided with at the beginning of this research project on Self-harm, this Participant Debriefing Document has been designed to make sure that you have a clear understanding of the work you have been involved in and to re-emphasise that you can still withdraw your data if you wish without giving any reason. Self-harm is a topic that has been well researched over many years. However, there may be a gap in the research literature, and clinical practice, which could be filled with ideas which include the possibility that experiential avoidance (i.e. an attempt to avoid distressing thoughts, feelings, memories or events) is a common, and perhaps universal, method of dealing (often unsuccessfully) with all sorts of psychological issues, including self-harm. Emotion regulation (i.e. trying to make oneself feel better) may be a priority for many, if not all, human beings. We may be prepared to allow our bodies to experience dreadful hardship if it makes us 'feel' better, sometimes to the point of inflicting harm on our bodies (self-harm) if it means that our 'minds' are soothed. It is possible that there are no exceptions to this. 'Normal' psychological processes and 'ordinary' individuals may therefore hold the key to developing appropriate supports and therapies for those who engage in the more serious forms of self-harm.

This project/thesis has been an exploration of what participants, including yourself, think self-harm actually is from a phenomenological and functional point of view. It has looked at what meanings are able to be extracted from data provided by people who considered that they have never self-harmed at all, those who said that they had only mildly or moderately self-harmed, and those who claimed that they had, in the past, seriously self-harmed or who had a close knowledge of someone who had. Implications there might be for support, intervention and staff training will be considered later on.

A small number of undergraduate psychology students studying with the Open University and others who formed part of an opportunity/convenience sample, were invited to participate in the study on the basis that they either considered themselves to be people who had never self-harmed in any way whatsoever, or had self-harmed in culturally acceptable ways only (such as smoking or drinking excessively), or, had at some point in their lives engaged in culturally unacceptable self-harming (or knew someone who had) such as deliberately cutting or burning. Individual subjectivity and meaning-making were investigated and the methodology employed was mainly qualitative rather than quantitative. It involved open, unstructured interviews / conversations (rather than semi-structured) for the collection of raw data and the principal analytic tool was thematic analysis.

It is my intention not only to provide you with a copy of the research when it is completed but also to send you, if you wish, the thematic analysis of your own session transcript and/or other information in which you might be interested. The idea is to give you the opportunity to challenge my interpretations and to add your own. By raising your status from that of participant to co-researcher, my plan is to try to give you as much influence as possible in the decision-making while the work is in progress. I would also like to remind you that you may interview me on the subject of

self-harm (role reversal) and I will attempt to answer all your questions as fully and honestly as I can. This interview can also be audio and/or video recorded at your request and sent to you.

As well as in-put from participants / co-researchers, I have two academic supervisors who will be providing advice and guidance throughout. Also, I will be using an experienced worker with people who self-harm, and someone with lived experience of serious self-harm, as my two non-academic, practitioner consultants. The consultants will be offering comment on the work at various stages to make sure that what is being done is worthwhile and being carried out in the most sensible way possible.

If your participation has been upsetting in any way, I will be happy to direct you to support offered by the Open University if you are an OU student, or, if you are not an OU student (or you are an OU student but would prefer support from elsewhere), I have made arrangements for external sources of help to be made available to you. One of these supports is a CAAP (a clinical associate in applied psychology) who specialises in CBT (cognitive behaviour therapy), and the other is a qualified clinical psychologist. They can be contacted indirectly through me by post, e-mail or telephone, or, directly via their own mobile numbers below:

John H. Jamieson Chartered Psychologist 22 Moorfield Avenue Kilmarnock KA1 1TS
Tel. 01563 534065 Mobile 07753425836
E-mail addresses: johnhjamieson@tiscali.co.uk j.h.jamieson@newcastle.ac.uk
j.h.jamieson@open.ac.uk
Support 1 - Clinical Associate in Applied Psychology (CAAP) mobile: 07834903852
Support 2 - Clinical Psychologist mobile: 07921393270
Other sources of support which you can pursue yourself, if you wish, include the following:
The National Self-harm Network www.nshn.co.uk/forum
Penumbra www.penumbra.org.uk
[Contact details of main supervisor: Liz Todd, Professor of Educational Inclusion, School of Education, Communication, and Language Sciences, Room 2.62, King George VI Building, Newcastle University, Newcastle upon Tyne, NE1 7RU. E-mail: liz.todd@newcastle.ac.uk].

Appendix 13 Questionnaire / Rating scale: self-harm to self-care

Questionnaire / Rating scale: self-harm to self-care Date:.....

Name:.....d.o.b.....Gender:.....
Address:.....
Telephone/mobile:.....
E-mail:.....
Why have you agreed to help with this project on self-harm?.....
.....
.....

On a scale from 1 to 10, with 1 being 'very self-caring' and 10 being 'very self-harming', circle the number which is most correct for you in relation to the items listed below, and any others you wish to add:-

	Self-caring									Self-harming
Exercising	1	2	3	4	5	6	7	8	9	10
Eating	1	2	3	4	5	6	7	8	9	10
Working	1	2	3	4	5	6	7	8	9	10
Alcohol	1	2	3	4	5	6	7	8	9	10
Drugs	1	2	3	4	5	6	7	8	9	10
Smoking	1	2	3	4	5	6	7	8	9	10
Sleeping	1	2	3	4	5	6	7	8	9	10
Friends	1	2	3	4	5	6	7	8	9	10
Partners	1	2	3	4	5	6	7	8	9	10

Family	1	2	3	4	5	6	7	8	9	10
Bullying	1	2	3	4	5	6	7	8	9	10
Relaxing	1	2	3	4	5	6	7	8	9	10
.....	1	2	3	4	5	6	7	8	9	10
.....	1	2	3	4	5	6	7	8	9	10

Thank you. If you want to write anything else, use the other side of this sheet.

Appendix 14 Main study transcript for Sharrie (referred to as SK)
[EXCERPT ONLY]

Sharrie's transcript dated 03.05.12 (recording length = 63 minutes).

