THE EXPERIENCE OF DELIBERATE SELF-HARM: A GROUNDED THEORY STUDY

by

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Abstract

This study utilized grounded theory methodology to examine the experience of transition towards, living with, and recovery from, deliberate self-harm from the perspective of people who had lived with these behaviours. The study aimed to transcend the tendency to focus on professional and clinical perspectives and to build a theory based on the direct experiences of people who have lived with deliberate self-harm. The grounded theory methodology (Strauss & Corbin, 1998) was utilized and consisted of in-depth interviews with 13 people who had recovered from deliberate self-harm as well as a registered psychologist who worked with people living with deliberate self-harm and a tattoo artist who practiced skin cutting as an art form. Interviews were coded and analyzed and a theoretical model was developed describing a process whereby: (a) exclusive and/or intrusive experiences play a central role in precipitating the discovery of deliberate self-harm, (b) a sense of loss of control results from these exclusive/intrusive experiences, (c) self-harming behaviours occur in an attempt to manage the sense of loss of control, and (d) continued exclusionary/intrusive experiences act to maintain self-harming behaviours. Recovery occurs in the context of an environmental shift, leading to the experience of Inclusion, which facilitates a sense of control. The findings of this study contribute to the field of counselling psychology by providing a model focused on client experience, and by building on a body of knowledge concerning a population that counsellors are encountering in increasing numbers (Zila & Kisela, 2001).
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CHAPTER 1
INTRODUCTION

Many labels have been attached to the cluster of self-harming behaviours of interest to this study. “Self-mutilation” is the most widely used conceptual label in the current professional literature (e.g. Zila & Kisela, 2001; Faulconer & House, 2001); other terms include “self-injury” (e.g. Hillery, 1999), “deliberate self-harm” (e.g. Favazza, 1987), or simply “cutting” (e.g. Harrison, 1997). The term “deliberate self-harm” (DSH) will be employed throughout this dissertation as this is the label attached to a proposed diagnostic formulation (Kahan & Pattison, 1984), is used by Favazza and other prominent authors whose body of work is concentrated upon self-harm, and constitutes a more appropriate term for the phenomenon of interest to this study.

As suggested above, DSH is widely regarded as mysterious and incomprehensible. In a society dominated by the medical model of disease, with the attendant ethos of the pursuit of “wellness,” the prevailing (and understandable) question is: Why? Why would anyone want to deliberately harm themselves in this way? This is not to deny that there are countless examples of socially-acceptable methods of self-harm, including smoking, coffee drinking, lack of exercise, body piercing, and so on, but when a person perpetrates self-harm with the intention of drawing blood, a social taboo is traversed (Connors, 2000), and societal response oscillates between disgust and morbid fascination (Levenkron, 1999).

There are numerous accounts of professional antipathy towards people who self-harm (e.g. Harris, 2000). The following quote, while written more than 25 years ago, is
frequently echoed in anecdotes and reports contained in more recent literature (e.g. Stong, 1998; Conterio & Lader, 1998).

Even after years of exposure to physical trauma, case hardened attendants, including medical staff, still react with revulsion to many of the insults to the bodies of self-mutilating patients... The reaction to a bloodied, burned, scarred, damaged individual is frequently a mixture of revulsion and guilt. No less common are reactions of frustration, incredibility, and outright anger at the apparently nonsensical assault that the person has made on his body (Ross & McKay, 1979, p. 10).

Several years ago, I was discussing DSH with a psychiatrist who works at a major suburban hospital in the Lower Mainland area of British Columbia. He told me of a patient who is frequently admitted to his hospital after having cut her stomach open; sometimes going so far as to pierce her intestines. With such injuries, this person naturally requires frequent surgical intervention. The predominant sentiment amongst Emergency Room staff and surgeons was one of anger at the waste of scarce medical resources. When I asked if this patient had received any psychotherapeutic help, the psychiatrist replied, ruefully, that this would be "too expensive" (personal communication). Apart from the bureaucratic absurdity of a system that will provide a person with reactive intervention in the form of expensive surgery, but will not fund basic proactive psychosocial treatment, this anecdote serves to further illustrate some of the disdain with which people living with DSH are regarded in the medical community. Levenkron (1999) writes of a similar experience when he first began treating people with Anorexia:
When I was treating severe anorexics in the 1970s in urban teaching hospitals, I discovered that staff was very angry at them. Both doctors and nurses were annoyed that they had to waste their time on patients who were starving themselves to malnutrition when they had plenty to eat. The anorexics were deliberately causing themselves harm and wasting valuable hospital beds that people with serious and involuntary medical problems could be using. The patients were uncooperative and self-sabotaging. They were also sabotaging the help their doctors were trying to give them. (p. 60).

The Problem

The current status of professional knowledge of, and attitudes towards, people living with DSH is that, both socially, and clinically, we are in the early stages of coming to terms with the phenomenon of self-harm. While there is a small, but growing body of popular and scholarly literature that examines DSH, and purports to provide solutions and suggestions for “change,” such insights remain tenuous at best, and as I shall discuss later in this dissertation, are generally unable to escape from the constraints of entrenched structural perspectives, particularly as to what constitutes disease and wellness, the role of the client/patient, as well as the pathogenesis of “illness.” As things stand, people with DSH are likely to encounter contempt and fear in their interactions with the mainstream clinical and medical community (Johnstone, 1997).

Rationale for the Study

This research arose primarily from a perceived need for theories of personal transformation that privilege the perspectives, experiences, expectations, and attributions of the recipients of counselling, psychotherapeutic, and psychiatric services. Many
studies of psychotherapeutic change, and the process of therapy, are conducted from the vantage point of the learned “professional,” which somehow serves to render recipients of psychotherapeutic services “beside the point” – as mere recipients of the healing powers and methods provided by “the expert.” In seeking to move beyond such a standpoint, I was influenced by a body of work exemplified by authors such as Tallman and Bohart (1999), and Duncan and Miller (2000) who argued for better understanding of the importance of client and relational factors (as opposed to therapist orientation) as key to successful psychotherapeutic outcome. Such a perspective is particularly pertinent when applied to people who self-harm, given the ignorance, disgust, and de facto oppression experienced by people who self-injure at the hands of both the “lay” public and professionals who are purportedly charged with helping them (Harris, 2000).

At the same time, I am aware that the mere intention of conducting research (or counselling/psychotherapy for that matter) that emphasizes the consumer’s perspective will not be sufficient to result in an egalitarian, value-free analysis (in other words I, as the researcher, am unable to simply disappear from the research dynamic). I am therefore influenced by the methodological paradigm termed “double-exposure” by Roman (1993) which enables researchers to “self consciously and reflexively expose how their prior beliefs and structural (class, gender, and racial) interests partially constitute the empirical evidence for or against their descriptions and analyses of the research subjects” (p. 2).

Delimitations

This study was conducted qualitatively, using grounded theory methodology, and as such, I do not claim that my conclusions are exhaustive or replicable. In this sense, I am in agreement with Glaser (1992) who indicated that the nature of conceptual coding
employed by the grounded theory method serves to render it unlikely that other researchers would reach identical conclusions. Therefore, rather than thinking of my research results as a generalizable or universal model of change from the perspective of people who have lived with DSH, it is more useful to suggest that my final theoretical model has relevance to other clinicians and researchers, as well as to people living with DSH. My hope is that this research will serve as a “piece of the puzzle,” and a possible launching point for future research into both the client’s perspective on change, and the experience of people living with DSH.

I also bring with me the baggage of gender, social, and class positionings that might serve to render some potential data unattainable to me (for example, stories of sexual abuse). I have, however, had experience working with women who have experienced abuse, and I believe that one of my strengths is the ability to both elicit, and accept the stories that people bring to me. Most importantly, in light of my socio-cultural positionings, I will diverge from traditional grounded theory analysis technique in directly considering how my own “prior beliefs and structural interests partially constitute the empirical evidence for or against (my) descriptions and analyses of the research subjects” (Roman, 1993, p.2).

Definitions

I now turn to an attempt to draw a conceptual boundary around what I shall refer to as Deliberate Self-Harm. This is important, as such a conceptualization, while tenuous, at least allows me to designate an entry point into research work with people who self-harm. In doing this, I necessarily start with a so-called “medical model” analysis. I shall outline alternative critiques below.
Topographically, a literature review of self-injurious behaviour conducted by Rojan and Esbensen (2002) found self-harming behaviours including: Aerophagia, head-banging, self-biting, cutting, gouging eye cavities, digging in bodily orifices, pica, skin picking, poking eyes, stuffing bodily cavities, and so on. Favazza and Conterio (1988) conducted a survey which found the following manifestations of superficial self-harm (term defined below): Cutting (72%), burning (35%), self-hitting (30%), interference with wound healing (22%), hair pulling (10%), bone breaking (8%), and multiple methods (78%). The variety of topographical manifestations partly explains why, for the most part, self-harm is difficult to define. In addition, there is disagreement as to what constitutes pathological self-harm, versus the self-harm we all indulge in at various points in our lives, including, as mentioned above, smoking, coffee-drinking, eating the wrong foods, and so on. Self-harm, in the pathological sense, is explicitly mentioned in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM) (American Psychiatric Association, 2000) as constituting a symptom of two psychiatric disorders. The DSM does not provide for a specific syndrome of self-harm.

Where the DSM does deal with self-harm is the source of a great deal of controversy. That is, self-harm is viewed primarily as a major feature of Borderline Personality Disorder (BPD). Criterion five for BPD is characterized by: “(R)ecurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour” (American Psychiatric Association, 2000, p.710). Self-harm is also subsumed under the category of Stereotypic Movement Disorder (SMD), and is regarded as a feature of people with intellectual disability who are diagnosed with SMD. The DSM states that: “The behaviour (must) markedly interfere with normal activities or results in self-inflicted
bodily injury that requires medical treatment (or would result in an injury if preventive measures were not used)” (American Psychiatric Association, 2000, p. 134).

Kahan and Pattison (1984) argued that a more useful approach to understanding and treating self-harm would be to formalize a distinct diagnostic entity in future editions of the DSM (although, to date, this has not been accepted by the American Psychiatric Association committee). Features of what Kahan and Pattison (1984, p. 17) proposed to label “Deliberate Self-Harm Syndrome,” would include:

1. An irresistible urge to harm oneself physically.
2. A psychological experience of existing in an intolerable situation from which one cannot escape.
3. Mounting anxiety, agitation, and anger in response to the perceived situation.
4. A narrowed perspective on the situation and of alternatives to action.
5. Self-inflicted destruction or alteration of body tissue done in a private setting.
6. A rapid, temporary feeling of relief following the act of self-harm.

In an attempt to provide further diagnostic clarity to the concept of self-harm, Kahan and Patterson (1984) suggested a continuum of self-injury, with reference to the following three broad components: Directness (how intentional is the behaviour?), Lethality (How likely is the behaviour to cause death?), and Repetition (How often is the behaviour performed?).

Favazza and Rosenthal (1993) demarcated three major typologies of pathological self-harm. These were:
1. Major: This includes such serious self-injury as castration, and limb amputation, and is usually carried out by people who are experiencing acute psychiatric illness, such as psychosis, or severe personality disorder.

2. Superficial: Including such behaviours as cutting, burning, and self-hitting. This category would encompass the group that was the focus of my study. Favazza (1996) further clarified his understanding of superficial self-harm, by delineating three subcategories: Compulsive (for example, trichotillomania, skin picking); Episodic (meaning self-harm carried out every so often); and Repetitive (characterized by a shift towards ruminating on self-harm, which is conducted on a regular basis. Self-harm ceases to be a symptom, and becomes a “disease” in itself).

3. Stereotypical: Usually observed in people with intellectual disabilities. Includes repetitive head-banging, skin picking, and so on.

One simple, and widely quoted, descriptive definition of DSH that was useful for the purposes of my research, was provided by Winchel and Stanley (1991, p. 306):

(Superficial self-injury is) the commission of deliberate harm to one’s own body. The injury is done to oneself, without the aid of another person, and the injury is severe enough for tissue damage (such as scarring) to result. Acts that are committed with conscious suicidal intent, or are associated with sexual arousal, are excluded.

It is noteworthy from the description above that suicide was regarded as distinct from DSH. Favazza (1998, p. 262) maintained that: “A basic understanding (of DSH) is that a person who truly attempts suicide seeks to end all feelings, whereas a person who
self-mutilates seeks to feel better.” While suicidal ideation may co-exist with DSH, self-harm should be seen as a form of coping (albeit one that might be described as “maladaptive”). Van der Kolk, Perry, and Herman (1991) noted another important distinction between attempted suicide and DSH, in that the latter brings about relief, while the former does not. Zila and Kisela (2001) pointed out that, where suicide attempts result in responses being taken by others in the person’s environment, diminishing the likelihood of multiple attempts, DSH is often done in secret, and when discovered, frequently elicits negative reactions that serve to reproduce self-harm. In addition, suicidal attempts tend to cease in the absence of a stressful stimuli, whereas people with DSH continue their actions regardless of environmental context.

Demographic Profile

The demographic profile of people living with DSH is an area of much controversy. Firstly, self-harm tends to be practiced in private, and is therefore not always reported. Known incidence is estimated to range from between 400-750 per 100,000 of the (US) population (Kahan & Pattison, 1984). Secondly, studies of the gender breakdown of people who self-harm have elicited mixed results. Whereas Favazza and Conterio (1989) found that more than two-thirds of repetitive self-harmers were female, others have reported an equal gender distribution, with (the usual) argument being made that women are more likely than men to seek treatment (e.g. Alderman, 1997). Conterio and Lader (1998), who founded a highly regarded treatment program (S.A.F.E, or Self Abuse Finally Ends) in Chicago, noted that (at time of writing) they had treated 25 men in their thirteen year history, as opposed to hundreds of women. They believed that this was accounted for by the following factors:
1. Men are more likely to turn their aggression outwards.

2. Men tend to deny emotional and psychiatric problems (as argued by Alderman, 1997).

3. Men are more likely than women to turn to alcohol and drugs as a means of self-soothing.

At the same time, Conterio and Lader (1998) pointed out that self-harm is rife in male prison populations. This they ascribed, partially, to the tendency of men with poor impulse control to commit impulse-driven crimes. But, more importantly, they argued that male prisoners experience:

1. A lack of stimulation, and sources for external expression of rage.

2. Self-harmers may be moved from the general population for medical treatment, which increases the incidence of self-harm.