JJ: That's it on, and I'll...just press record... Hearing me is important maybe but not as important as hearing you. I also thought, Sharrie, that I might require a second interview at some stage but that would be up to you say I'm too bust or... SK: No, that would be absolutely fine. .. JJ: ...or I'm not sufficiently interested...Here's something that I've managed to persuade my supervisor about a month ago to do during the supervision session. A kind of dry run if you like. And I thought it might be of use...It's a kind of rating scale / questionnaire thing. I thought it might be of use not to get quantitative data since it is a qualitative study into self-harm but I thought it might be something that, depending on how participants responded to it, it might be something worth talking about as part of the interview. You know how the interview is unstructured, not even semi-structured in the sense that I don't have a list of topics in front of me that we'll be going through. I just want it to be open. I just want the interview to go, depending on what happens between you and me...If you are interested in it, just cast your eye over it just now. Apart from the demographic things on it like name, address and so forth...There's the important bit [JJ pointing to the items to be rated on the bipolar scale from self-care to self-harm]. I'm really inviting people to rate themselves on the scale, you know, from 1 to 10 with respect to how they feel, where they think they are in relation to these topics. So for example the first one is 'exercising' and we have 'self-caring' and 'self-harming'. What do you think of exercising in your life. I mean, are you able to put yourself on the scale? SK: You mean in terms of what I think about it or what I actually do? JJ: Ehmm...in terms of what you think about exercise in relation to what you actually do, not what you think you should do. And whether any exercise you engage in you would see it as...ehmm...definitely highly self-caring or definitely highly self-harming. My academic supervisor did not like this and she was saying that...We had a talk about prejudice here and if you want to be 'open'...Then I actually persuaded her to do it and she actually quite enjoyed it when she got into it. She challenged and discussed with me each item as she was going through it. She then thought that maybe as part of the interview that could be quite useful. So, what I'm really saying to you is that it's not compulsory... SK: No, I'll fill it out ... JJ: Would you like to do it and even talk...well, she talked out loud. She just kind of...she had her thoughts as she was doing it so...If you would like to do that, I'm quite happy to respond to your thoughts as you articulated them. SK: Well, for instance, for exercising, I think that that is, that should be '1' because it's supposed to be good for you but I probably don't do as much as I should [looks at JJ and smiles]. So...[pause]... JJ: But when you do do it, do you do it to excess, to the extent that you would say it's self-harm? SK: Well for me it probably is...It probably is back to the good old weight ...For me it's probably not so much a health issue as...an aesthetic thing. It probably is exercising to lose weight or whatever. I go through periods where I don't do any at all and then I'll have a mad episode where I do it all the time [SK waves her pen in the air in circular movements]. I suggest the harming bit because I go through so long not doing it and then really doing it. I do it the

next day and it's sore and it's painful and I probably have harmed my body in some kind of way but I think I would still view it as being self-caring. JJ: Right so you'd have...you'd circle one of these numbers ...? SK: I would say...I would probably...just at first glance I would say '1'. JJ: Can I also ask you questions ... SK: Of course……FULL TRANSCRIPT CONSISTS OF LINES 1-474……

Appendix 15 Main study transcript for Martha (referred to as MB) [EXCERPT ONLY]

Martha transcript dated 11.06.12 (recording length = 74mins)

JJ: That's it and I've got a wee audio recorder as well just in case that doesn't work. It should be easier to set up. It was very good of you, Martha, you were the one that chased me up. [Martha smiles]. It wasn't that I'd forgotten about you it was just that it was taking me too long to get myself organised and to get through the various ethics committees and that kind of stuff. ..So this is the wee audio. It saves me taking any notes and I can just talk to you. MB: I don't like them...I don't like them. JJ: You don't like these wee recorders? MB: Nope. JJ: Do they embarrass you? MB: No, I've got one and I forget to turn it off and my son and his pals are talking and it picks up all the talk...I used to use these in the college and they picked up everything. Being dyslexic you try to correct yourself when you write and you canny just write. I had scribes as well which was a nightmare because it's the same thing. The first thing that comes into your head, you say it. Then somebody says to you: 'What did you say?' and you're like [Martha looks away and moves her left hand to and from her lips] it's gone, it's gone. If you keep it here, [she points to her head] it stays here, but once you've spoken it, it's gone. When you are doing exams you're trying to look for a different answer which is not the answer you already had. JJ: So you had a scribe? MB: Yes. JJ: That's interesting... My main job, I'm a psychologist although I'm doing this research on self-harm for Newcastle University but I've also worked part-time for the Open University. I tutor on one of their courses. But sometimes I invigilate and sometimes if it's a student doing an exam in their house, I'll be the scribe and the invigilator. You know maybe they're disabled and they can't write or they've got some other issue. So I know what it's like scribing. But while it's a hard job scribing, it's even harder doing the job that the person has to do 'cause you've got to speak it. MB: When I was writing, my writing was too slow for my brain, if you know what I mean...So when I was a kiddie, I didn't know what I was writing. I looked at the board and it went into my eye and it went into my hand and it went just like that...I could read things by scanning them. I read things by scanning. I take a lot more in by scanning. Then I go back and I have to go into the thing. JJ: Right...Is that not the best way to read, that is, to scan...? MB: And I'm very visual... JJ: I'm a poor reader myself. I tend to read it word for word. And people say that I don't scan properly. And you're not supposed to read word for word 'cause that's a bit slower...but I suppose people have all got their own techniques. MB: I used to have a kind of photographic memory. I can remember things specifically. I can remember conversations. I mean you come back and ask me and I can see it in my head. I can see a thingmibob...a whole picture. Sitting here I can tell you the conversation that you had and I had. And now I haven't got because of my head injuries...I now get more enjoyment out of it. Now I don't need to do exams...or anything like that...and you don't get that enjoyment having done all that studying. I've done all that work so I'm entitled to that thing. So if you don't do all the hard work and you get the thing at the end of it, it's not the same...Like sports come easy to me. JJ: Sports? MB: Yes...Everybody's sitting there going...I can climb a building or anything like that 'cause I don't have that kind of fear aspect. Everybody else gets so excited but I go like: 'Is that it?'... JJ: So if you are into sport does that mean you're into the Olympics? [Olympics were due to take place in about one month's time] MB: Not really. It makes you a bit jealous. I was the first woman assessed to play rugby for Scotland [MB is in a wheel-chair]……FULL TRANSCRIPT GOES FROM LINE 1-689…….

Appendix 16 Main study transcript for Nancy (referred to as NS) [Excerpt only]

Nancy transcript dated 21.06.12 (recording length = 78 minutes)

[Some discussion takes place as I try to set up the recording equipment properly with NS's assistance...]. JJ: That's it fine. That's audio and that's video. When I'm transcribing it's so much easier if I can actually see the person, although if it's going to be off-putting to the person, I'll just not bother. NS: No, it's ok. I record people for interviews so it's my turn to be on the receiving end. [Nancy smiles and laughs]. JJ: It's interesting that you should say that because I...in my real job...not in this research...I don't record people. In fact...ehmm...I recently interviewed...nothing to do with the research...I interviewed foster carers and the young person who was with them for a court case and they complained, not only because I did not record it but I didn't take notes and they thought that I might misrepresent what they said. I didn't take notes because I wanted to establish rapport. NS: Yeh, you don't want to create that barrier. JJ: I think I probably sent you that [JJ passes over consent form]. If you are happy just to sign it...It's for the ethics committee. NS: Have you got a pen? There's a pencil here. JJ: I'm sure I have but it doesn't matter, just sign in pencil. NS: No problem. JJ: My pen's actually in that folder [JJ indicates the folder which the recording equipment is sitting on]. NS: And we don't want to disturb that [NS smiles and laughs]. JJ: It just says things like you know you can withdraw at any time, if you are not happy with the data then it can be destroyed and all that kind of stuff. It's exactly as one of the e-mail attachments which I sent you. There shouldn't be anything that I'm slipping in so that you can sign your soul away [NS takes her time to read the consent form before signing it]. And you can always go and check it later on and phone me up and say 'no way am I doing this, I didn't realise I was letting myself in for that' [Smiles and laughter from both JJ and NS]. By the way, I don't know whether this will make you more relaxed or more anxious, I don't have a semi-structured interview or a structured interview for that matter. I've experimented with that kind of thing and it seems to me to be too artificial. For some individuals who maybe would claim that they don't engage in any self-harm whatsoever, I'm using this kind of thing [JJ displays the self-care / self-harm rating scale] but for someone like yourself you may find it boring and not as useful as simply having a chat about the whole thing but I'm open to be guided by... NS: I'm happy to do it either way, whichever works for you. JJ: Ok, we'll see whether it feels right for you to do this. My work is being supervised by Professor Liz Todd and she doesn't like questionnaires or rating scales of any sort, and I'm recording our sessions just for practice. And I put this in front of her and she moaned about it 'oh this is rubbish'. But once she got into it she began to say 'hey, this is quite good fun', and because she was able to talk her way through it...She was just really sharing with me her thoughts, it turned out to be not such a barrier after-all. So it's there if we want it but if we don't want it, forget about it. NS: Sure. JJ: I don't know how much you can remember of the stuff I sent you [JJ referring to the various e-mail attachments about the research], but I think if I just told you what my research question is... NS: That would be great... JJ: ...I'm just really seeking a number of people to talk about my research question with a view to me transcribing the interviews and then thematically analysing what's said, to see what comes out of it, to see whether my research question is answered. The research is, assuming you can't remember it, 'What is self-harm?' That's the basic thing. That's what I'm trying to find out. What is it from a functional point of view, that is to say, what does it do for people, and what is it from a phenomenological point of view, how do they experience it? Not my definition.....FULL TRANSCRIPT GOES FROM LINE 1-681……..

Appendix 17 Main study transcript for Mattie (referred to as MC) [Excerpt only]

Mattie transcript dated 01.08.12 (recording length = 54 minutes)

MC: Oh, it's the 1st of August [2012], isn't it? JJ: Yes, and we're off. Everything is just hunky-dory. In some ways I don't need to go through much of a spiel with you, Mattie, because you came to my little talk. MC: Yeh, that's right. JJ: And if you remember, I think the last slide or second last slide was just a statement of the research question or questions. I should be able to remember it off-by-heart given that you are my 3rd participant. MC: Oh, alright, you're getting there. JJ: I've done 3. You're my 4th but you're my 1st at summer-school. I was concerned, though I don't intend these conversations to be upsetting, I was concerned about some of the students who have come and given me their details. They haven't just come and given me their details but they have come and talked to me about various things and I was just...you know how some of these summer-schools can be jumping...Well I'm a wee bit reluctant to go for some people so maybe between now and Christmas I'll chase them up. The trouble is they don't live in Scotland. MC: No, but if you could do an e-mail interview with them...? JJ: Well, one or two of them suggested even a telephone interview but I've got a thing about face-to-face stuff... MC: Well, you pick up all the other stuff that...the not said stuff... JJ: I shouldn't be quite as sceptical about telephone interviews or indeed about e-mail stuff because I...D'you teach the online version of this [the summer-school module DXR222]? MC: No, I don't. JJ: Well, I do that and I also do DSE232 Applying Psychology. D'you do DSE212? MC: I don't do anything apart from this [DXR222]. JJ: Oh, it's no use talking to you about this...My research question is: "What is self-harm from a phenomenological point of view i.e. if individuals have experienced it. And from a functional point of view i.e. what does it do for people? I'm interested in, and I'm hoping to be able to interview a number of people, maybe as few as 5 people who consider themselves to be not self-harmers at all in any shape or form. And maybe the same number of folk who see themselves as culturally acceptable self-harmers over the years e.g. they exercise too much or too little or who bite their nails or who smoke or things like that. And then maybe the same number of people who are seriously into what I'm calling culturally unacceptable self-harm. The middle lot I'm calling culturally acceptable self-harm. MC: I actually think...I mean, one of my issues as you see is overweight and you've known me a number of years and you know my weight goes up and down in this 4 stone band... JJ: Does it indeed? MC: Yeh, my wardrobe goes from size 16 to size 22. JJ: Gosh. MC: And there are times when I'm at that end of the wardrobe and at the moment I'm at this end of the wardrobe so it's time for me to start going down again. And I've done that pretty much all my life. And I would say that overeating which is a form of self-harm in my opinion is becoming culturally unacceptable in a way that it used to be okay. Smoking and drinking too much were bad but overeating was okay, but it's now in the popular culture, and certainly led by government, has been demonised to the extent that people are saying that fat people are using up all the NHS's resources and fat people are costing this country, without actually going, now hold on 'Why are these people fat? What's the issue there?' And I know there's a great a great deal of issue around, you know the high fructose...(indecipherable)... in the food replacing all the decent nutrients that used to be in there because it's cheaper. But actually there is a functionality to being obese as well. JJ: Meaning? MC: For me...you know I wasn't going to talk about me, I was going to talk about my daughter. JJ: I thought you were as well but let's stay on you for a wee while……FULL TRANSCRIPT GOES FROM LINE 1-443……

Appendix 18 Main study transcript for Ellie (referred to as EMS) [Excerpt only]

Ellie's transcript dated 03.08.12 (recording length = 52 minutes)

[General rapport building comments made by JJ e.g. reference to the sock containing the audio recorder etc.] JJ: So you are quite happy with the consent form.? EMS: Yeh. JJ: This is another form here but we don't necessarily have to use it. I have used it with one of my 4 participants so far, and the reason I used it...I'll just let you see it in case you think it's absolutely awful or you're interested in it at all. I'll just put it there [EMS looks at the self-harm rating scale]. With people who are quite serious self-harmers, it hasn't been any problem having a conversation with them about self-harm but one of the early people I interviewed was one of my OU students on DSE212 and she didn't have any experience of self-harm at all. And that was okay 'cause I want to try and get a range of views as you may or may not remember from my little talk, ideally I'm looking to interview 5 people who would consider themselves not to be self-harmers at all in any shape or form, 5 people who are maybe mild self-harmers and who maybe smoke when they know that smoking is not good for them, or they maybe drink too much or whatever, and 5 people who are serious self-harmers. Now the serious self-harmers, they've got a self-harm story, so it's no problem having a conversation with them but the others, particularly those in the first category who don't think that self-harm figures in any shape or form in their lives, I've invited them to have a look at that. EMS: Okay... JJ: ...and consider...So depending on how you feel we might...I mean I haven't actually used it as a rating scale as such, I've just used it as a conversation piece... EMS: Yeh... JJ: ...and we've just looked at these different items and how people have responded to them. D'you remember or will I recap for you what my research question was... EMS: Well, the actual research question...I remember things from the talk but not the question. JJ: Well, the question...it's really more than one question. The main thing is what is self-harm? It's what is self-harm from what I am calling a phenomenological point of view and from a functional point of view? By phenomenological I mean how it feels, how it is experienced by the individual I am talking to. And from a functional point of view, I mean what function it actually has for them if they do engage in self-harm. I mean do they do it because it relieves tension, do they do it because they want to punish themselves or whatever function it actually has for them. EMS: Yeh. JJ: So that's the sort of first bit of it, and I'm looking to see if I can make sense...eh...of data obtained from these 3 groups of people, assuming these 3 groups actually exist. But in my mind they exist. And the final question is, from this data I collect and thematically analyse, just as you'll be doing [in a project involving thematic analysis], I'm hoping to cast some light on what kind of supports and therapy might be offered to serious self-harmers. It seems to me, and in my professional life, I don't think I've been especially helpful to people who have sometimes been quite major self-harmers. So I'm kind of hoping that the data, the extra knowledge which I'll gain as a consequence of these interviews...and, of course, writing up my thesis for my doctorate...will produce some insights. EMS: Oh, it's all for a good cause as well though... JJ: Okay...do you have a self-harm story? EMS: So-so. I don't know whether it's...not what you'd usually call self-harm but...you know what you said the other day about people cutting themselves, burning themselves, but when I was...ehmm...gosh... 17...my 1st year of my O-levels, my appendix burst...at the beginning of the summer holidays……FULL TRANSCRIPT GOES FROM LINE 1 – 481……