3. A lack of power leads to attempts by prisoners to engage in activity that is beyond the ability of anyone else to control.

Besides the controversy around gender distribution, the basic “profile” of a person living with DSH that emerges from the literature (e.g. Favazza & Conterio, 1989) is of a female, in her early 20’s to mid-30’s who began self-harming between the ages of 14-25. This profile (while “typical” as opposed to definitive) leads to another important element in coming to understand DSH, that is, the increasing interest in DSH being shown by feminist authors.
The Feminist Perspective on Deliberate Self-harm

Many authors (including some considered central to the mainstream of work involving DSH e.g. Linehan, 1993), have noted the historical link between current medical conceptualizations of DSH, and the archetypal "hysterical female," that so interested earlier, particularly psychodynamic, clinicians. Wirth-Cauchon (1991) captured the general feminist disquiet with medical conceptualization of DSH (which as indicated earlier in this chapter, is often subsumed under the label of Borderline Personality Disorder):

At the beginning of the twentieth century, "hysteria" as a medical or psychiatric diagnosis was primarily applied to women. In fact, the term itself comes from the Greek, meaning "wandering womb." This diagnosis had evolved from certain assumptions about women's social roles and mental characteristics, and is no longer in use. The modern equivalent of hysteria, however, may be borderline personality disorder. This diagnosis is applied to women so much more often than to men that feminists have begun to raise important questions about the social, cultural, and even the medical assumptions underlying this "illness." Women are said to be "unstable" when they may be trying to reconcile often contradictory and conflicting social expectations. (p. 6).

Feminist writers have argued that dominant conceptions of DSH tend to take individualistic, as opposed to socio-contextual understandings. Johnstone (1997, p. 423) argued that seeing DSH as an individual problem made it "easy to lose sight of the relevance of their (people living with DSH) network of relationships past and present, the culture they come from, and their socio-economic circumstances." For Johnstone, self-
harm had to be viewed in the context of a pervasive pattern of violence considered endemic to western culture. Another author (Harrison, 1997) pointed out that:

A woman who injures her body is condemned because her behaviour mutilates society’s expectations of passivity and beauty. In hospital (Harrison was hospitalized in England for self-harm) a charge nurse, male, told me I’d look prettier if I plucked my eyebrows and put on makeup. Is it any wonder that I want to slice up my face? I was visibly saying “fuck off” to my abusive keepers. (p. 438).

Jeffreys (2000) went one step further in terms of emphasizing the link between DSH and a history of sexual abuse. She felt that “mainstream psychology” downplayed such a link, even though such abuse was instrumental in engendering a sense of hatred in women for their own bodies. Whereas the tendency in the literature was towards viewing self-harm as something to be “cured” in and of itself, little was done to tackle the underlying factors which gained expression through self-harm.

Jeffreys (2000) was also critical of feminist authors who viewed self-harm as a form of “liberation” from male-dominated culture and society (in this perspective, self-harm became a tool that enabled women to retake control of their bodies):

(Some) feminist therapists and commentators ... (A)re keen to see self-mutilation as serving a useful function for women. (Such authors) are caught up in a contemporary post-modern determination to attribute agency to women even in the most inappropriate situations. (p. 411).

Jeffreys (2000, p. 427) went on to argue that culturally-sanctioned acts of self-harm, such as tattooing and body-piercing were situated within the discourse of bodily
liberation, whereas, in fact, such behaviour was better placed on the continuum of harmful bodily abuse, mainly practiced by members of “degraded” social categories, such as women, lesbians, and gay men. According to Jeffreys, membership in one of these groups, when combined with childhood abuse, was a potent factor in the pathogenesis of “more extreme forms of self-mutilation.”

Research Questions

In this chapter, I have attempted to argue that people living with DSH often experience ignorance, fear, and oppression when interacting with existing clinical and medical systems. In addition, while there is an emerging, and tentative conceptualization of what characterizes DSH, such understandings are themselves interested view-points that focus on symptoms as opposed to underlying and structural factors that are salient in gaining an understanding of the phenomenon of DSH. My research was guided by the question of: What is the experience of transition towards, living with, and recovery from, deliberate self-harm (DSH) from the perspective of people who have lived with DSH? I sought to build a theory that privileged the viewpoints of recipients of mental health services, rather than clinicians and, as shall be discussed in Chapter 3, I viewed the grounded theory methodology, with its emphasis on knowledge gained through inductive investigation, as a suitable means to conduct “bottom-up” research.

Significance to Counselling Psychology

I consider the study of clients’ experiences and perspectives to be one of the central, emerging elements of Counselling Psychology as a discipline. This investigation served as an extension to my own developing theory of what brings about change in counselling in that it broadened my understanding of clients’ implicit models of change.
An additional benefit of this research is that it served to further build upon the body of knowledge that our discipline can call on in working with people living with self-harm – deliberate self-harm being a phenomenon that counsellors are encountering with increasing frequency in their day-to-day work (Zila & Kisela, 2001).

Situating the Researcher

For the past six years, I have worked with people with so-called developmental disability (the currently acceptable term for what is labelled as mental retardation in the DSM-IV-TR (American Psychiatric Association, 2001) in my capacity as a therapist employed by a mental health team specializing in work with clients with concurrent developmental disability/psychiatric diagnoses. One of the most troubling behavioural manifestations observed in this population is self-injurious behaviour (SIB). During much of my early clinical work, what I had been observing and treating was self-injurious behaviour, that is, repetitive, self-inflicted injuries, leading to tissue damage (e.g. Hillery, 1998) manifesting mainly in people with severe to profound developmental disabilities. And then I took on the role of training new caregivers (who had recently been hired to work with people with developmental disability) in behavioural intervention techniques. My usual way of introducing the subject of self-injurious behaviour, was to elicit comments from the “audience” that indicate that self-injury is practiced by all of us in forms such as unhealthy eating, smoking, etc. However, with this group of young people, two women mentioned that they knew of friends who deliberately cut themselves. In subsequent talks to new caregivers, this response became routine, and marked the beginning of my interest in self-harm in non-developmentally disabled populations.
Glaser (1978) suggested that researchers put all their pre-existing assumptions and hypotheses behind them before embarking on grounded theory research. I believe this is impossible given that researchers do not simply materialize out of thin air as ahistorical beings. Therefore, it is important to declare my pre-existing assumptions and structural relationships. I have largely been schooled and immersed in the medical, DSM-based model of disease, however, I do not believe in biological causality, or indeed, in a single domain of causal factors for what we currently term “mental disorders” (Kiesler, 1999). I have largely practiced cognitive-behavioural interventions in my professional career, although I have come to appreciate the ideas put forward by the integrative psychotherapy movement (e.g. Duncan & Miller, 2000).

I am also male, white, and middle-class and most of my research participants were female. In addition, my field of study, namely psychology, carries with it connotations that are not necessarily positive for people who have felt re-abused by the clinical system. These issues will be further expanded on in the Methodology.

Overview of the Dissertation

This dissertation consists of five chapters. In the Introduction chapter, I have attempted to delineate the subject under investigation, provide a rationale for my research, and situate myself as a researcher in an attempt to acknowledge that I do not assume that I approached this study from a value-free perspective. In the second chapter, I provide a review of the literature concerning the client’s subjective experience of psychotherapy and counselling, the general literature on self-harm and the literature regarding current treatments and attitudes towards clients living with DSH. The aim of this literature review goes beyond the general format of the starting point of this study
and pointing to gaps in the extant literature; rather, in the grounded theory tradition, the literature is a source of data and constitutes part of the process of theory building. In Chapter 3, Methodology, I outline my rationale for choosing grounded theory as my methodology for this study. Furthermore, I provide an explanatory outline of the method, as well as definitions of key terms. Chapter 3 also contains an outline of the procedure I followed in conducting this study. In Chapter 4, I provide a detailed account of the study findings. Chapter 5 begins with a discussion of my findings with reference to current literature in the area of DSH, and counselling and psychotherapy with people living with DSH. Also contained in this final chapter are implications for further research, practice and policy making. The reference list and appendices can be found at the end of the dissertation.
CHAPTER 2
LITERATURE REVIEW

The literature review constitutes an important component of any psychological research report, providing as it does a discussion of the history and priority of relevant past research (APA, 2001). In the grounded theory tradition, the literature review takes on a more fundamental role, for in this perspective, such a review does not merely comprise an introduction to the background of an area of interest to research, rather it represents a useful source of data in the process of inductive theory building. In other words, when working within the grounded theory paradigm, the literature review is itself part of the research project proper, in that the technical literature constitutes a source of comparison for data collected during the course of a study (Strauss & Corbin, 1998).

The present review will delineate literature matching the focus of this study; that is, looking at transition towards, maintenance of, and recovery from self-harm, including related phenomena, such as suicide, sexual abuse and mental illness.

The Development of Deliberate Self-Harm

Several studies have examined factors thought to be instrumental in the development of self-harming behaviour. In a survey of adolescents in English high schools, Hawton, Rodham, Evans, and Weatherall (2002) found that self-reported DSH was significantly higher in: (a) Females living with one parent, (b) Males and females who reported drug, alcohol and tobacco use, (c) Students who had experienced bullying, and (d) Males and females who had experienced physical and/or sexual abuse. In another UK survey of adolescents, this one a longitudinal study conducted in Oxford, Hawton et al. (2003) found that the following precursors were most commonly reported by
adolescents admitted to hospital as a result of self-harming incidents: (a) Relationships with family, friends and partners (this was reported at a significantly higher rate by females than males); (b) Difficulties with school or employment (more commonly reported by males than females); (c) Housing difficulties; and (d) Social isolation. Similar precipitants were reported by De Leo and Heller (2004), who looked at factors associated with deliberate self-harm in adolescents living in Queensland, Australia. These authors also noted the presence of DSH in peers and family an important “causal” factor. In other words, survey participants indicated that others modelled self-harming behaviour as a coping mechanism.

Such survey studies are, by their nature, relatively superficial means of gaining broader etiological understandings. It seems to me that factors implicated by these studies as causitive of self-harm, for example, isolation from friends and family, are themselves symptomatic of dynamics that are less easily defined or articulated by participants, for example, early attachment difficulties.

In particular, while mentioned as a factor in one study (Hawton, Rodham, Evans, & Weatherall, 2002), there is no broad indication in the research literature of the role played by trauma in the pathogenesis of DSH. This is surprising given that, traditionally, the link between the experience of sexual and physical abuse and self-harming behaviours has been assumed by many, at least in the theoretical literature, to be strong. For example, Jeffreys (2000) asserted a direct link between DSH and a history of sexual abuse, which, she believed, engendered in abused women a hatred for their own bodies, expressed via the medium of self harm. Similarly, Harris (2000) proposed a model of self-harm that emphasized the role of DSH as a cleansing mechanism; people cut
themselves in an attempt to excise traumatic, abusive experience which Harris termed “the bad.” In this model, “the bad (that is the emotional pain) is an externalized phenomenon that is called into existence and thereafter may take up residence within the women’s’ bodies,” (Harris, 2000, p. 166). It is clear that, for Harris, self-harm was explained only in terms of a reaction to viciously aversive events. Contrerio and Lader (1998), directors of a major American treatment centre for people living with DSH, concurred with Harris regarding the brutality experienced by most of their clients, but went further in arguing for a bio-psycho-social interplay of predisposing factors. These authors viewed self-harming behaviours as learned, communicative actions.

Other authors focused on the primary experiences reported by people living with self-harming behaviours. Gardner (2001), a psychoanalytic therapist, wrote that, of 15 women who were referred to her for help with DSH, four had been sexually abused, eight came from families where the parents had divorced or separated, four had been deserted by their mothers and four by their fathers. Another was adopted and felt she had been abandoned by her natural parents. Four of the young women were at boarding school and generally felt emotionally neglected or rejected by their families. While some had obviously experienced more than one trauma, others felt they were neglected or emotionally abused in a general sense as opposed to having lived through a specific trauma. A similar profile was reported by Levenkron (1999), who pointed out that traumatic experiences can take forms other than direct sexual and physical abuse:

Some of the trauma is subtle and may include having a parent with a mental or physical illness; being overlooked and neglected; having the family broken up or
separated for a period of time. Some of the trauma is very unsubtle: physical abuse, sexual molestation and, incest rape. (p. 47)

Levenkron (1999, p. 47) believed the key outcome of a personal traumatic history, whether “subtle” or “direct,” is that people with such experience come to believe they have “no one to depend on or trust.” This sense of “social isolation” was a point of focus for literature that examined the relationship between trauma and “attachment,” which makes it useful, in this context, to examine that literature.

**Poor Attachment and Social Isolation**

Van der Kolk, Perry and Herman (1991, p. 1665) examined the histories of people living with “self-destructive” behaviours (identified behaviours included self-harming, attempted suicide and eating disorders). They found that, while traumatic experiences in childhood contributed to the “initiation of destructive behaviour,” “lack of secure attachments” helped to maintain such behaviour.

In a similar vein (Lipshitz et al., 1999) found that emotional neglect was a more potent indicator of suicidal behaviour than physical and emotional abuse.

Gratz, Conrad and Roemer (2002) reviewed the literature on self-harm and concluded that:

(The) empirical literature suggests that both disruptions in attachment and the perceived quality of attachment to caregivers may play an important role in the etiology of self-harm. (p. 130)

Poor attachment was also of interest to Wright, Friedrich, Cinq-Mars, Cyr, and McDuff (2004) who noted poor mother-daughter relationships in the histories of adolescent girls with “at-risk” behaviours, including self-harm. In an earlier study, Martin
and Wait (1994) found that adolescents who rated their parents as “affectionless” on the Parental Bonding Instrument (PBI) were three times more likely than other adolescents to also report self-harming behaviour. Arato (1999) found a strong link between insecure attachment and suicidal behaviour in adolescents.

Studies have long implicated poor attachment and social isolation as factors leading to repetitive self-harm in animals. One example of this area of the literature is an article examining the phenomenon of self-biting in captive macaques monkeys. The authors (Reinhardt & Rossell, 2001) concluded that:

(Self-biting) typically occurs in emotionally disturbing situations over which the (animal) has no control. Separation of affectionate companions, separation of sexual partners, excessive disruption of daily routines such as cage transfers, presence of fear-inducing personnel, or simply being confined alone in a cage can be such distressing experiences that they prompt self-biting behaviour. (p. 287)

Reinhardt and Rossell further noted that the United States National Research Council had specified that laboratory animals should be housed socially, rather than individually in order to combat self-injurious behaviours.