Appendix 19 Main study transcript for Kate (referred to as KS) [Excerpt only]

Kate's transcript dated 04.08.12 (recording time = 58 minutes)

[KS starts to fill in the self-harm/self-care rating scale while JJ sets up the recording equipment] KS: Can I ask what exactly you mean by this one? JJ: What one's that? KS: Bullying. JJ: Bullying? Well, what does bullying mean to you? KS: Ehmm...I don't know, I guess it depends which side of the bullying you're on. I was always on the wrong end. JJ: You were always on the wrong end? KS: Yeh [KS smiling]. JJ: It looks as if we've launched right into our interview. KS: I guess both are the wrong end really. JJ: You guess...? KS: Both ends are the wrong end...You don't want to be the bullied but I wouldn't say that being a bully is being on the right end of bullying. JJ: And have you been on both ends or is it just... KS: I don't...I don't...well, I hope not...I definitely...well, I was bullied a lot at school. I was ehmm...I was ehmm...the chubby, out-group teacher's pet. I was never, sort of with the in-crowd. I don't know, I got a lot of stick for my weight and for...eh...at primary school as well I was an early developer as well and I got some stick for that as well... JJ: What's your first name by the way? KS: Katherine, but you can call me Kate. JJ: Kate. Okay, Kate. Right, and is there a link between bullying and self-harm, your knowledge of self-harm or your experience of it? KS: Ehmm...It used to make me quite angry at myself sometimes that I never did anything about it...Ehmm, I don't know, I never really spoke to anyone about it. I didn't talk to my mum about it or my teachers...I started to at secondary school but I didn't really talk to anyone when I was at primary school and I think...ehmm...that affected who I became at secondary school...Ehmm, I think it made my quite reclusive. Reflecting on it now, I think it made me quite withdrawn. I had to stay away from people a little bit because I didn't want them to...I wanted to stay out of the light sort of thing. JJ: And what age are you now? KS: 21 JJ: Could you put your date of birth there just in case the things that people talk to me about are different...I wouldn't anticipate that age would necessarily be something that would...eh...separate people out by what they say about self-harm, but just in case, I've been asking people to give me their dates of birth...So at secondary school were you suggesting that that was the stage when you were looking to discuss it with your mum or discuss it with teachers. KS: I found that I had a more secure group of friends around me, so I felt more comfortable talking to them because they spoke to me about various things that I wouldn't have spoken about...I felt comfortable sharing my experiences as well. So I at least had somebody to talk to, whereas I think at primary school I was so in and out of friends. I mean my friends changed quite a lot. A lot of my close friends moved schools. Their families moved away. I had a lot of really good friends taken away from me at various times and I had to start all over again with new friends... Ehmm... And all of a sudden at secondary school I had some friends that I could keep for a long time and I'm still friends with some of them now. JJ: So are you saying that secondary school was a better experience for you all round than primary? KS: Ehmm, in some respects 'yeh'. I still felt... ehmm...I didn't say very much...I think back, I could have said something there. I could have included myself in what was going on but I felt more of a watcher than anything else... Ehmm...by the time I got to college I really started to get to know a lot of people and I had a much bigger...I still had a lot of close group of really close friends but...ehmm...I knew a lot of people which I don't think really happened at secondary school.....FULL TRANSCRIPT GOES FROM LINE 1 – 473……

Appendix 20 Transcript of 2nd Supervision Session [Excerpt only]

09.01.12, 2nd Supervision Session: JJ/LT (1st one to be recorded)

JJ: Press a button and its away…Can I just check to see that it's got your mouth in…
LT: You just want me, you don't want the two of us?
JJ: Well it would be better if it had the two of us but I don't think I'm going to be smart enough to do that…I don't think it's so good at getting the voice…
LT: Ok… JJ: I think it was Simon in his feedback on what I call my 4th Assignment, I think he said that he wonders whether it's worthwhile doing the videoing and maybe I should simply audio…
LT: Yeh…that's what I was thinking, yeh…
JJ: But it's just the fact that I've got this and I used it for assignment 3 when I was interviewing the known self-harmer and the worker-with-self-harm and I'm getting more comfortable with it…
LT: through using it, yeh…
JJ: I think it is maybe easier transcribing when you actually see the person. It's more interesting… maybe more boring when you are just hearing the sound. I'm happy to change it if it turns out that way.
LT: Or, if you find out you are not going to listen to it again. I quite often video things and never listen to them again…and audio things, thinking I am going to use them.
JJ: Well, a long time ago I stopped videoing football matches but this is my thesis and that's pretty important. LT: I think videoing your sessions with the people you are interviewing is a really really good idea but you've got to be careful then about the analysis because if you start doing interaction analysis, it takes forever. But I don't think you're interested in that, are you?
JJ: Well, I'm not sure yet. Also, I wondered if it might be upsetting to some people. It could make them ill-at-ease. LT: Yes, it could, couldn't it? JJ: I'm kind of hoping it will be like 'Big Brother' and people will forget about it. I certainly do if I'm being recorded myself. Then you just forget about it. LT: Yeh, yeh. JJ: The proof of the pudding will be in the eating. LT: Mmm mmm.
JJ: What I was hoping to do, Liz, was just to bring you up to date with what I've done and what I haven't done. LT: Yeh, sure. JJ: And give you the opportunity to say 'Yes, that's fine or that's not fine or you need to push on with that or that's not worth doing and so forth. Is that OK or have you got other things. LT: No, no, no, I don't have any agendas. JJ: Well, something I have done is – I've got myself a little book that I'm calling Reflexive Log. LT: Good JJ: So, I'm taking wee notes. Some of them retrospective in that I've got a couple of pages on assignments 1 on 'What is Self-Harm. A couple of page on Assignment 2, Assignment 3, Assignment 4. I'm calling my thesis Assignment 5. LT: OK. JJ: So there will be a couple of pages on everything I've done beforehand. So you might think, what's he doing that for? It's just to remind myself of what I've done. LT: No, that's very good. JJ: There was one occasion. I don't know whether this is to do with old age, I almost bought another book on self-harm. I say another book because I actually had it and I had read it. I saw it and I said 'That looks interesting but I've seen that before. In fact I had bought it for one of the other assignments. So I think this, just to remind of what I've…. LT: It's worth talking about the possible purposes of this I think. What are the purposes you're thinking of?
……..THE FULL TRANSCRIPT GOES FROM LINE 001 TO 403……

Appendix 21 Transcript of 3rd Supervision Session [Excerpt only]

19.03.12, 3rd Supervision Session: JJ/LT (2nd one to be recorded)

LT: Is the video recording not going to be of both of us? JJ: I'd prefer that as well but it would mean that… LT: Is it too small a…Is it too small a camera? JJ: Yeh. So in addition to the transcribing, I've now done what I call 1st order thematic analysis. You won't want to necessarily read it all but just having it to skim it, Liz. I have it and could send it to you. I could send this by ordinary e-mail the actual transcript. I've looked at it and was surprised to find I spoke so much. LT: I'd probably look at it and decide that I spoke too much. JJ: Well you might, you might, ehmm… LT: See one of the benefits is, I think is, knowledge happens between 2 people. It happens when you are talking. It doesn't happen when you are thinking. Certain things happen when you're thinking that don't happen when you are talking. Often when I'm having a supervision session, somebody I'm talking to, say a student [Liz gestures as if to put the word student in inverted commas], and people say something which they wouldn't ordinarily say and they say I wish I had taped that and so on, you know. So it isn't always the pearls of wisdom from me but it's the things that you end up saying yourself because of that conversation. JJ: I've also found that my remembrance of the session [Liz is looking at the transcript at this point] wasn't in fact 100% accurate. Now that sometimes I wanted you to say something and you didn't actually say that, you said something else. And it's in there [in the transcript]. LT: That's very interesting. So in some ways this [she points to the transcript] this might end up becoming data. JJ: Well it might, it might. And things like, I wanted to ask you about , to tell you about, what I'm doing by way of thematic analysis. I made this table and I just put all these numbers down there. Is that an okay thing to do? [I'm pointing to the transcript that is in the form of a table with numbers down the left hand side]. LT: Did you put them [the numbers] in yourself or did you get the computer to do it? JJ: I did it. LT: Did you know that Word can do that for you? JJ: Yes, but I'm a bit technologically illiterate. I tried to get Word to do it for me and I couldn't get it to do it. LT: Well say you've got a document…I only learned this a few weeks ago. I'm trying to find a document. Say this document here [Liz is working on her laptop and endeavouring to demonstrate the process]. OK, say this document and you were going to do it. No I don't know how it's going to show on your computer since you're computer is not a Mac. But it will be a similar place. Now down here there's things that tell you things. Now that one is a numbered list and that's…that's…no it's not this one…ermm, where is it? Eh here you go. So this is the one that says 'Layout', layout of your document. JJ: So, I've got to go to Layout? LT: So in 'layout' you've got 9 numbers on it. You click on 9 numbers and you decide which…You've got a choice… Continuous… Shall we start each page. Let's select 'continuous'. And maybe I've got to 'select all' – select all [she demonstrates]. Now where has it gone to? Oh, it's there. JJ: Gosh that could have saved me a lot of work if I'd been able to work that out. Well, if I can't get it to work, it's not a problem because I can just delete… LT: But you don't want to do that, do you? JJ: Can I tell you what I've done to see whether it's in line with what you think thematic analysis is and how you think it should be done. I mean I've transcribed all this with the numbers and I've highlighted in green all the bits that I found at all interesting. You see, as you can see here [JJ points to the highlighted transcript] I've highlighted quite a bit. LT: Good. Did you find some of the things you said interesting? JJ: Well, let's see 'cause I've got LT and JJ all through it. [JJ then goes on to quote something JJ said in the transcript] "Well, I wasn't actually thinking of doing it during the interview, I was thinking of doing it a long time before". Now I said that and I said that in relation to……

……FULL TRANSCRIPT GOES FROM LINE 1 – 514……

Appendix 22 Transcript of 4th Supervision Session [Excerpt only]

28.05.12, 4th Supervision Session: JJ/LT (3rd one to be recorded)

JJ: I'll have to get my glasses to make sure this is working. And that is something else [JJ produces an audio recorder contained in a sock]... LT: A sock? JJ: I bet you're wondering what that is? LT: Yes I was wondering why you put a sock on the table. Has it got something inside it? Do I need to look at that? JJ: No, you don't need to look at it. But when it comes out [of the sock], if you have a problem with it I'll put it away again. [LT laughs and smiles for several seconds]. JJ: I got it from my daughter. Remember there was an issue about whether I actually video record these sessions or simply audio. LT: So you are going to do both. JJ: Well, I thought I could get away with that with you and we can talk about it whether I can do it with... LT: It's up to you. I don't mind. I don't have any views. It doesn't bother me but it feels like an awful lot of extra work for you. You are obviously finding it useful which is fine. JJ: Yeh, I'm finding it very useful. While I said that this might be the last session I record with you...It might not be. It depends what we decide. LT: I can obviously say 'no' if I don't like it but apart from that...I've decided it's fine. JJ: And you can change your mind as well. LT: Once I've decided it's fine for me, it's your decision, isn't it? JJ: Well, that's right...LT: ...[comments indecipherable]...Do I have a veto or not? JJ: It's interesting your reaction to this [rating scale used at last session]. You were using terms like 'this pisses me off'. LT: [LT laughs for a few moments and smiles broadly]. Did I say that? [Continues laughing]. JJ: More than once. More than once. That's one of the great things about this transcribing because...eh...it contradicts me...it contradicts my memory. I say 'I don't think she said this' or 'I don't think they said that' but there it's there. LT: Oh, it's there [LT shakes her head slowly and smiles]. It's terrible using that language...these professors...so erudite. JJ: But you got from using the 'pissed off' comment twice to saying 'Hey this is interesting'. LT: Oh, did I? JJ: And, and, you were saying things like all questionnaires are really rubbish and I used the words 'nonsense data' and you agreed with me that it probably would be nonsense data. But once you got into it, and once we used it, instead of just like a questionnaire to fill in and take away...when we used it for you to just be thinking out loud...you began to say things like 'hey, this is good. LT: That doesn't contradict me being pissed off with it. I was pissed off with the simplistic use of it but ok with the more extensive use of it. JJ: Yes, that's right. I didn't mean 'contradict', I just meant 'changed your mind'....One of the good things is, we spend a lot of time talking about ethics in relation to my thesis [at previous supervision session] and about 3 days later on the Wednesday...and I had already got through Sue Pattison who had asked for a couple of things to be changed...one was about audio rather than video, and the other one was about...I've forgot now...Anyway she was satisfied...It then went to Gerry Docherty and it kind of got lost for a wee while. LT: It will do, yes. JJ: People eventually tracked it down. That's thanks to you in a sense. I was able to check the transcription and you were saying 'John, you've got to drive this. You can't just expect things to happen', so I made a few enquiries and low and behold a few days after this Gerry got back to me or Louise Davidson did 'cause Gerry had 4 points he wanted me to tackle. They got back to me saying the 4 points are fine you are through it [i.e. through the final ethics committee]. So 3 days after our last supervision session I'm through it. LT: What power I have! [Said somewhat jokingly]. No, I mean what power our conversations have [LT smiles and laughs out loud]. JJ: You would say that. So...ehmm...I've been a bit slow after ethical approval by way of doing much by way of getting participants and so on. So much so that some participants, at least one participant has been harassing me and saying [by e-mail] 'Are you ok John? Where are you?' LT: That's interesting. That's nice. JJ: This particular one, I e-mailed her a few days ago to say we'll meet...what day is this? Monday?...to say we'll meet next Tuesday. And I have already interviewed one participant. LT: Ahh, good. JJ: That was at my last tutorial 2 to 3 weeks ago. She just waited behind after the tutorial and we used this [JJ points to audio] because we've got permission for this and we use this [JJ points to video] though we don't have permission for that. But I thought we could maybe talk about what I don't have permission for. I think I could probably.....FULL TRANSCRIPT GOES FROM LINE 1 – 436……..