To summarize this section examining the literature on the discovery of deliberate self-harm, there is some research into the etiology of DSH, but this literature appears to be relatively superficial in approach – focusing on participants’ recent memories concerning factors that may have precipitated their self-harming behaviours. Such literature does not examine more extensive historical dynamics that might provide a broader understanding of precipitants to DSH. There is a theoretical and case-study-based literature postulating a connection between trauma and emotional neglect in the
pathogenesis of self-harm. While important, such literature does not enable a deeper perspective into the mechanisms through which traumatic and neglectful experiences translate into DSH. This perspective is currently provided by literature concerned with attachment, trauma and suicide, but not specifically with deliberate self-harm.

The Maintenance of Deliberate Self-harm

The understanding that self-harm is a coping mechanism receives such widespread agreement throughout the literature that it might be considered a truism. Therefore, the interesting question becomes: What are people who self-harm coping with? Authors such as Harris (2000) argued that self-harm serves as a means of dealing with emotional difficulties, but stressed that the behaviour constitutes a re-enactment of historical abuse.

Favazza (1996) attempted to understand self-harm from a psycho-cultural perspective. Thus, modern cutting recalls religious symbiology and ancient cultural understandings wherein bleeding served to heal through the purging of “bad blood.” Favazza viewed scarring, the lasting remnants of cutting incidents, as visible biographical markers of life-events, which also serve as evidence (to the person living with self-harm) that healing is possible:

With a few strokes of the razor the self-cutter may unleash a symbolic process in which the sickness within is removed and the stage is set for healing as evidenced by the scar ... The cutter in effect performs a primitive sort of self-surgery complete with tangible evidence of healing. (Favazza, 1996, p. 280)
Some authors have suggested that self-harm functions as a “cry for help” (e.g. Derouin & Bravender, 2004), however there are also arguments that it might be more useful to understand motivations for self-harm in terms of the concept of “control.” The suggestion that control (or lack thereof) is core to an understanding of deliberate self-harm was most prominently highlighted by Stong (2000), who quoted a young woman as describing her pre-cutting self in these terms: “I felt I had lost control of my thoughts, my emotions, and my actions,” (p. 41). In a study of coping strategies amongst women who had survived sexual abuse, Morrow and Lee Smith (1995) found that respondents viewed self-destructive behaviours as a means by which they could re-gain control lost to their abusers. According to these authors, self-harming served to mirror experiences of abuse, except that in this form, survivors were able to achieve control over their pain, both in the sense of rendering their pain more tangible, and in the sense that the injury was now caused by their own hands.

Not surprisingly, “control” has been most thoroughly explored in the literature on sexual abuse, where “lack of control” is explained, in developmental terms, as the outcome of an early upbringing that lacked secure attachment. According to Putnam (1997), children learn to regulate their emotions through modelling from parent-figures, and from having a secure base of attachment to which they can return as they explore further afield. Van der Kolk and Fisler (1994, p. 147) pointed to physiological evidence of emotional “mirroring” between mothers and their children, and suggested that: “The capacity of mothers to modulate physiological arousal in their children may be a powerful component of the attachment bond between mother and child.” Children who experienced neglect and abuse often experienced difficulty regulating their emotions and
were therefore more prone to behavioural difficulties, including aggression towards themselves and others. Such children often had difficulty soothing themselves, and rarely gained the ability to trust others to help with emotional dysregulation. Also affected was the person's sense of self in relation to others (described as a sense of separateness), and his/her ability to "positively affect (his/her) environment" (Van der Kolk & Fisler, 1994, p. 145).

Self-harm therefore emerged, in accordance with this model, as a method bringing about temporary emotional equilibrium amongst people with a history of abuse and neglect, who were isolated from others and lacked more "appropriate" self-soothing abilities as a result of deficient or abusive attachment experiences (Stong, 2000). To reiterate a point made above, Van der Kolk and Fisler (1994, p. 146) argued that lack of secure attachments:

(M)ay produce the most devastating effects (on long-term identity) because consistent external support appears to be a necessary condition in learning how to regulate internal affective states and how to modulate behavioural responses to external stressors.

To summarize this section on the maintenance of self-harming behaviour: There is a strong body of literature looking at the psychological sequela of poor attachment, traumatic experience and abuse in a general sense. Such literature does not always explicitly mention self-harm, but does note the role of such experience in the maintenance of "self-destructive" activities, including suicidal and self-harming behaviours. There remains a paucity of literature directly examining the subjective experience of people who have specifically lived with deliberate self-harm.
In the following section, I will examine literature concerned with recovery from DSH.

Recovery from Deliberate Self-Harm

Much of the literature on deliberate self-harm is focused, broadly, on the subject of recovery (e.g. Zila, & Kisela, 2001), and this literature shall be outlined below. It will also be noted that much of the literature on “recovery” tends to take a “prescriptive” form, that is, it provides a solution based on the experience and observations of clinicians, rather than the testimony and experience of people who have lived with DSH. It is, therefore, worthwhile to briefly examine literature where clients’ points of view are emphasized as key to constructing effective intervention strategies.

It should be noted at the outset of this section looking at the literature on recovery from self-harm, that a study conducted by Hawton, Rodham, and Evans (2006) found that 53% of people living with deliberate self-harm did not seek any help. Reasons provided by those who did not seek help included statements such as: “I didn’t need it. I could get through on my own better than if anyone had helped me”; “I don’t talk about my problems because they are MY problems”; “I was ashamed” and “I didn’t feel like anyone could help me anymore.” (Hawton, Rodham, & Evans, 2006, pp. 105-106). I include this finding because it should not be assumed that all, or even most, people living with DSH ever officially engage in help-seeking from anyone, let alone professional clinicians. The same study asked British adolescents living with deliberate self-harm for their opinions on factors that would make them more likely to seek professional intervention. The most common response was a request to be listened to and not judged. In other words, respondents were voicing a desire for clinicians to interact with them as
"equals" as opposed to taking command of their situations. In other words, respondents rejected the notion that clinicians should be in a position to impose power over them (Morrow & Lee Smith, 1995).

Client Perspectives in Counselling and Psychotherapy

Duncan and Miller (2000, p.1) advocated a model of psychotherapy that viewed clients as "star(s) of the drama of therapy (attaining) directional control of the action as it unfolds." These authors emphasized the importance of working within the client's model of change. In other words, they proposed a mode of intervention that, rather than seeking to impose the therapist's model of change, attempted to ascertain how the client viewed the unfolding process of change (Tallman & Bohart, 1999).

Historically, research into psychotherapy tended to disregard the perspectives of clients (Duncan & Miller, 2000). Macran, Ross, Hardy, and Shapiro (1999) believed this neglect of client perception could be attributed to the following broad biases held by researchers in the field of psychotherapy:

1. Due to cognitive distortions brought about by their "psychopathology," clients were unable to render reliable opinions regarding their treatment. For example, a client living with depression might render a negative evaluation of therapy as a result of the cognitive style inherent to depressive thinking.

2. Clients lacked the expertise and skill necessary to truly understand or assess the minutiae of the therapeutic process.

McLeod (1998) suggested that the paucity of research into clients' perspectives was an artifact of the positivistic culture in psychotherapeutic research, where the client's feelings, beliefs, and state of mind about psychotherapy were difficult to objectively
quantify, and were therefore not viewed as legitimate topics of interest. Earlier, McLeod (1990) argued that therapists (and researchers) tended to approach psychotherapeutic research through the lens of their theoretical perspectives. This served to dismiss the client's legitimacy as an observer. Thus, a psychodynamically-oriented researcher might interpret the client's perspective as "fantasy" or "defense," and a behaviourally-oriented researcher would be interested in observable manifestations, as opposed to "vague internal events such as experiences" (McLeod, 1990, p.67).

Where research into clients' perspectives has been undertaken, startling distinctions have been documented regarding the most basic expectations of the therapeutic process held by clients and therapists. One example of this phenomenon was observed by (Llewelyn, 1988), who found that clients entered psychotherapy with the expectation of finding basic solutions to their problems, whereas therapists were most concerned with understanding the origins of clients' difficulties, and in helping their clients gain insight. More recent research has found that, when clients were asked about the most helpful aspects of psychotherapy, they placed far greater importance on the nature of the relational bond with their therapists than they did on orientation. In other words, clients placed a great deal of importance on psychotherapeutic process, rather than techniques dictated by therapeutic orientations (Teyber, 1999).

In summary, there would appear to be differences between clients and their therapists in terms of basic understandings of the nature, course and expected outcomes of counselling/psychotherapy.
In the section that follows, I examine the literature concerning counselling and psychotherapy with people living with DSH. This section has been organized in terms of therapeutic approach.

**Therapeutic Community**

Ross & McKay (1979, p. 145) recommended a therapeutic community approach (termed “co-opting”) for people living with DSH. These authors outlined the philosophy and methodology of their approach as follows:

1. Clinicians were to avoid imposing a conceptual view of the client’s behaviour; rather, they were instructed to attempt an understanding of the client’s own view of what motivated his/her behaviour.
2. It was important to avoid “pathologizing” the behaviour. The focus of treatment was on the client’s strengths and skills.
3. The concept of “peer power” (p. 148) in the context of a therapeutic community, was considered a critical tool for neutralizing the effects of self-harm. The authors encouraged their clients to provide peer-support, and even trained their clients in psychotherapeutic methods.
4. The principle of “helper-therapist” (p. 146) encouraged clients to view themselves as valuable in terms of their own ability to help their peers.
5. Therapists formed close relationships with leaders of the “peer groups.” This was regarded as an important way of maintaining professional influence over the therapeutic community.

While a method of intervention that encouraged peer engagement in the therapeutic process was a positive first step, the paternalism evident in the very name of
the method of therapy, “co-opting,” renders the potential egalitarian nature of this form of therapy somewhat hollow. More recent advocates for a therapeutic community approach tended to dismiss the need for professionals altogether, arguing that clinicians experienced tunnel vision in viewing the phenomenon as a disease in itself (that is isolated from structural factors), or as a symptom of borderline personality. Authors such as Johnstone (1997) advocated a treatment community that was conducted entirely by people living with self-harm, as such people brought more expertise and experience of DSH than any professional could offer.

A vastly different approach to the therapeutic community model was offered by Conterio and Lader (1998) (as well as Crowe & Bunclark, 2000). Conterio and Lader were the founders of the residential S.A.F.E. program in Chicago and they stated their philosophical departure point as follows:

Our major emphases are on treating clients with respect and empathy, and placing the responsibility for recovery squarely on their shoulders. We do not view self-injurers as victims, we do not think their behaviour is an addiction, and we do believe they can get better. (pp. 212-213).

Conterio and Lader believed the structure of a residential treatment program could be beneficial to their clients, but they eschewed outpatient treatment. Their program borrowed heavily from cognitive-behavioural models, and emphasized the use of therapeutic contracts. Their program can be summarized as follows:

1. The right frame of mind: People living with DSH had to want to get better.

2. The right therapist: Clients were required to have an external, personal therapist to enable them to “weather emotional storms” (p. 241).
3. **The S.A.F.E. toolbox:** This included a “no harm contract,” an “impulse control log” (a diary that listed environmental and emotional contexts in which the urge to self-harm occurred); “five alternatives” (that is, alternative behaviours that could be carried out in lieu of self-harm); and “writing assignments” (these consisted of 15 pre-designated writing tasks. The aim of these assignments was to enable clients to “organize their thoughts and focus their energy in a safe and constructive way” (p. 259).

4. **Creating the window of opportunity:** The authors encouraged their clients to think of self-harm, not as an emotion in itself, but as a response to a feeling. The aim of this program-component was to encourage clients to widen the gap between their thoughts and feelings and the impulse to engage in a self-injurious act. This was usually accomplished through learning to recognize feelings, and substituting delaying behaviours for immediate self-harming gratification.

5. **Deeper analysis:** This involved the client reviewing writing assignments and log notes, and developing a broad understanding of his or her patterns of self-injury, as well as contingencies that maintain the behaviour.

6. **Experiencing feelings:** During this stage, clients learned to avoid displacing feelings onto their bodies. This involved coming to recognize that feelings should be worked through, rather than acted upon. In addition, clients were taught to communicate their emotions more effectively, and to develop patterns, such as journal keeping, as a means of “dealing” with their feelings.

7. **Planning for an injury free life:** This marked the end-point of a client’s involvement in the S.A.F.E. program. The client developed a list of coping
strategies to employ when they felt the urge to self-harm. Clients also developed a list of goals that enabled them to progress with their lives.

I could find no direct critique of this program in the literature. I suspect, however, that the rigidity of the program model might meet with disagreement from authors such as Johnstone (1997) and Jeffreys (2000) in the sense that S.A.F.E. ignores socio-cultural factors, imposes an extremely rigid and top-down model of therapy, and punishes clients who continue to self-harm with banishment from the program. In other words, if one believes that self-harm is an expression of traumatic experience, then by forcing someone who is unable to desist from self-injury to leave a treatment program, you are both denying the depth of the client’s suffering, and colluding in perpetrating an act of re-traumatization.

**Behavioural Models**

Such models of intervention are usually applied to people with developmental disability living with self-injurious behaviour. Key to these interventions is the process of functional analysis (Pyles & Bailey, 1992; Simeon & Favazza, 2001). Functional analysis is carried out in order to ascertain which environmental contingencies are supporting the continuation of the self-injurious behaviour. Some authors (e.g. Donnellan, 1988) viewed serious behavioural manifestations as a form of communication utilized by people who had no other more “functional” means of expressing their needs. Once the function of the behaviour is determined, behavioural therapists proceed to reward alternative behaviours, or lowered rates of response (Hillery, 1998). At the same time, clients might be encouraged to wear protective headgear (if she or he is “head banging”).
Psychodynamic Models

Guralnik & Simeon (2001) divided psychodynamic models of understanding and treating DSH into two categories:

The classic approach. Self-harm is viewed as a regression to earlier states in which drives and a somatic mode of expression were manifested. The treatment approach in this modality would be to work at making unconscious drives conscious, thereby diminishing the compelling nature of self-harm.

The trauma approach. This perspective underlies many models of conceptualizing and treating self-harm. However, it is firmly rooted in the psychodynamic tradition. Here, self-injury was viewed primarily as a re-enactment of earlier traumatic injuries such as sexual and physical abuse. Guralnik and Simeon noted that abused children have been shown to use fewer words to describe emotional states, resulting in impaired impulse control. Treatment focused on enabling people living with DSH to find more appropriate ways to express internal emotional states. In addition, the ongoing process of narrating their past abuse enabled clients to develop awareness, and make sense of their past experiences of abuse. The process of narration could be painful, but was considered a necessary step on the path to developing new modes of coping.

Dialectical Behavior Therapy

Developed by Linehan (1993), Dialectical Behaviour Therapy (DBT) claimed to be the most empirically validated form of therapy for working with people with DSH. The therapy was listed as an empirically validated therapy by the American Psychological Association. DBT can be summarized as a model of therapy that employs mainly cognitive behavioural strategies, and involves one year of weekly individual and
group therapy sessions. The basic aim of DBT was to teach “adaptive coping skills” (Ivanhoff, Brown, & Linehan, 2001, p. 152). DSH was regarded as occurring within the framework of the larger diagnosis of Borderline Personality Disorder. The therapy aimed to engender (a) emotional regulation, (b) distress tolerance, (c) interpersonal effectiveness, (d) reduction of identity confusion, and (e) skills training. The central philosophy of DBT was Dialectics, a philosophy that conceptualized self-harm as both a positive event that enabled clients to cope and a destructive behaviour that contributed to a variety of negative feeling-states such as depression, shame, and suicidal ideation (Linehan, 1993). Thus, self-harm was not judged to be pathological, it was accepted as necessary for the person. At the same time, the behaviour was not condoned, and clients were encouraged to recognize that the effects of self-harm are overwhelmingly negative. As Ivanoff, Linehan, & Brown, 2001) put it: “Dialectical strategies are best described as the struggle to balance acceptance of patients as they are now, with the production of, and movement towards change” (p. 159). Like the methods utilized by Conterio and Lader (1998), DBT requires that clients agree not to self-harm or attempt suicide while undergoing treatment. However, treatment is not denied if such events occur. Rather, continuously self-harming clients are not permitted to move on to a further stage in the treatment protocol.

Conclusions and Final Rationale

The literature review began with an examination of factors implicated in the discovery of self-harming behaviours, then examined these issues in more depth, particularly the literature on the relationship between trauma and attachment, and the counter-intuitive nature of self-harm as a form of coping.
I drew the following inferences from this literature review:

1. There is an emerging medical literature focused on attempts to discover factors that are precursory to self-harming behaviours. Such investigations, while important, tend to lead to superficial findings by their very nature. That is, people who self-harm are surveyed regarding their experiences prior to commencing self-harming behaviour. It is logical that such a mode of questioning will place more emphasis on recent memory and concurrent experiences, rather than on broader histories, emotions, experiences and motivations of people living with DSH.

2. There is a general acceptance of a relationship between traumatic experience and the development of self-harming behaviour. There is, however, disagreement concerning the nature of such trauma, with some authors arguing that, for example, physical and, especially, sexual abuse underlie all self-harming behaviour, while others point to a broader range of experiences that might be considered subjectively traumatic. Given this controversy, it was useful to examine literature examining the role of early attachment in shaping later self-harming behaviours. This literature offers a model explaining both the tendency towards self-harm, as well as answering the question as to why people would come to experience self-harming behaviour as a form of coping.

3. Finally, there is a paucity of literature examining recovery from self-harming behaviour, except through the lens of therapeutic methodologies designed to bring about such change. As expected, such literature tends to take a prescriptive form – I could find no literature examining the point of view of recipients of mental health services engaged in these dominant treatment modalities.
This research was carried out in order to fill a perceived gap in the literature concerning the experience and perceptions of people who have lived with, and recovered from, deliberate self-harm. In particular, while there is some literature that attempts a thorough examination of the experiences of people who have survived abuse and other traumatic events, there is no literature comprehensively examining the experience and subjective interpretations of people who have lived with, and survived, deliberate self-harm. Thus, the need for this study which asked the following question: What is the experience of transition towards, living with, and recovery from, deliberate self-harm (DSH) from the perspective of people who have lived with DSH.

In the following chapter, I will outline in more detail both my rationale for utilizing the grounded theory method in conducting this study, and the process I followed in gathering and examining the data.
CHAPTER 3

METHODOLOGY

My research was guided by the central question: What were participants’ experiences of discovery, maintenance and recovery from deliberate self-harming behaviours? Given that I was interested in recipients of mental health services’ experiences of DSH, I decided to conduct my research with the aim of developing, rather than testing, theory. Specifically, I noted the historic paucity of literature concerning the reflexivity, let alone personal theories of change, brought to the counselling situation by clients. In sum, I was interested in conducting this research as a means of developing a model that primarily honours the perspectives of clients living with deliberate self-harm.

Grounded theory analysis is inherently suited to making explicit the implicit understandings of people. Glaser (1992) described the grounded theory approach as “a general methodology of analysis linked with data collection that uses a systematically applied set of methods to generate an inductive theory about a substantive area” (p.16). Strauss and Corbin (1998) defined grounded theory as “derived from data, systematically gathered and analyzed through the research process. In this method, data collection, analysis, and eventual theory stand in close relationship to one another.” (p.12) Grounded theory analysis is an inductive process, where theory emerges from the data. Strauss and Corbin (1998) continued: “Grounded theories, because they are drawn from data, are likely to offer insight, enhance understanding, and provide a meaningful guide to action.” (p.12)

Theoretical Assumptions

Urquhart (2001, p. 27) has stated that:
Grounded Theory is by definition a rigorous approach – it demands time, it demands a chain of analysis and the relating of findings to other theories. As it is an inductive, emergent method that is located mainly in post-positivism, this means that researchers need to carefully consider their own philosophical position.

In other words, researchers using the grounded theory method are required to make explicit their epistemological biases, as the methodology depends on the interplay between what the researchers observes, and how she/he interprets these observations.

With this in mind, it is important to outline my fundamental theoretical assumptions, as making these explicit is useful in understanding my choice of methodology, my research practice, and the findings of this study.

**Epistemological Assumptions**

In the research context, “epistemology” refers to “the relationship between the researcher and knowledge, posing questions such as, are researchers and the objects of study separate, independent elements, or is bias, or influence by the researcher on the studied objects inevitable,”(Carspecken, 1996, p.26). My personal epistemological assumptions can be described as constructivist. Although I accept the existence of an “objective world,” what people know is dependent on what they have experienced, and what people have experienced is dependent on how those experiences are perceived. Perceptions are filtered through interdependent cognitive, emotional and biological processes that are themselves shaped by experiential/perceptual loops. Such processes, or constructs, are dynamic and adaptive (Mills, Bonner, & Francis, 2006).
In sum, I believe there is an objective world, but it is always subject to human interpretation. Hence the decision to use the grounded theory methodology, as this method is empirical to the extent that it recognizes a world that “can be known,” but that such knowledge is dependent on human induction and deduction.

Initial Sampling

Strauss (1987) stated that initial sampling of participants should aim to identify people who are most informed about the phenomenon of interest in order to obtain the clearest possible initial understanding of the area. At the formative stage of the study, I was unsure of the boundaries of the concept of DSH; indeed I relied largely on conceptualizations obtained through reading the lay and academic literature, as well as informal discussions with therapists, psychiatrists, and people living with DSH. Hence, in this study, it was assumed that the most useful initial informants would be people who self-identified as having successfully “recovered” from DSH, whether through psychotherapy/counselling or other means. That is, such participants were assumed to have a better overall understanding of the phenomenon under investigation.

Theoretical Sampling

While initial sampling enables a preliminary understanding of the phenomenon of interest, theoretical sampling encourages researchers to seek further sources of data in accordance with emerging theory.

Theoretical sampling can be defined as: “(T)he process of choosing a research sample in order to extend and refine a theory” (Auerbach & Silverstein, 2003). In other words, theoretical sampling is the process by which a researcher asks the question: “How
do I maximize the value of my data?" Such sampling enables a maximum return in terms of variation amongst concepts, and richness in their properties and dimensionality.

An important aspect of the theoretical sampling process is the practice of constant comparison. As Glaser (1992, p. 102) noted:

The general procedure of theoretical sampling is to elicit codes from raw data from the start of data collection through constant comparison (between codes) as the data pour in. Then one uses the codes to direct further data collection, from which the codes are further developed theoretically with properties and theoretically coded connections with other categories until each category is saturated. Theoretical sampling on any category ceases when it is saturated, elaborated, and integrated into the emerging theory.

Such a process is both inductive, and deductive, in that it allows for verification or refutation of emerging theory, while opening (or closing) further avenues of data collection.

As suggested by Regev (2001), theoretical sampling was utilized in this study in the following ways:

1. Modifying the interview guide. Such modification occurred on an ongoing basis following the initial interviews. For example, following initial analysis of the first and second interviews, it became apparent that participants were describing a home life where they were not encouraged to express strong emotions. Therefore, the interview guide was modified to explicitly ask about this phenomenon prior to meeting the third participant.
2. Re-examining previous interviews in the light of emerging categories and concepts. In other words, when analysis of later interviews yielded new categories, I would return to previous interviews to determine whether earlier information could be integrated into these emerging categories.

3. Testing new data against existing categories to determine their continued reliability in the light of more recent information.

4. Interviewing diverse participants, that is, attempting to find people with potentially differing experiences from the initial sample. For example, while my initial interviews took place with people who had recovered from self harm, I went on to interview two therapists who specialize in working with people living with DSH, and a tattoo artist who uses cutting as a form of artistic expression.

By utilizing theoretical sampling, I was able to gain confidence in the categories and links between categories as I coded and re-coded throughout the research process. In other words, my emerging theory had undergone continual “testing,” rendering it more likely that it provides an explanatory and descriptive model of the experience of people living with deliberate self-harm.

Description of Study Sample

For the purposes of this study, 15 participants were interviewed. Of these, 13 described themselves as having “recovered” from DSH, one participant was a tattoo artist who specializes in cutting elaborate patterns into his own and his clients’ skin, resulting in decorative scar tissue. Two participants described themselves as therapists working with people with DSH; one was a registered psychologist, while the other was a “lay counsellor” who self-identifies as a person who has recovered from DSH and who also
provides workshops aimed at professionals such as teachers, social workers and psychologists on working with people living with DSH.

The participants were recruited via:

1. A notice posted on notice boards around the campus of the University of British Columbia
2. A notice posted at UBC Hospital
3. Notices posted at Vancouver-area community mental health teams
4. Referrals from existing participants who knew other people who had lived with DSH
5. Recommendations from mental health professionals who knew therapists working with this population.

Volunteers were provided with a phone number at which to contact the researcher. Twenty-seven people made the call, but their numbers were trimmed as a result of screening questions, or else they were hoping to receive monetary compensation for participating in the research. The most common reason for screening out potential participants was confusion over the meaning of the term “self-harm” - some callers stated that they harmed themselves, but their descriptions of their behaviour was indicative of past suicidal behaviour. Two callers were under the age of 19, and therefore outside the boundaries of the study’s intended sample.

All but one participant were resident in the Lower Mainland of British Columbia; the exception being a participant resident in Kelowna, BC who travelled to Vancouver to take part in the interview. All except one were born and raised in Canada, and spoke English as a first language. The sole non-Canadian-born participant held Landed
Immigrant status, and had moved to Canada from Pakistan to study at the University of British Columbia. This participant was fluent in English, and had attended English-language schools in Islamabad.

Participants ranged in age from 20 to 54, with a mean age of 30 years. The mean length of time since stopping DSH (in those with a history of self harm) ranged from 0.6 to 20 years, with a mean of 3.6 years. The median length of time since ceasing self-harming behaviour was 10 years.
Table 1

Demographic Details

<table>
<thead>
<tr>
<th>Name</th>
<th>M/F</th>
<th>Age</th>
<th>Identified as</th>
<th>Place of Birth</th>
<th>Years since self-harm</th>
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<td>F</td>
<td>21</td>
<td>Recovered</td>
<td>BC</td>
<td>0.8</td>
</tr>
<tr>
<td>Erica</td>
<td>F</td>
<td>27</td>
<td>Recovered</td>
<td>BC</td>
<td>3</td>
</tr>
<tr>
<td>Karen</td>
<td>F</td>
<td>30</td>
<td>Recovered</td>
<td>BC</td>
<td>1</td>
</tr>
<tr>
<td>Dee</td>
<td>F</td>
<td>20</td>
<td>Recovered</td>
<td>BC</td>
<td>0.6</td>
</tr>
<tr>
<td>Jacqui</td>
<td>F</td>
<td>43</td>
<td>Recovered</td>
<td>Quebec</td>
<td>2.5</td>
</tr>
<tr>
<td>Elwood</td>
<td>M</td>
<td>34</td>
<td>Tattoo Artist</td>
<td>BC</td>
<td>n/a</td>
</tr>
<tr>
<td>Debra</td>
<td>F</td>
<td>45</td>
<td>Psychologist</td>
<td>BC</td>
<td>n/a</td>
</tr>
</tbody>
</table>

Note. Names have been changed to protect the identity of participants

Data Collection

Initial data collection was conducted through the use of semi-structured interviews. In conducting interviews, I drew from the advice of Kvale (1996) who noted the importance of the interviewer listening to both explicit and implicit descriptions and meanings when conducting qualitative interviews. Thus, in the course of interviewing, the implicit message, as perceived by me, the interviewer, was fed-back to the interviewee for confirmation or elucidation. In addition, I drew from Rennie (1992, p.
who recommended an “active, co-constructing role in obtaining the client’s representation of experience.” This strategy is similar to that proposed by Kvale, in that the interviewer and interviewee actively engage each other in clarifying and developing the “story.”

Data Analysis

In the initial phase of the research, questions were open-ended, becoming more focused as the theory developed. Initial questions included: “What do you understand by the term self-harm?”; “Can you tell me something about your experience with self-harm?”; “What, if anything, was helpful in transitioning away from self-harm?” An example of a later, more focused question is: “I have been told that people who self-harm tend to find each other. Is that your experience?”