Appendix 23 (Example of early thematic analysis coding table of supervision session)

1st order coding (mainly descriptive)	2nd order coding (more interpretative)	3rd order coding (pattern / thematic / super-ordinate)
1. Vid v Aud (video versus audio recording)	1.Vid v Aud dropped; not enough data	1. Research Question(s)
2. Analy (analysis; analysing raw data) →		
3. Refl Log (reflexive log)	2. Refl Log	
4. RQ (research question)	3. RQ	
5. RPs (recruiting Ps; Ps and potential Ps; opportunity / convenience samples; legitimate recruiting)	4. Ps	2. Reflexive Log
6. Labels (labelling of self-harmers; not self-harmers as such; not 'deliberate' self-harmers)	5.Labels	
7. Func SH (the functions of self-harm; what's it for; why do people do it)	6. Item 7 joined with 11 and re-coded Causes SH	3. Participants (ethics; recruitment; infotoPs etc)
8. Ethics (all matters to do with participant / researcher ethics)	7. Ethics	
9. InfotoPs (information given or not to Ps)	8. InfotoPs	
10. SH support (self-harm support; what has been done to help people who self-harm)	9. SH support	
11. Why SH (causes of self-harm)→	10. Item 11 joined with 7 and recoded Causes SH	4. Recording (of raw data; video vs audio etc.)
12. Contra (contradictions with respect to self-harm) →	dropped; not enough data	

Appendix A-B

Appendix A

(Nancy's synoptic story continued)

"…The last time that I was self-harming, what I really felt was that I wanted to do myself some damage because I deserved that...It was somebody else who said that that sounds like punishment...It's not quite how I would have defined it. And I think it was just, this is going to sound a little bit odd, but I think part of it is knowing that you can still do it, that you have still got that avenue open to you. So I think that was part of it. I needed to check that I was still able to do this. And I think the kind of thing…I was doing wasn't enough. It wasn't damaging enough. And then I got stuck in that circle of, 'I'm a crap person, you know, you can't even do this right. I can't get this correct' ...Stuck in my head is that thing of, 'I kind of deserve this and it doesn't matter if I...[pause]…*'. I mean, I don't matter enough to try not to do it. Ehmm, does that all make sense?...I remember...feeling that I was a very bad person…I was really evil inside. And if I cut myself open there would be all this black gunk coming out of me rather than blood because that represented the bad person I was. And so in some ways I was getting to check this. Ehmm, but I don't think that's really the whole story. I did know other people from school who had cut themselves. But I don't subscribe to this idea that it's an epidemic among young people, and they copy each other, because I think if somebody wants to go to that extreme*...[pause] …*I do have a couple of friends, one my flatmate at the time who tried to cut herself to see how it would feel. And she just couldn't do it. And another friend of mine who said, 'Oh, I did try self-harming once and it really hurt and I didn't want to do it again'. I think if someone actually goes ahead with it and continues to do it, there's more to that than copying someone else. With my flatmate, it was after I'd done it, and it was after she realised what I'd done...I had a close friend from school who had self-harmed, and I had known her since I was 15, and I didn't do anything till I was 19, so I really don't think it was a copycat type of thing. It was more that I felt that I was in a really bad place and that this was what I really needed to do...I guess we all know that pain can, in some ways, bring you back to yourself a bit - in some ways! So I suppose there's that knowledge in there. And I don't really like being out of control… I've never been a big drinker and I've never taken any drugs. I really don't like that idea at all, you know, the thought that I could put substances into my body and it would make me less inhibited and I wouldn't know what I was doing. To me these aren't ways to gain any sort of control or to*...[pause]…*They're not things that would be helpful...But I suppose…once you know you'll get something out of it, why would you not do it again? And it's also coming from a place where you're really, really desperate, not knowing what else to do and then finding something that actually works, ehmm, and thinking then, 'Why would I not continue to do this?'...* [Drinking or drugs is] *not a thing I've ever done and I've never wanted to do it either...I suppose, ehmm, there have been times when, ehmm, I guess I've, like, I've self-harmed to bring myself back to myself...But there are other times when, you know, you can*

definitely feel it, and it is painful. But I think, you know, we all...[pause]...*It definitely is painful. It kind of brings you back into yourself and it gives you that kind of adrenaline thing and...I think, ehmm, I don't like feeling pain at the time, ehmm, but to me it's satisfying that it hurts later. And I feel that I've done what I needed to do, and I've got the proof of that and*...[pause]...*Sometimes it's to check I can* [cut]*. I suppose that's still about control as well, but it's to check-out that I still could, and I've still got that tool at my disposal, you know, but sometimes it's just been about, yeh, I want to do some damage, and thinking I'm not a good person. Ehmm, but, yeh, sometimes it has been about feeling really stressed and emotional and wanting to just step back out of that...I think that instinctively I guess I always assumed that if there is a disagreement or something, then it's me in the wrong, ehmm, that my colleagues generally are doing a better job than me. Ehmm, you know, if there's something gone wrong in my relationship then it's probably my fault. That kind of thing...I think, ehmm, probably partly that my parents both have mental health issues and I think in many ways they were not able to give emotionally to me and my brother what we needed. And I think I was a really sensitive kid, and, you know, 'Stop making a fuss', and I guess, not remotely intentionally, but I guess quite invalidating of your experiences and your emotions and being allowed to express them and that kind of thing. And I was bullied quite a lot in school, and I guess that kind of message that you're not good enough, you're not one of us, you're not allowed to join in. Ehmm, you get that message...I guess there's people who are self-harming who are trying to release*…[pause]…*to release emotions…I think it's important not to make assumptions about why somebody is doing something, about what it's for..... I think 'What is self-harm?' is a really, really broad question…I suppose if I was trying to answer that, I would be drawing on a lot of different experiences, not just my own...I guess I'm comfortable with the fact that I can't define it because that means it can be for different reasons and things like that...So I guess not being able to define it leaves it open to having different functions...It's not so much about what someone's doing, it's about why they are doing it...I think you are at a higher risk of suicide* [if you self-harm]*, ehmm, but also what comes from the figures are that people generally use a different method to commit suicide than they would to harm themselves…I think self-harm is, I guess, trying to stay with it, to stay in the moment, and suicide is about ending that. And I think they are generally quite different... Sometimes there isn't an easy answer...I've met a lot of women who self-harm…My definition and my views on it are not just mine anymore…My job is collective advocacy, about gathering a lot of experiences, and it's not about my opinions, it's about everybody else's opinions. So I think in some ways it has become a bit more outside of me than purely a really personal thing. But, ehmm, I suppose that's the way life is. You have influences and you change your views accordingly..... I lived in Germany for a while and a therapist there actually showed an interest in trying to help me work out why I might be doing it* [cutting]*...I went to Germany after uni to work for a while. Ehmm, but I think it's, ehmm, I don't know, maybe it was just the fact that someone showed an interest that helped me...I think I would find it very difficult to talk to a friend about it because people's emotions are very involved in*