Glaser (1992) explicitly advised against note-taking in interviews (he suggested jotting down impressions following the encounter). I chose to tape record interviews, and transcribe them for analysis. Following each interview, I wrote down my perceptions of what I had learned, and noted preliminary impressions regarding the implications for the theory suggested by the interview. This is termed memo-writing by Glaser and Strauss.

Grounded theory analysis is a complex procedure of reading and re-reading textual sources (text can be defined loosely as observations, field notes, memos, literature, etc.). In analyzing my data, I made use of the basic elements of a grounded theory analysis (Strauss and Corbin, 1998), each described in more detail below.

Open coding

Open coding refers to a process of initial conceptualization where labels are applied on a line-by-line basis to what is observed in textual sources, and are then further
grouped into higher order, more abstract categories (Charmaz, 1996). I approached this stage of the grounded theory process as an opportunity to explore emerging data and to apply labelling and some initial categorization and linkages.

Another way of understanding my approach was to see me as involved in digging through data, applying labels on a line by line basis, but returning to earlier data as later sources appeared to provide more information about a phenomenon. I attempted some initial linkages between labels at this stage, merging lower order concepts into categories, which themselves were merged with other categories as the process continued.

In order to understand how this process worked, consider the piece of text illustrated in Figure 1.

<table>
<thead>
<tr>
<th>Depressed</th>
<th>Lost contact with daughter</th>
</tr>
</thead>
<tbody>
<tr>
<td>I got really depressed, when I didn’t see my daughter. My daughter’s a major part of my life. I really love her a lot. She’s sort of made up for my loss of my first daughter; you know ... I felt less hope when I never saw my daughter for a long time.</td>
<td></td>
</tr>
</tbody>
</table>

Figure 1. Example of open coding as practiced during this research.

Ultimately, labels or codes attached to this small vignette, might be collapsed together to form the higher order category “Loss of hope” which was ultimately merged into the still higher-level category, “Loss,” and yet again into an even higher-level category, termed “Exclusion” (See Chapter 4).
I initially attempted using a computer program (Atlas.ti) for this stage, but found that this method hampered my analysis. In other words, I found it easier to “visualize” the data when coding by hand with a pen and paper.

**Axial Coding**

Axial coding refers to the process of relating emerging categories and their properties to each other, allowing the development of a framework of relationships. Relationships can be structured with reference to the paradigm outlined in Table 2.

<table>
<thead>
<tr>
<th>Element</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phenomenon</td>
<td>Answers the question: “What is going on here?” This is the concept that holds the elements together.</td>
</tr>
<tr>
<td>Conditions</td>
<td>“(S)ets of events or happenings that create the situations … pertaining to the phenomenon, and, to a certain extent explain why and how persons or groups might respond in certain ways.</td>
</tr>
<tr>
<td>Action</td>
<td>Refers to how people or groups act in response to the phenomenon, intervening conditions, and context.</td>
</tr>
<tr>
<td>Consequences</td>
<td>The outcome of the action strategy.</td>
</tr>
</tbody>
</table>

*Note.* Taken from Strauss and Corbin (1998, p. 130)

In approaching the process of axial coding, I took categories emerging through the process of open coding and attempted to make sense of their relationships by applying
them to Strauss & Corbin's (1998) paradigm model. In essence, I was taking disparate elements of my analysis and placing them in rough models that became more elegant as the analysis progressed. For me, this process acted as a sense-making mechanism; I was able to articulate the emerging theory in terms that both fit the data as I understood it, and also to bring together different parts of the data in a way that made sense to me as the researcher. One attempt at axial coding is provided in Table 3. Note that categories had not yet been formalized and were written out in a longer prose form at the time. In addition, the process of axial coding requires that some categories become properties of other categories in terms of the hierarchy of linkages.
Table 3
Example of Axial Coding as Utilized for this Research

<table>
<thead>
<tr>
<th>Element</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phenomenon</td>
<td>Transitioning towards cutting: Cut adrift</td>
</tr>
<tr>
<td>Causal conditions</td>
<td>Traumatic experience. Quite literally discovering one is alone and cannot rely on others for support/or sense of not being “hearable”</td>
</tr>
<tr>
<td>Context</td>
<td>Major Life change – e.g. Entry into puberty; children growing up ... Important because appears to occur when shifts in identity social roles are occurring</td>
</tr>
<tr>
<td>Intervening conditions</td>
<td>Caregivers or significant others (if present at all) exert control, emphasize the powerlessness of the participant, rather than support and acknowledge attempts at adjustment. Punished for failure, not rewarded for success. Growing isolation as peers readjust to life changes in different directions</td>
</tr>
<tr>
<td>Action strategies</td>
<td>Desperate attempts at finding social connection, become increasingly self-destructive, and/or surrender power at a social level, ability to exercise control directed towards self.</td>
</tr>
<tr>
<td>Consequences</td>
<td>Loss of sense of self and social efficacy</td>
</tr>
</tbody>
</table>
Selective Coding

Selective coding refers to the process of refining the theory, by choosing one category to be the core category, and relating all other categories to that “central explanatory concept” (Strauss & Corbin, 1998, p.161). In other words, the core category becomes the central relational category – all other categories are placed in the context of the core category. As will be outlined below, at this stage of the process, I followed Strauss and Corbin’s recommendation to validate the substantive theory by presenting it to participants for feedback and reaction.

Rigour

Strauss and Corbin (1998) referred to three broad criteria for judging the methodological soundness of a piece of research. These were:

1. The rigour with which the researcher followed the grounded theory process guidelines.
2. Reproducibility and generalizability.
3. Empirical grounding of the study (which refers to the degree to which the theory is demonstrably related to the data).

In terms of my own pursuit of rigour, I observed the following procedures:

1. As noted above, during the initial interviews, I sought constant clarification and feedback from participants concerning my understanding of what I was hearing from them. By doing this I was attempting to engage in a process of “active co-construction” as recommended by Rennie (1992, p. 216).
2. Following initial analysis and coding of interviews, I offered all participants the opportunity to read the transcript of their interview, and to make corrections or
provide additional clarifying information. At this stage, I also provided my notes and initial analysis of the participant’s interview and asked participants to comment on my own perception of their stories, as well as my initial analysis. In one case, my tape recorder had accidentally shut off five minutes into the interview, so I approached the participant with my notes only.

3. About a year later, I met for a second time with five participants, four of whom were people self-identified as having recovered from DSH, and one who identified as both a person who had recovered from DSH and a therapist working with people living with DSH. The purpose of these follow-up meetings was to allow participants to comment upon my final analysis in terms of accuracy and “goodness of fit.” In other words, at this stage, I asked participants to discuss the relevance of core categories generated through my analytic efforts. Strauss and Corbin (1998) noted that participants should at least be able to perceive the theory as a reasonable explanation of their experience, even if it is not a perfect “fit.”

Feedback was generally in agreement with my analysis. In fact, agreement was such that I would include, for example, a focus group format in future research designs to allow participants to discuss my analysis without the direct presence of “the researcher” who has strong potential to be viewed as “the expert” in possession of infallible knowledge.

Summary

This study utilized the Grounded Theory methodology (Glaser and Strauss, 1967; Strauss and Corbin, 1998). This methodology is qualitative, and provides researchers with the ability to build, rather than test, theory. A grounded theory researcher is
expected to approach data without pre-suppositions, thereby allowing the data to “speak for itself,” and, as such constitutes an ideal methodology for making explicit people’s implicit perceptions.

Data was collected using open-ended and semi-structured interviews with participants who presented themselves as having recovered from self-harming behaviour. Two participants had no history of self-harm, but were interviewed as part of a sampling process known as “theoretical sampling” where people with different experiences from the initial sample are interviewed for comparative purposes. Furthermore, all data was collected using the process of constant comparison, where emerging data is compared with existing information (and vice versa) in an attempt to further clarify the emerging theory (Strauss & Corbin, 1998).

Analysis of the data was carried out using the three basic elements of grounded theory methodology: open coding, axial coding and selective coding. In an attempt to boost the methodological soundness of the theory that emerged from the data, and in line with the process of constant comparison, I checked with participants to determine whether my emerging understanding of their stories was sound within their initial interviews, and then again in follow-up meetings. I also met with five participants about a year after the interviews were completed to allow them to provide me with feedback on the “goodness of fit” of the final model.

In the chapter that follows, I shall report on the results of the study.
CHAPTER 4

FINDINGS

This grounded theory study resulted in the development of a theory that describes people’s experience of discovering, living with, and recovering from, deliberate self harm. The study design was retrospective, and data was gathered through interviews with 13 people who described themselves as having recovered from DSH, as well as two participants who had occupationally-related experience working with people living with DSH.

The theoretical model, illustrated in Figure 4.1 below, emerged from data in such a way as to answer the research question: What were participants’ experiences of discovery, maintenance and recovery from DSH?

The categories of Exclusion and/or Intrusion and Inclusion (which can be conceived of as states of relationship to the social world), emerged as core constructs in this model. In other words, these categories represent the crux of the theory –the relational conditions coded under Exclusion and/or Intrusion were necessary for the discovery and maintenance of DSH, whereas the relational conditions coded under Inclusion were necessary for recovery from self-harming behaviours.

Viewed as a whole, the model proposes a transitional process that proceeds from a sense of isolation from social support (categorized as “Exclusion”) and/or what are perceived as unwanted intrusions on the self, abuse being an example (categorized as “Intrusion”), the development of a sense of lack of control as a result of Exclusion and Intrusion, and the discovery of self-harming behaviours as a mechanism for coping with this sense of lack of control. The model suggests that self-harming behaviours are
perpetuated in the context of continued experiences of Exclusion and/or Intrusion – a pattern that tended to be broken only in the context of an environmental shift (such as the loss of a parent, and the subsequent need to be more “responsible,” or starting to attend university). For such an environmental shift to lead to recovery from DSH, an experience contrary to Exclusion and/or Intrusion was required, that is, a sense of Inclusion.

In the following sections I will illustrate and expand upon this transitional model.
Figure 2. Theoretical model for discovery, maintenance and recovery from deliberate self-harm.
Discovery and Maintenance of Deliberate Self-harm

The discovery of DSH emerged from the data as a reaction to environmental transitions that resulted in an increased sense of vulnerability in people who had lost or lacked external emotional support, whether as a result of literal loss of early caregivers or alteration in environment, or as a result of the loss of a sense of safety or control over their person and environment. Self-harm appears to have developed as a coping mechanism through which participants were able to regain, however tenuously, a sense of control over their bodies and environments. Continued reliance on self-harm as a coping mechanism (that is, maintenance of DSH) occurred in the context of the continued presence (or perception of the presence) of exclusionary and intrusive experiences. Indeed, these two broad categories of experience emerged from the data as instrumental in the discovery and maintenance of deliberate self-harm and were labelled as: (a) Exclusion and (b) Intrusion. These two categories were centrally implicated in the process of discovery of self-harm and will be illustrated and elaborated upon in the subsections that follow.

**Exclusion**

The data suggested three precipitants to the sense of exclusion described by many participants. These included experiences of (1) Environmental shift, (2) Loss, and (3) Emotional neglect. The category labelled Exclusion encompasses participants’ descriptions of the manner in which they came to feel excluded from society at large, plus their futile early attempts at gaining recognition of, and help with, emotional pain from their primary caregivers. From the point of view of participants, their emotional turmoil was met with denial, disinterest, or was attributed little plausibility at best, or stigmatized
at worst. Such attempts at finding help, being unanswered, were experienced as further evidence of participants’ dislocation. That is, initial attempts at seeking help for coping with emotional pain met with the proverbial “brick wall,” the inner pain was forced underground and close caregivers were definitively ruled out as agents for emotional coping and safety.

What follows is an explanation of the “Exclusion” category, with illustrative examples drawn from the text.

Environmental Shift

Shahar was 16-years-old when she began attending a Convent High School in Islamabad, Pakistan. She had recently moved from another city and, like many young people isolated from familiar surroundings and social connections, gravitated towards a troubled classmate on the social periphery. Shortly after their meeting, Shahar expressed curiosity about a series of scars on her new friend’s hand:

She used to like this guy so much, but he wouldn’t like her back. So, she thought that if you know, if she...if she like carved his name on her...chest or on her arm like then you know. He would know ... how much she likes him and that way he... would probably reciprocate her love. And, then like you know, this is...she thought this was a way of proving to him that she really, really loved him. She just told me this one time and I was pretty shocked right. And, she first did it on her hand and she like carved his name right on her chest and it’s there forever now right.
Like most people encountering self-harm for the first time, Shahar was “shocked” by her friend’s actions. Yet, less than three months later, she too found herself with a deep, unrequited crush on a boy in her school:

And, so like so then I went through the same sort of situation and like I just at that time, I guess I was feeling really low so well, because I had seen this (her friend’s attempt to impress a boy by carving his name on her body) right, so I thought that maybe if I do this (cut herself), like I can show to him you know, how much I like him.

In essence, from Shahar's perspective, her cutting behaviour began as an imitation of a coping mechanism observed in a role model. To put it another way, she adopted a means by which a person, powerless to effect a desired change on her environment, was able to express powerful inner feelings in the hope they would be noticed. At the same time, the act of cutting served as a gesture of alliance with a new friend, at a new, western-oriented, co-educational school, in a new city, and in a part of the world where the idea that young people could experience, and act upon romantic feelings towards their peers was very foreign, not least for Shahar herself.

Loss

John traced his acquisition of self-harming behaviour back to the time when he lost visitation rights with his daughter. He described this experience as follows:

And so, I had an, I got an affidavit that was served me abruptly that my daughter didn’t want to go to any more visits with me, and I’m not sure exactly what that was about, but my visitation rights were suspended “cause the next visit was to be ... going swimming at the swimming pool. I’ve never had to feel so low (as) when
I haven’t seen my daughter for a long time. I got really depressed, when I didn’t see my daughter. My daughter’s a major part of my life. I really love her a lot. She’s sort of made up for my loss of my first daughter; you know ... I felt less hope when I never saw my daughter for a long time.

While it is apparent from the above quotation that John experienced a profound, literal loss in his life, it is perhaps more important to note that, while he emphasizes the sense of depression precipitated by his loss, he also experienced a concurrent shift in his sense of identity; his sense of who he is in relation to others, or his social “role.” A similar precipitant is noted by Sarah:

(I)t was also the kids were growing up. They didn’t need their mother as much. It isn’t true, because the older they get, the more they do need you. It just becomes a whole different set of problems. It’s not dirty diapers anymore...

The experience of loss, of losing a loved one and the resultant loss of support and love at an early age was a common experience reported by participants who began self-harming at a younger age. This contrasts with participants who began self-harming later in life; the latter spoke of losing people who were dependent on them, while the former spoke of the loss of people they depended on. Tanya, whose mother was living with alcohol addiction, described a key memory from the period after her father died:

It was after my Dad died, but I remember I cried and cried, and I just sat in my room and I, all I remember is I said to myself I wanted someone to love me. I mean it sounds really weird, but (as an adult) I’ve wanted to just go back and hug myself. Just that little girl, if I could just hug her “cause I was just so alone and it’s terrible.
Emotional Neglect

Two weeks after my father died, my grandmother said to my mom: “How’s Tanya dealing with it?” And my mom said: “Oh she’s fine. She’s way over it.” I never cried in front of my mom. I never felt like I could, I guess. I remember when she said my dad died, I said, can I have a piece of gum now? But I remember I was thinking about (his death), but I didn’t want her to know it, and I wouldn’t cry.

The above quote, taken from an interview with Tanya, exemplifies an experience that was ultimately coded as falling within the sub-category labelled “emotional neglect.” This category included phenomena in which the emotional life of participants went unheeded, intentionally or unintentionally, by people close to them. Many participants indicated their emotions went “underground” (in the sense of being consciously suppressed) due to lack of reciprocation from caregivers. In other words, participants experienced distressing emotions they were aware of (in Tanya’s case, she knew she was sad about her father’s death), yet felt unable to display. Why? Perhaps the answer can be partly found in Tanya’s description of her mother’s general unwillingness to listen to her, or to acknowledge her emotional life.

She (her mother) wouldn’t listen so, “cause I came up to her once with a magazine and it was, “Are You Depressed” some sort of, I don’t know, quiz or something, so I did it. It was one of the Seventeen magazines, and everything pointed out that I was depressed and I, so I got the guts up like a day later and went and talked to her and said you know, I think I have a problem, and it was very hard for me to do that, and she said oh don’t believe everything you read,
and she wouldn’t at all even acknowledge the fact that I came to her with it, so that pretty much knocked me down from wanting to talk about anything.

This experience was mirrored in a slightly different context by another participant, Linda:

There was one time where I had overdosed and went to school, and the counsellor notified my mom in a second. So I ended up going home, passed out on the floor with my dog. My brother came home, found me on the kitchen floor, wasn’t sure what was going on, called my mom at work. Mom came over and just shook the living hell out of me to see that I was awake. So I told my mom, you know, this is what happened. This is what, this is why I was on the kitchen floor, and she’s like, well if you’re tired, you go to your bedroom. But I wanted to be with the dog, I wanted something comfortable. So, she didn’t appreciate that, and I was like fine. Whatever. So, I just left it.

Both statements conveyed a sense of emotional incapacitation. Whereas Tanya’s mother would not listen and, therefore, did not hear the message her daughter attempted to convey regarding her emotional life, Linda’s mother appeared to downplay an overdose attempt. Here, the excerpt is interesting, not so much in terms of a mother ignoring a suicide attempt (it is possible Linda’s mother was used to such behaviour on her daughter’s part); rather, it is important that this participant perceived her mother as indifferent to the emotional message behind the suicide attempt. In other words, Linda believed her mother was more concerned that she was sleeping on the kitchen floor with the dog and not in her bedroom, than with what she was attempting to communicate through the overdose attempt.
In many families, a refusal on the part of significant others to “hear” the emotional message was perceived to have come from an indifference to the distressing emotional life of a young person, as well as the apparent sense of stigma associated with mental illness. Nicole said:

I felt mostly going through high school that (my parents) cared more about my academic studies than my emotional and mental health, and that it was a lot easier to ignore anything, deny anything was wrong. They wanted to protect their own... Their own stability... My parents were of the generation where only crazy people went to see a shrink.

In summary, participants who reported experiences of exclusion, found themselves severed, either from support structures, familiar surroundings, or from roles central to their identity, such as parenting. The key outcome of this stage for all participants was a perceived loss of control over their environments.

**Neglect by Health Care Workers**

In this section, I show how people living with self-harm, by coming into contact with mental health professionals (defined here as psychiatrists, psychiatric nurses, psychologists and counsellors), found themselves deprived of their sense of being in control of their own environments and destinies. In this sense, contact with the medical system can be said to have been, somewhat ironically, an example of a phenomenon that while not necessarily primarily responsible for engendering self-harming behaviour, at least served as a context for maintaining such behaviour.

Later in this chapter, in the section titled “Intrusion” I shall outline participants’ perceptions of their contact with the mental health system as an “intrusive” experience.
Here I focus on those who indicated that they felt excluded by the system in the sense that their need for care was less of a priority as a result of the self-inflicted nature of their injuries.

Karen described her experience of attempting to receive medical care in the emergency department of a major Vancouver hospital. Most significant in her account was the revelation that hospital staff gave what they call "frequent flyers" (people who visit the emergency room regularly) nicknames, and their patients become aware of these nicknames.

(Th)e nurses and the doctors (would say) "Oh, she's back." I just think it's really, you know, disrespectful, and their job is to help people not ridicule them ... I just don't think the staff has the compassion, or the education to know what a person is going through when they've cut or when they've overdosed or whatever ... I think the nurses and staff should be more educated. Because I know I'm not the only one that comes in there with self-abuse issues and the more times you show up (in the emergency department), the more they talk about you, and say okay, yeah she's back, she's a frequent flyer. You get nicknames, and it's like, that's not who we are. We need the help. This is what we came for, and in return, they're treating us with disrespect and they have no understanding on what is going on.

Margaret reported being greeted with a similar lack of respect when she visited emergency departments in Ontario. She also mentioned an experience reported by most participants in this study, whether they were receiving voluntary or involuntary care, regarding a staff attitude that they were less deserving of care because their injuries were self-inflicted.
The abuse was being told that I was stupid, that I did stupid things, that I was wasting their time, especially in emergencies. It was always that I was no good, that I was taking up their time, that I was a bad person type of thing. Now, not necessarily would they say it in those words. That’s how I interpreted it. I would often, you know, those nurses would come in and they wouldn’t say anything to you, and they just sort of roughly clean it up, and cause as much pain as they could, and the doctor would come in, and be nasty and sew it up, and walk out, and it was like you didn’t, you weren’t a human being sitting on that table. You were just a piece of meat that they decided to fix up. What really bothered me was that people who would be drinking and driving would be, you know, and get into an accident would be in another room, and they would be all over that person, and they were doing the same thing I was doing.

Dee described her contact with medical personnel during her time in hospital as “condescending,” to the point where she believed her right to informed consent regarding medical tests and treatment was infringed upon:

I found the psychiatrist and a lot of the nurses very condescending, and I felt like I was treated like I couldn’t think for myself, and I’ve always been quite independent, so it sort of infringed on that. When I was in the emergency room, a nurse – she kept coming to take my blood, and I was like “why are you doing that? You took it just a little while ago.” She’s like “you put yourself here.”

John stated that he had tried to obtain admission to a hospital at a point in his life where his sense of depression and self-harming behaviour had become of particular concern to him. Possibly because he was well-known as a “frequent flyer” by staff, he
was refused admission to various Victoria-area hospitals. According to John, he became so desperate for help that he crossed the line from self-harming to suicidal behaviour, which finally resulted in him being admitted as a patient:

I tried to go into the hospital in Victoria, and I was turned down. I couldn’t get into the general hospital in Victoria or the Royal Jubilee Hospital. I felt kind of depressed and so I came back to my apartment and I just, was sort of fed up and everything and about everything. I lost hope and I, so I took all the pills out of my drawers and cupboards and took about hundreds of pills or whatever and overdosed, and the housing manager ... found me in my apartment on the bed with my coat and clothes on and say, phoned the intensive care, you know, phoned 911 of course and they took me to the intensive care unit.

In summary: In this section, I have used participants’ reported encounters with the health-care system to illustrate the ways in which experiences coded under the categories of Exclusion/Intrusion serve not only to induce self-harm, but also maintain this behaviour.

Two broad strands of interaction were identified here; the first being one of involuntary health-care interaction – where participants were literally forced into receiving “treatment” for their “own good.” The second involved people living with self-harm volunteering for treatment, but being received with lack of respect, disdain and, often, cruelty by health-care staff who viewed them as the authors of their own misfortune, rather than as people in need of care and support. Either way, the result of contact with the health-care system was viewed by participants as disempowering which is rendered especially troubling in the light of data obtained in this study suggesting that
participants transitioned into self-harm as a means of gaining a sense of control over their physical and emotional selves.

**Intrusion**

As noted above, many participants described exclusionary experiences as instrumental in the process of their development of self-harming behaviours. For some participants, self-harm was preceded by physically abusive experiences that were coded under the category of Intrusion, differentiated from Exclusion in the sense that these were experiences where other people invaded participants' personal space. In other words, their attention was unwelcome.

**Abuse**

Sarah described one of the forms of discipline utilized by her parents when she was a child:

They (her parents) expected a lot from all of us, and when we were young, we, if we didn't come home with straight A's in school, we'd get a whipping and everyone had to kind of stand around to watch. It was an example.

Sarah went on to state that she began to self-harm in response to the excessive control and discipline exercised over her life by her parents. She had learned from her parents that "not being perfect" resulted in physical punishment. From her perspective, she began cutting as a means of re-taking control of her body and herself. Interestingly, as will be discussed later in this chapter, Sarah stopped cutting once she had to take control over her family following her parents' divorce and a family tragedy, and began
again when back pain resulted in a loss of her sense of independence – she became reliant on medical help, medications, and welfare (she had to stop working for a time).

Margaret, who had begun self-harming as a high school student, and who had been free of the behaviour for ten years, stated that the experience of being physically abused by her husband became an act of self-harm in itself:

... I had a husband who was quite willing to do it (self-harming) for me. He was, he wasn’t abusive all the time, but once in a while, he would real, beat me up all over the house. He never beat me up to the point where I was bloody, but he would slap me or hit me, and I would push him, and I would deliberately push him until he, but I don’t know, I just, I just felt that, that was a way to do it (self-harm).

Some time later, Margaret began to cut herself again:
When I started self-harming again, what I realized is that he (her husband) wouldn’t hit me if I was self-harming. It was almost as if I had control over this situation with my self-harm, and it became a revenge more than anything. So that was interesting. I quite liked that.

Thus, for Margaret, cutting herself was a method of re-taking control, in the sense that (1) she became fully “in charge” – or active – in the act of self-harming, as opposed to the “passivity” of being the victim of her husband’s abuse, and (2) self-harming became, paradoxically, a form of protection against her husband’s physical abuse.
Involuntary Treatment

Just as the data suggests feelings of exclusion and intrusion were instrumental causative factors in the development of self-harming behaviours; there was also evidence that these experiences helped to maintain DSH.

As noted before, most participants indicated that contact with the mental health system was an overwhelmingly negative experience. There were two divergent, types of mental health contact reported by participants (which matched the causal conditions suggested by this model). The first, as discussed above, was termed Exclusion, the second, labelled as Intrusion, will be outlined in this section.

One example of the “intruding” experience was provided by Erica, and her description is worth reproducing in detail as it provides a good overview of the experience of hospitalization from the point of view of the “patient.”

Erica: This last time, she (her psychiatrist) brought me, well she got security to bring me over to emergency and they certified me there. This last time I didn’t really hold it against her. She was just … She couldn’t take the risk of letting me go and if something happened she would have felt responsible, so … I don’t hold it against her. And often being hospitalized will lead to suffering for me, especially when they take me away and they just leave me in an isolation room. I’ll usually start head-banging to soothe me, to calm me down. Just the rhythm of it, and the pain sort of focuses you. But then they always come in and restrain me and get me out of it, so it doesn’t last too long.
Interviewer: So when they restrain you and stop you head-banging, what you’re
telling me, is the behaviour of banging your head is, for you, a soothing
behaviour, so you’re prevented from doing your self-soothing. Or am I wrong?
Erica: Yeah, well they, of course, interpret it differently.
Interviewer: I’m interested in how you interpret it.
Erica: To me it was calming myself down. It’s really very stressful to be brought
in by security, and then just stripped of all your clothes and put in hospital
pyjamas and just left in a concrete room.
Interviewer: It’s a concrete room?
Erica: Yes.
Interviewer: It’s not padded or…?
Erica: No. Not any of the ones I’ve been in. They just restrain you from hurting
yourself in the bed.
Interviewer: Do you feel safe in that kind of situation where they restrain you?
Erica: No. No.
Interviewer: What is the predominant emotion in that kind of situation?
Erica: Fear.

Another vivid description of a specific encounter with the mental health system
was provided by Tanya. Two points are worth highlighting about the quote that follows:
(1) People who cut themselves are often labelled as being “borderline personality
disorder” (BPD) and, while I am, of course, unable to comment on the validity of the
diagnosis as applied to the participants I interviewed, participants usually indicated that
this particular diagnosis was a blanket label that, they believed, enabled mental health
professionals to shut off any further attempt at understanding or listening to the needs and concerns of the labelled. (2) It should be kept in mind that my inclusion of descriptions provided by participants of their experiences in psychiatric hospitals are not meant to be judgmental of decisions made by staff at these institutions, rather I am attempting to highlight the perception of powerlessness in the face of the mental health system, as reported by participants.