that, and ultimately very, 'Look just don't do that'. And I think it's very difficult to stop if you don't know why you're doing it in the first place. So to be able to talk to someone who is impartial, and is accepting of where you are at, and this is what you are doing...How can I help you to unpick that and unravel that so that it makes sense to you?...That seems to me to be the primary aim, rather than just, 'Let's get you not to do this'…I felt that was quite a helpful approach…… Think about if you were working with someone who had an alcohol problem or a drug problem. You might be working towards stopping but you…wouldn't say, 'Stop!' because they would find that almost impossible…I really like to read. I go on the internet…These are things that help me relax. They help me cope…If I go home and my broadband connection is down, I'll be like, 'Ahh, ahh, ahh! What am I going to do with my evening?' And I suppose it's that kind of thing…If someone has developed this as a way to cope then telling them to stop without putting something else in place…is not a very...[pause]...*All that the person is going to hear is, 'You are telling me not to do what I*...[pause]...*the very thing that helps me to carry on. So what am I going to do instead?'...Being able to accept that's where someone is, and working more on a Harm Minimisation approach, helping someone to look at, 'Well, if you have to do it, how are you going to do it really safely? How can you let me work out what your triggers are? How to distract you? Can you think about, ehmm, how to extend the time between episodes?'...Not everyone wants to stop, and so it's not… very useful…to make someone stop...It might not even be the biggest issue to them. It might not be something they want to look at at all...People get very, very focussed on* [self-harm]…*and you might miss the bigger thing...I guess it's that kind of thing when you focus on a symptom rather than a cause...I think, again it's very individual, but I think it's the right* [thing] *asking the person, 'Is this a concern to you? Is this a problem to you, and how and why is it a problem to you?'...To lay out some kind of contract and say that you can only have my support if you don't do that* [self-harm]… *it's not kind of empowering...I prefer…a more collaborative relationship...Punishing somebody who's already punishing themselves*…[is not]…*a helpful thing...I think the bottom line is acceptance. This is where somebody is at. This* [self-harm] *is what they need to do…It's a very paternalistic thing for a person, or a service, to say, 'What you need to do is stop doing this'…People who are providing support and services need to recognise that sometimes the way they're responding to self-harm is a lot about their own anxieties, and their own needs, and their own fears, rather than what's best for the person...I think also, because I've had this experience too,* [we need] *people not being so blasé about it…not seeing it as a concern by saying, 'Ok, so you do that, that's fine, and let's not talk about it'* [Nancy makes a sweeping, dismissive gesture with her left hand and arm]*...The other extreme, yeh, I've had that as well, 'Oh, you're just going to write this in your notes but we're not going to talk about it or going to explore it'. So I think it's important not to go too far in the other direction…It's an area which is really emotive and people's instinctive*...[pause]...*I mean I've friends who self-harm and my instinct is still, 'Don't do that, don't hurt yourself'… I think that's totally understandable… It's… important to be quite honest and say, 'Well…I find it upsetting because you're a nice person, and I don't feel that*

you should have to harm yourself, but I understand that that's what you need to do at this point in time'…I found it useful that my therapist in Germany…said to me, about my self-harm, 'I'm disappointed for you because I know you can manage. I know that you can manage not to do this'…There's very much this focus on fixing people…and then send them on their way. But at the time someone has been self-harming, they've probably been in a really bad state...Something like an A & E department is quite a scary place. There's a lot of sensory stuff going on [Nancy flickers her fingers]. *But for a lot of people, certainly in my experience, when I'm really distressed and very heightened to sensory in-take in that sort of environment where's there's lots of lights, noise and people, it's going to be a very difficult environment to deal with, and I probably want to get out of as soon as I possibly can...It's not rocket science. It's not about having huge specialist training. It's about being able to accept where someone is. It's about being able to listen to them. It's about being able to help people come to their own understanding of their experience, not trying to push your understanding of it...I can see exactly what people are saying about a service that's not working. I can see how it needs to be fixed. But equally I can see how that's going to throw up a whole bundle of other issues...I'm not a therapist or anything like that...I think there's a huge value to peer support, and I do run a wee peer support group…I think it really reduces people's kind of isolation, and in some ways there's no substitute for someone else who has been through the same experience. But I don't think that would necessarily make you better at treating or working with people. Ehmm, I don't think you necessarily need to have that, but I do think you need to be very open-minded to other people's experience and not be*… [pause]… *and be willing not to make assumptions and not to judge people's experiences…You know, I've had some really good help from people who've been really experienced in their fields…Equally, I've got a lot out of people who have been in the same situation. So I think there is room for both of those things...I think we need reminding that each person is an expert on themselves, and sometimes the doctor or psychotherapist is there to unravel and articulate that. Because if you imagine you are in a great deal of pain, either physical or emotional, you're not necessarily going to be able to express yourself that well if you haven't had a great deal of experience of people expressing emotions in your family...I guess I see that as somebody's role to help someone to do that, and be able to help someone to learn that language...It's…not about one person knowing stuff and one person not knowing stuff. It's about both people in the room working together, using both people's experience to work out what's happening...She* [the German therapist] *was actually a British qualified psychiatrist and psychotherapist but just happened to be working in Germany...I hadn't had very good experiences of the psychiatric system here* [Scotland]*. I felt just a little bit like a number and to have drugs stuffed at. I had told people that I was self-harming, and it was noted in my notes, and nobody ever mentioned it again...*[With the German psychiatrist] *was the first time that I thought somebody was interested in me as a person, was interested in helping me with stuff that I thought was an issue...I was able to see her for long enough to form a, you know, a relationship where I could really trust her...For me that was quite an*

important point … Before…I felt… 'What's the point of this…service 'cause it doesn't do anything really helpful?'…I felt much more in charge of what was going on when I was in Germany…I felt involved, and that my treatment was coherent, ehmm, and that it was all coming from the same place, and that I had a say and a choice about what was going on, rather than having stuff done to me. And I think that's really significant...Just sticking it out in a relationship with somebody might be the biggest thing you can do for them regardless of your profession or what you feel you ought to be achieving…These kind of things have been under-rated, you know. And, ehmm, acceptance and caring are what people are looking for, and potentially not getting… or, not knowing how to get it…".