They (the ER staff) just kind of, they talked to me maybe for five minutes and they’d say, no, you’re borderline personality disorder, and that’s it and wouldn’t talk anymore. The worst was when I was at (a hospital in the British Columbia interior), I was really upset. I mean my arm was pretty bad. I didn’t want to stay there. I said okay we can go to get it cleaned up, and they said okay, well you’re going to have to spend one night here, and I said okay fine, and so I was crying of course, and I got calmed down and I was sitting on the bed and I was completely fine, and they said, well, here take these pills. I said well, no, I don’t want to take pills. See when people tried to, I didn’t like those drugs. I’d take drugs off the street, but not from them. I said no way, and they said well, just take them, and they were trying to force them upon me. I said no. So, they said well if you don’t, we’re going to give you a shot. I said, no, I’m fine. I don’t want anything. I’ll be, I’ll calm down, and I was being very rational about it, and they took, they came in and brought like a, I don’t know, big security guard guy and they had a needle and she’s a real bitch, this nurse. Then she came in and she’s like here roll over, and tried to give me the needle, I said no. They had to get a couple of guys and actually pinned me down, and I was screaming, and I bit one guy, and I was,
of course then I’m freaking out, because they’re trying to restrain me and give me
a shot, and they gave me a shot of something. I don’t know, I was so mad. So
then of course I got frustrated and I retaliated and ripped off my bandages. So I
would have been fine but I ripped it all open and I threw blood everywhere, all
over the room, and I wouldn’t even. I forced myself to do something to put me to
sleep or force myself to stay awake. I don’t even know how long I, I’ve never
been that high in my life. So whatever they gave me, it was to the point where I
was hallucinating, and finally I just had to pass right out. So I don’t know. I, so I
didn’t really, I never had a good experience in the hospitals either.

Thus, the hospital experience, instead of being viewed as therapeutic by
respondents, was experienced as being abusive. In other words, contact with the health­
care system was often intrusive in the extreme. In the following section, I will outline the
sense of loss of control reported by respondents to result from Exclusive/Intrusive
experiences in their lives, and how this loss of control leads to both the discovery and
maintenance of DSH.

Loss of Control

An important category to emerge from the study was termed “Loss of control,”
based on in vivo coding; the word “control” was common in all interviews. As noted
above, “Control,” in this context, refers to a person’s ability to affect his or her
environment. Hence, “Loss of control” is synonymous with an increased sense of
helplessness, powerlessness and vulnerability. Some examples of experiences that
described the pivotal nature of control in the lives of participants are provided below.
Sarah described overcoming self-harming behaviour by becoming very self-reliant; however, after several years of abstinence, she began to experience back pain (an intrusive experience) that limited her ability to work (an excluding experience). She states:

It's the loss of control of my own element. It wasn't an outside stress that affected me. Loss, it's the loss of control again, and last year, it (self-harming behaviour) began again, and it was because I had a back condition …

Margaret described the effect of her self-harming behaviour in terms of the ability it gave her to stop her husband's physical abuse towards her:

It was sort of, I felt in control for the first time in that marriage. Yeah, I was in control. I could choose, to, actually I had the power to make him cry or to stop it (his abusive actions towards her). Yeah, I liked it.

For Debbie, powerlessness was inherent in the progress of her life. She stated that she experienced difficulty coping with change, and felt that events and other people controlled her (intrusive experience); in other words, she felt powerless over her own destiny:

I couldn't cope with change. I let other people take over my life. I had to move out (in her second year of university) to get physical distance (from her roommates).

Management of Loss of Control

In this section, I examine the strategy participants employed as a means of managing the phenomenon described above as "Loss of Control." The strategy constituted an attempt, not only at finding an outlet for internalized, non-tangible pain,
but also a means of retaking control of their bodies and emotional lives. In other words, they sought to become less reliant on others for physical and emotional support. The act of self-harm became, for most participants, the way in which they could be in charge of their own destinies. In addition, self-harm became a means of “self-medication” – leading to a feeling of calm for many, or acting as a means of calling attention to that intangible emotional pain for some.

Discovery of cutting, as a means of coping with a sense of loss of control, was not always described by participants as the automatic next step. Some participants described finding alternative, if arguably “self-destructive,” coping methods, such as drinking and taking drugs. Tanya, who had experienced the death of her father, and felt uncared for by her mother, told of a dangerous attempt to connect with another person, which turned into a profound experience of rejection:

Yeah, I was only about 16 and we talked to these guys on the party lines (phone-based dating service) and oh well I’m going to meet up with him, smart thing for a young girl to do. So my girlfriends, we all, I don’t know, went for a walk and I went to this guy’s apartment. So of course he just wanted to sleep with me. That’s how come, he was like 26 and I was 16 or something. Nothing really happened “cause he looked down and he saw my legs and he bounced off and I’ve never seen anyone so scared in my life and “cause I had a lot of weird writing and stuff on my legs and he just kind of backed away on all fours and looked at me and he said get the f-ck out of my house now and said don’t ever come back, and he freaked out. He was like scared, like terrified, and that was really, really hard for me to take.
This vignette, while describing a young woman's apparently “reckless” attempt at attaining emotional connection with another person, also lays bare the sense of rejection she experiences in the face of the man’s unease at the markings on her legs. In other words, she had experienced social rejection on the basis of self-inflicted corporeal markings that rendered her as fearsome in the eyes of this man. It should again be emphasized that these were not yet cuts, but merely writings and drawings on her legs. Her act of expressing her pain -- literally using the medium of her body had invoked sanction – she was no longer living up to a social expectation of female bodily presentation.

For some participants, self-harming behaviour arose out of the experience of witnessing the behaviour being acted upon by role-models (see Shahar’s experience related earlier in this chapter). Lucy claims that she was “taught” to self-harm by a babysitter when she was a young child. Later, when she became a victim of sexual abuse during her teen years, she began to make use of the coping mechanism which had made a vivid impression on her as a child:

I actually had a babysitter teach me how to self-harm. She showed me the scars on her arm. And then she proceeded to tell me, I’m not sure if she actually brought stuff with her, but I do remember her showing me her scars and telling me how, what instruments to use, which way to cut and all those things so it was, at the time I was told, you know, respect your elders, do as they say. And then when I hit high school, things just kind of went downhill from there. I started cutting because I was getting abused a lot (by a neighbour). So her, my babysitter’s version of when to cut was whenever I was feeling angry, whenever I was any
type of emotion, and so I thought okay. So after a while, after I just kept getting abused over and over again, I just finally had enough and I just starting cutting.

Some participants indicated that their transition into self-harming was a gradual process, starting with relatively innocuous injuries that increased in intensity. Nicole described her transition from nail-biting to cutting:

I started, well I'd always be biting my nails and try and trim my nails off when I was younger. Well also used to pull out my hair too and then I got so depressed, the cutting really started. It would just be little scratches and then it would get deeper and deeper...

Sandra, a former elite athlete, described her self-harm as having been preceded by bulimia. She stated that, prior to developing bulimia, she had been gaining weight, and this had affected her athletic performance, much to the displeasure of her coach. For her, bulimic behaviour was an attempt to gain control over her weight and athletic career. She found this attempt at gaining control to be ineffective:

I was never a very successful bulimic because I hate throwing up, so I would just do like ridiculous things to force myself to throw up, and sometimes I would throw up naturally, but actually using vomiting was never something that I – never really stuck...

Then Sandra accidentally burned herself and found this to be more effective method of coping with her sense of powerlessness over her body, and consequent anger at herself over this powerlessness, than purging food. She described the physical sensations provided by cutting:
Yeah, I think it (cutting) was more just um numbing at first. I felt soothed, and then it would hurt, and then I would take care of myself.

This description of the feelings brought on by cutting is important for two reasons: (1) The sequence of sensations - numbness, followed by feeling soothed, were commonly reported by participants; and (2) There is an indication here that people who self-harm experience physiological sensations that transcend “pain” – this being the sensation most people would expect following a knife or razor-blade wound to their bodies. Indeed, participants tended to emphasize that self-harm served to ameliorate pain. Margaret states:

I self-harmed because, what else did I have to do? You know like, nobody wanted me. Nobody cared about me. Nobody loved me type of thing, so I self-harmed. I think it’s … I think that what self-harm did for me is it became my self-soothing. The way I self-soothed, looked after myself, cared for myself. It was, as I said, my fuzzy blanket. It took away the pain, it helped me to sleep, and I think it was, sometimes I would take care of myself, and sometimes I would go into the hospital and get somebody else to look after me. It depended on my need at that moment. If I didn’t need human touch, then I was okay. If I needed a human’s touch, then I would go (to the hospital). (Emphasis added).

Also interesting is the emphasis respondents placed on “after-care” as part of the ritual of cutting. Author and television personality, Rosie O’Donnell, voiced a similar statement regarding the importance of self-care as part of her self-harm ritual in her biography, Find Me. She described her first experience of self-harm:
I took a bottle cap and bent it down the middle. I was alone, my mom was dead. I was feeling everything and nothing at once. I held the pinched metal disc in my hand and started to slowly run it back and forth over my forearm. I was rubbing and thinking about having to go back to school where everyone would know I had a dead mother. About getting my period, and how horrible that was going to be with just a dad. I felt a raindrop on my leg. Then another drop, I looked down and saw it was my arm. I was a bloody mess, red, vibrant, alive, and flowing. I ran into the house and washed the cuts out; I found some band-aids, and Neosporin.

Then I was finished, all cared for and cleaned up” (Rosie O’Donnell describing the first time she self-harmed in her book, “Find Me”, 2002.)

Notable, again, is the lack of reporting on a physical experience of pain; Ms. O’Donnell indicated that she only became explicitly aware of her injuries when she noticed she was bleeding. At the end of the process of self-harming, she experienced a sense of relief; she felt “all cared for, and cleaned up.”

Two participants indicated that self-harm helped to render intangible, nebulous emotional feelings as tangible physical, concrete “pain.” This was surprising in that, anecdotally speaking, this is a widely-reported causative reason for self-harm in the popular media, and in everyday discussions with “laypeople” who do not self-harm. Nicole provides an excellent illustration of this “motivation” for cutting when she described her own need for self-harming behaviour in terms of both giving herself “something else to do” (in other words, a desperate attempt at taking control of her emotional state) and making intangible feelings more “real”:
I'd be so depressed that I was, I was sick of crying, and sick of being sad, and it just gave me something else to do, and you know, it took from what I was feeling inside, and it took it on the outside so it didn't seem so, like lofty and floating around, like it was something real.

**Summary**

In this section, I have outlined the role of DSH in (1) Providing participants with a sense of self-control; (2) Attempted to demonstrate that, for participants, the act of self-harm led to a sense of relief from pain; and (3) Suggested that the act of taking care of oneself after an self-harm episode appears to be a major theme in the experiences of people living with self-harm. From this perspective, self-harm emerges as a coping strategy, a “treatment” in medical parlance, albeit one that is self-administered by people who appear to believe themselves to be completely isolated from external sources of physical and emotional support.

**Recovery from Deliberate Self-Harm**

**Environmental Shift**

Thus far in this chapter I have attempted to illustrate the process whereby people discover self-harming behaviour. The data suggest this transition occurs in the context of an environmental shift. Essentially, participants found themselves severed, either from support structures, familiar surroundings, or from roles central to their identity, such as parenting, leading to a sense of loss of control over their selves and environments. Contact with health-care personnel was universally experienced as disempowering, and was therefore not viewed as a panacea by participants; rather, it appears to have been a
disincentive for “change.” In this analysis, self-harm emerges as a means to re-exert personal control.

In the section that follows, I will show how yet another environmental shift was needed by participants to lead them out of this strange comfort zone, and was the necessary and “common ingredient” in participants’ accounts of transition away from self-harm as a coping strategy.

For Shahar, the “environmental shift” came in the form of the death of her father. She states that she was forced to change her focus from herself and her friends with whom she used to cut, to the needs of her family:

So, I... I completely stopped, and with this incident with my father dying and like spending more time with my family and like really... it sort of changed me, so that’s when I realized that how stupid I’ve been and like hanging out with these people and they’re just being so stupid. I realized that you know it was a thing of you know like just looking at what my friends were doing and just doing following them. So, I think it was really childish and immature at that time.

Shahar’s self-injury had occurred within the context of a group of friends who were self-harming together. Therefore, when family duty required her to spend time away from these friends, and towards more “mature” concerns, she was able to stop cutting on her own, without any outside help. Another participant, Margaret, also experienced a family crisis that precipitated her decision to make a real effort at transitioning away from cutting behaviour:

Well my kids had been taken away (by social services). I ended up divorcing. I felt like it was, when I saw the program (a residential treatment program for
people living with self-harm in Chicago, Illinois), I thought here’s hope. Here is
the one avenue that I might have still open to me. Unfortunately, what I also
thought is if this didn’t work, I wasn’t coming back alive.

In essence, Margaret is saying that her impetus for “change” occurred in the
context of dramatic loss of people she cared for. For Margaret, successful treatment
became imperative; without “recovery,” she believed she had nothing left to live for.

As noted earlier in this chapter, Sarah, who stopped self-harming behaviour
without outside help, was another participant who identified a family crisis as a
precipitant to transitioning away from self-harm:

My brother was murdered, so they (her parents) were going crazy too. My mom
was drinking and taking barbiturates, and my father was combing the Fraser River
looking for my brother’s body. Don’t ask me why he picked the Fraser River, and
my brother, my other brother lives in Australia, and all the responsibility came to
me to keep this, to keep this insanity from getting out of hand. So, and that was
actually not bad either. I actually stopped self-harming during that time. I had to
take care of everyone. For the first time I had utter and complete lack of
dependence on my parents.

Thus, for Sarah, the contextual shift that precipitated her first transition away
from cutting (as noted above, she began self-harming again later in life), was twofold: (1)
She felt forced by circumstances to shift towards responsibility for her parents and (2) she
was no longer dependent on her parents (who, as noted above, were abusive towards her).
Her self-harm had occurred within the context of her sense of lacking control over her
life; she now gained that control over herself, and, in the sense that her parents now relied on her, control over her family too.

Karen described her impetus to seek treatment for her self-harm as stemming from her frustration with the cruel encounters she had with the health-care medical system:

It was getting a little easier each time not to self-harm because of the fact that I didn’t want to go to the hospital. I didn’t want to deal with the nurses and the doctors and hearing them say, “Oh she’s back.”

While not necessarily an environmental shift in the same vein as others detailed in this section, Karen’s decision to work towards other methods of coping took place in the face of increasingly negative feedback from the people she was approaching for help. In other words, the compulsion to work on transitioning away from deliberate self-harm occurred as a result of environmental conditions, as opposed to an exclusively internal cognitive shift, or “desire to change.”