Appendix B

(Mattie's synoptic story continued)

…When it's my daughter...'*I gave you that skin. What the hell are you doing to it?'* [Mattie smiles, laughs and leans forward and then backwards in her seat]*...It did feel like an attack on my mothering skills*...[long pause]...*It was enormously personal, enormously. Well, you can see I get quite*...[she pauses and clasps her throat]... *enormously personal. She's spent a lot of time working through it...She was sectioned once, and then twice more she voluntarily went into a clinic for about 6 weeks / 2 months at a time, mostly for bulimia rather than the*…[Mattie stops in mid sentence]…*although obviously the self-harm. The clinic, ehmm, they have a policy of, 'If you cut we throw you out'...She would get to the point where she used to carry a little knife* [Mattie shows the size of this knife by holding her thumb and index finger about 2 inches apart], *a little Swiss army knife in her bra all the time. And if she didn't have a knife, she would have some kind of panic attack. Not because she needed to use it but because she had to know it was there, so that she COULD use it……...*
……...
Interestingly, her husband, and how he coped with this, I don't know [Mattie shakes her head]. *I mean, she was self-harming when they met...He's stuck by her. He takes her to casualty in the middle of the night...He sharpens her knife for her...He physically sharpens the knife because he says the sharper the knife, the less damage you'll do. And then he says to her, 'Right, if you have to cut then you'll only do it with this specially sharpened blade, and you have only to cut the length of the blade, that's it'...And she agrees to this……*
……
She's had some horrendous experiences in casualty...Nurses who have stitched her up without anaesthetic...They pulled the stitches really tight like, 'Ummph, that's sorted you!'...And then they go, 'Well, you cut it without anaesthetic, why would I waste National Health Services on you?'...[pause]*…'Well, you come in here taking up resources. We're not here to nurse you'.* [Nurses] *who would never say to a 30 stone cardiac arrest, or someone who's drunk till their liver's packed in, or somebody*

who's been in a road accident for careless driving. [JJ: A complete lack of understanding?] *Absolute complete lack of anything. And that was horrendous to listen to...For 'G' the NHS HAS DONE NOTHING* [said slowly and deliberately] *...Absolutely no use at all...The feeling I got from what she said to me was that the nurses treated it like an attack on their profession...Which is why I'm going, 'But if that was someone who'd drunk themselves to a heart attack or liver disease, they wouldn't see that as an attack on their profession'.....*
……..
Ehmm, she's had a lot of treatment and it's all been private...Where she's worked she's had private health insurance, and that was the only way to get any effective treatment. Treatment for self-harm when you're sectioned, and she was briefly sectioned once, is just being put on a locked ward with no access to anything... whereas she went to a lovely place called the Cardinal Clinic in Windsor. And she had, I'm not sure if it's 2 or 3 stays in the Cardinal, and that really, really helped her...I think [it was] *her psychiatrist, Shvonne, that she built up a really good, trusting relationship with. She still sees her now even though she's no longer under the Cardinal Clinic…She pays privately to see Shvonne. Ehmm, just the fact that she's got this relationship that she can absolutely trust..... She's done a lot of work with the National Self-harm Network…She's a moderator on their website...She did her, her, ehmm, dissertation on self-harm and poetry, people using poetry as an alternative to harming. She has a 1st class degree in counselling. I mean, the pair of us, how fucked-up can you get? Her psychiatrist said, 'In our co-dependent relationship'...* [pause, and deep intake of breath]...*The most understanding I got was when she* ['G'] *said to me, 'It's the least harm that I can do. I have to be controlled about it, and I do the absolute minimum that I can get away with'. So it's like she's trying to avoid suicide...She says, 'If I do a little cut and then wait, is that alright? Can I get away with that?' She said, 'Because otherwise it's the gas oven'.....*
But, of course, now she's had the baby...She's had 8 [repeats the number 8] *8 miscarriages. Which is hideous, isn't it? But she's now got the baby and he's 13 months old...Oh, he's gorgeous. He walked yesterday for the first time. I mean, she's, the pair of them, are besotted with this baby...She has not harmed since she realised that the pregnancy was going to continue. She had to have daily injections to keep pregnant. She has that blood clotting factor problem. But since she realised that the pregnancy was working, she hasn't cut. So that's been just over 2 years now...She said* [that] *if she cuts then probably social services might be concerned about the safety of the baby. I mean, when the baby was born they had the psychiatric consultant come to the maternity ward to talk to her about...how she felt...She was seeing a psychiatrist weekly at that time...She will not cut again. No, she won't...I'm convinced that because of R* [baby], *that's it. She won't cut again. She would be...[long pause]...I think the risk that social services would involve themselves, even though there is no way on this earth that anything would put him at risk...She's a brilliant mum...Until he walked yesterday, I don't think she's actually put him down. I mean they sleep together. He rides on her wheelchair. They are just*

together the whole time...I think a lot of the problem when she was a teenager, and, of course, when she was a teenager that was when I left work and went to university, and I think she found that quite difficult to cope with...I was at university all day, then I would work in a supermarket in the evenings, and then I would come home and write my essay until about 2 in the morning, and get back up and go to the university the next day...[JJ: You have another child?]...*Yes, I do...She's a girl...2 years older.* [JJ: Has she had similar problems?]...*No, no, I mean that was my way of holding on to sanity while I was going through all G's difficulties. She* [G] *was not a nice teenager. Now I can understand why she was really not nice, but it was very difficult to live with. I used to go, 'But I'm E's mother too and she's fine, so it can't be all me'* [Mattie smiling broadly]...*Well, nobody is the same parent to each child, but it can't be all me because otherwise they'd both be messed up...They hate each other... They're better now that they've both got children. Of course, G is desperate to have children and E just produces twins just like that!* [Mattie makes a sweeping movement to signify something quick and easy]. *Oh, I'm pregnant. Oh, look, I've got 2 babies……*
…….....
She [G] *tries very hard now to be out and proud of her scars. 'They are there and this is who I am'. But the reaction of other people, it's like, we go shopping together, and we're walking down the street, and the first thing people walking towards you is, 'Look at the baby on that wheelchair, not on that mother, but look at the baby on that wheelchair'. And then, just as they get past her they say, 'Did you see her arms?'* [Mattie is whispering now; JJ: She doesn't hide them?]. *No, I think that's been part of her therapy. She hid it for a long time…It's a hot summer day and she's going to wear a tee-shirt…And one thing she says is, 'Well, okay, I've got my scars on the outside, and other people do other things* [e.g.] *drink too much'. She said, 'They're just as damaged as I am, but nobody can see it'.....*
[Moderating for the Self-harm Network is] *massively therapeutic…She says if ever you feel you need to cut, you can go there and say you need help now, and you'll have half a dozen people. I mean she has a network of 'fruitcakes' now. They call themselves 'fruitcakes', whom she could ring at a moment's notice and say, 'Talk to me'. Interestingly, she has 2 vigilante cats, and, if she's feeling like self-harming, the cats know and are there and will sit on her...These 2 cats will just cling to her like limpets if she's feeling that she needs to cut…It's almost like they're reminding her that she mustn't do it. And I have actually seen that behaviour…I mean, they'll drape themselves around her* [Mattie puts her hands and arms round her neck and shoulders]*..... ……..*
I find it very difficult as her mum…As a teacher I can talk to the kids in my care, but as her mum...[long pause]...*I try to cope with it...It really does feel like, 'Well, what did I do wrong then?'...She's* [older daughter, E] *not sympathetic at all...They couldn't be more chalk and cheese...He* [father of Mattie's children] *sees them now and again...And obviously he's seen the scars now, but I don't know whether he's ever even mentioned it.....*
Nobody ever wants self-harm to be culturally acceptable but you've almost got to get

to the point where it's not acceptable but it's understandable, and it's not necessarily blameworthy...So it's a little bit of re-categorisation there…[Why should it be less acceptable than]...*driving dangerously or playing stupid sports or not looking after your body to the point where you get ill? Why is it any worse than those things..?"*

[The end]