In this section, I have outlined examples of a trend that emerged from the data whereby participants experienced further environmental shifts (the first were theorized as having occurred prior to discovery of self-harming behaviour). These external shifts can be experienced as positive, such as gaining opportunities to support others (which in itself becomes an alternative “coping mechanism”) or experienced as negative, such as Margaret, who reported having her children removed from her by social services as an impetus to seek treatment. In essence, this phase of the model suggests that external events are a necessary condition for people living with DSH to seriously engage in the process of transitioning away from self-harming behaviours.
Inclusion

In the previous section, I discussed the apparent necessity for an environmental shift as a precursor to successful transition away from self-harm as a coping mechanism. This section examines participants’ views regarding factors they viewed as important in helping them overcome their self-harming behaviours, as well as their views on what would help people who continue to live with DSH.

Knowledge/Experience of Helpers

For Karen, the most important ingredient in her own successful transition away from DSH was a counsellor who had direct experience, and understanding of, people living with self-harming behaviours. She contrasts her counsellor with her previous encounters with hospital staff:

They need to say: I am here, you know, I am listening to what you’re saying. But they don’t seem to grasp that, and they don’t, I don’t, I just don’t think they have the compassion, or the education to know what a person is going through when they’ve cut or when they’ve overdosed or whatever. I know because I was diagnosed with borderline personality disorder, nobody knows how to deal with people like that which makes it even harder to treat the person, and I’m just getting more frustrated, and it’s like if you read on it, I mean you guys read everything else, why can’t you read on different disorders so that you can deal with your patients in the proper manner and not ridicule them right in front of their face or behind their back or whatever.

Tanya indicated that a youth-worker was able to “reach” her as a result of personal experience with self-harming behaviour:
She was a youth worker or something like that, but she, we were talking and she like showed me her scars and she said look, I used to do it myself and I thought you know, that’s really cool, “cause she didn’t judge and she had scars to show, not just one of those people reading out of the books, and just saying well I read in a book once that this and this and like, I don’t know. She knew from experience and I just, know that that helps so.

Similar sentiments were stated by Dee who transitioned away from self-harming behaviours with the support of a group of friends who were working together to overcome self-harming behaviours:

It’s nice knowing that someone understands why you do it, and doesn’t ridicule you. I was living with roommates this summer. One of them found out (that she self-harmed), and went around telling everybody I was psychotic. It was very unpleasant, but it’s nice to have people like you know, if you screw up – yeah I cut today. It’s I’m having a bad day and whatever and they understand.

At the same time, Dee found it difficult to interact with peers who continued to self-harm:

However, and that usually goes with (C, a friend working on overcoming self-harm) whereas T (an actively self-harming friend) is just a huge stress in my life, and I don’t know so much triggering, like her actual acts of cutting herself are triggering me, so it doesn’t really help with her like so much as far as the cutting goes.

For Margaret, interaction with counsellors and medical personnel served to exacerbate her self-harming behaviour. This was because, in her experience, support from
such professionals was reliant on her being “sick.” In other words, she was desperate for attention, even when it was negative:

When I stopped seeing somebody (a therapist) I could go months okay. It was almost like I would actually, before I started self-harming I would actually be starting to see a therapist, then I would start to self-harm to keep the therapist, and it was, yeah that was really interesting. I remember thinking about that not too long ago that.... If I didn’t see a therapist, I didn’t need to self-harm because it wasn’t anybody to impress or try to manipulate with it. When I went back and started somebody again, then I’d just start self-harm again.

Note that, for Margaret, self-harming behaviour was a way to “manipulate” her therapists; in other words, it was a means by which she was able to exert some control over her people from whom she wanted support. This “negative” pattern of help-seeking behaviour was broken when she was able, like most participants, to interact with people who had personal knowledge of DSH. Margaret had enrolled in a program for people living with self-harming behaviours in Chicago. At first, she felt nothing but disdain for the program and its expectations. One day, however, she sat in on a group session, and discovered that:

People didn’t go, oh my God, what’s wrong with her, but sat there and went yeah, yeah I know what you’re talking about. The groups became a safe place to tell my feelings, to say what’s going on, and then to practice the skills that I was learning in the program.

The data overwhelmingly support the notion that the most powerful therapeutic environment for people living with DSH is the support of people with similar
experiences. Linda provided insight into the utility of the group modality as a forum for sharing experiences:

You don’t feel alone any more. Other people are saying their stories which sound like your story. And then, when someone has... we sort of share what helps us and that might give you ideas. And hearing other people...finding things that really helped them get over it gives you hope that you can do so, as well.

For some participants, such as Dee (discussed earlier in this section), peer groups were informal, with no structure, made up, literally, of friends endeavouring to overcome self-harm together. For others, such as Margaret, the structured group context was essential in enabling them to focus on the healing process. Linda provided a clear explanation regarding the benefits of having some degree of structure in peer-support groups:

I’ve been to two different ones (groups), and one, the facilitator didn’t really do very much, very much at all. The other one, she structured it a bit more. We would check in at the beginning, check out at the end, and she would sort of encourage each one to participate, ask questions. To make you think a bit deeper, sort of direct it so it was not just random. The stories were kind of focused on an issue instead ... I prefer the one with more direction. I think you get more quality out of it. (The facilitator) would help you go a bit deeper than just your initial comments and I found it more productive to have it...have the time more focused on a couple issues rather than just anything.
Feeling Needed/Useful

Most participants stated that they were, in various forms, active in supporting others living with self-harm. For most, this occurred in the context of formal and informal peer support groups where help was not only received, but given. It should also be noted that all participants in this research stated that they were taking part in order to help others like themselves. One participant, Margaret, took the concept of helping others a step further; she established an international support and education program for people living with DSH and those who support them. She therefore provided a unique perspective as one who had lived with DSH, and one who had devoted her life to working with people living with self-harm. She described her utility as someone conducting therapy with people living with self-harm in these terms:

The first thing is, I have an understanding of why somebody would pick up a razor blade and cut themselves. The second thing is, I can be totally honest with them (people living with DSH). I can tell them exactly the things; I can talk to them in ways that most professionals can’t talk to them in. I can challenge them in ways that professionals can’t challenge them, but also I think, for me what it’s done is listening to other people talk has opened my own understanding about myself, and I learn everyday something new about myself when I talk with clients I say, oh yeah, that’s what that was all about.

In other words, for Margaret, working with people who self-harm continued to provide her with self-understanding, and could perhaps be seen as facilitating her long-term abstinence from DSH.
Sandra was another participant who described increased responsibility for other people as a key catalyst in her successful attempt to overcome self-harming behaviour. She became very friendly with a family, began to take part in family activities, and provided child-care, which made her feel useful or “needed”:

On Sunday’s they come pick me up for church. I go to church with them. I take care of their two little girls and I just baby-sit them on Fridays, Saturdays, whenever they need someone. The parents actually need someone. If I’m always around, I totally don’t mind taking care of the kids, and I just feel like I’m helping them out and it helps me to stay alive because it matters that I help them out.

To summarize this section: Inclusion was the final phase of the model developed through this research; that is, the phase in which participants transitioned away from DSH as a coping strategy. A key theme that emerged from this phase concerned the quality/experience of helpers. More specifically, participants indicated that their success in overcoming self-harm occurred through interaction with people whom they perceived as having direct experience and knowledge of DSH. Indeed, most participants did not identify a professional health-care worker as instrumental in their recovery process. Even Margaret, who had participated in a structured, residential treatment program, emphasized the primacy of her peers in helping her to achieve her goal of overcoming her self-harming behaviour. Linda’s account of her experience with peer groups makes mention of the role of group facilitators in providing (or not providing) structure, but not their knowledge of DSH.
Summary

This chapter examined and illustrated the theory that emerged from data collected in this grounded theory study. The theoretical model presented here is descriptive, providing an overview of the process whereby participants discovered, lived with, and overcame self-harming behaviours.

More specifically, the model suggests that DSH emerged as a response to environmental shifts that resulted in relationships with others characterized by experiences of exclusion and/or intrusion, resulting in an increased (and increasing) sense of vulnerability in people with no external sources of support and/or no inherent “adaptive” coping skills. In other words, self-harm developed as a coping mechanism in that it provided participants with a means of exerting control over at least one part of their environment, that is, their own bodies.

All participants reported negative, arguably abusive, interactions with health-care professionals. Where participants did not wish to be helped, they believed treatment had been forced upon them, which meant they lost control over themselves and their environment. Those participants who sought treatment were often derided by hospital staff who provided them with grudging treatment.

Participants indicated that the impetus to overcome their self-harming behaviour occurred in the context of an external shift, that is, as opposed to an internal, cognitive shift. Given participants’ experience with the health-care system, it is not surprising that most participants reported that their successful transition away from DSH was facilitated by inclusive experiences, that is immersion into a community of people with direct, personal experience with self-harm.
The implications of these results are discussed in the chapter that follows.
CHAPTER 5

DISCUSSION

In this chapter, I discuss the results of this study in the light of the following factors: The contribution of this research to existing theory, suggestions for future research, and the implications of this study for practice and policy making.

Contribution to Existing Theory

The question asked by this study was: What is the experience of discovery, maintenance, and recovery from, deliberate self-harm from the perspective of people who have lived with DSH? In this section, I examine ways in which the theory developed through this research answers the central research question, and hence contributes to understanding of the experience of living with self-harming behaviours.

Discovery and Maintenance of Deliberate Self-Harm

The results of this study suggest that the discovery and maintenance of deliberate self-harm occur in the context of similar factors – that is a sense of Exclusion and/or Intrusion. Therefore, “discovery” and “maintenance” will be discussed together in this section.

For many participants in this study, the discovery of DSH occurred in the context of a sense of exclusion from support structures, familiar surroundings, or from roles central to their identity, such as parenting. For other participants, a sense of social isolation was precipitated by intrusion into their personal space, in the form of, for example, physical abuse from caregivers. The key outcome of these experiences of exclusion and intrusion was a sense of loss of control. In effect, participants began to feel themselves powerless to affect the course of their lives.
The model developed through this research complements the extant literature on self-harm in postulating a link between what might be distilled down to a sense of social isolation amongst people who, through some form of trauma, whether objectively or subjectively catastrophic, lost a sense of control over their lives.

This phenomenon of exclusion and/or intrusion as precursory to losing a sense of control has been fairly well documented in the literature on psychosocial sequelae of traumatic experiences; for example, Silove (1999); Joseph, Williams and Yule (1997); Lockhat and Van Niekerk (2000). There is, however, little research literature examining, in depth, the particular experience of people living with self-harming behaviours. Where the present theory might be said to expand on current understanding is to suggest diversity in the nature of exclusionary/intrusive experiences. In other words, participants in this study described disparate experiences leading to a sense of isolation, including: lack of affection from parents, harsh discipline, moving to a new city, and so on. Indeed, many participants tended to emphasize a sense that their emotional anguish was not recognized or supported, as opposed to having experienced a complete breakdown in parental attachment, or lack of parental figures, or physical or sexual abuse. In addition, participants who began self-harming in adulthood pointed to loss of attachment in later life – that is, loss of children who they were either prevented from seeing, or who became less dependent on them as they grew up.

The intent here is not to argue there that there is no role for the “catastrophic trauma” model (e.g. Harris, 2000), but rather to note the disagreement in the general literature concerning the utility of this causative model. My study suggests the sense of exclusion and/or intrusion that occurs prior to the onset of self-harming behaviour is
multifaceted (Levenkron, 1998); sometimes subtle, sometimes obvious, leaving people with a sense of disconnect from a psychological or physical zone of safety, with a diminished expectation regarding their ability to both control their environments, or to rely on others to do this for them.

The Health-Care System and the Maintenance of Deliberate Self-Harm

One of the most striking findings of this research was the perception of most participants that the health-care system played a key role in maintaining their deliberate self-harming behaviours. That is, participants reported excluding and intruding experiences when coming into contact with health-care workers. Thus, instead of coming to regard the health-care system as a resource for recovery, participants found that the very sense of powerlessness identified in the precipitation of their self-harming behaviours was reinforced in the clinical setting. In other words, participants reported that contacts with the professional health-care system resulted in a loss of their sense of personal control gained, however tenuously, through their self-harming behaviour.

As discussed in Chapter 1, it is well-documented in the literature that people living with self-harm often report aversive experiences when interacting with health-care systems. Where previous literature differs from the current theory, is in the way these experiences are conceptualized. Thus, for Harris (2000) such negative contact with medical professionals served to reinforce, in people living with self-harm, a sense that they continue to be unloved – that their bodies were “disgusting,” a notion reinforced from childhoods of abuse and neglect. This study suggests that it is more useful to understand contact with health-care professionals as an analogue to a history of exclusion from social resources, or intrusion by others into one’s personal space, leading to a sense
of lack of control, and hence maintenance of self-harming behaviours. It is, nevertheless, certainly plausible to view the current data in Harris' terms. That is, participants reported experiences with the mental health care system that are reminiscent of sexual and physical abuse, such as being restrained, having "street" clothing removed in favour of hospital-wear, and forced medication. Conversely, participants who felt excluded from care experienced neglect and emotional abuse in their interactions with medical personnel. In analysing these experiences, however, I found the concept of re-experiencing childhood trauma in the mental health care system to be a partial answer. To me, the more compelling question concerns the process by which the experience of neglect and abuse translates into self-harm, and this process appears to stem primarily from experiences of exclusion and intrusion that serve as precipitants for a sense of lack of control.  

In summary, the current model extends existing theories by conceptualizing exclusion/intrusion as primary experiences in the development of self-harming behaviours. In addition, continued exclusionary/intrusive experiences play a key role in the maintenance of these behaviours. The key example provided here was exclusion/intrusion in the health-care system, which perpetuated a sense of loss of .

1 Harris (2000) did recognize the concept of "control" as a component of self-harming behaviour. She did not, however, consider it to be a central element motivating people living with DSH. She noted an interesting dichotomy: While physicians see the patient living with self-harm as "out of control," that patient sees herself as in control through her actions.
control, leading to a continuation of the person's temporary means of alleviating this sensation – that is, self-harming behaviours. In other words, based on this study, contact with health professionals was not therapeutic; rather such contact was experienced by participants as inimical to regaining a sense of control over themselves and their environment.

Recovery

It is notable that all but two participants in this study believed their process of "recovery" from DSH occurred almost completely without help from professional mental health practitioners. An additional participant noted the utility of a trained group facilitator in ensuring an effective peer support group experience. All but two participants emphasized the importance of discovery of, and interaction with, other people living with self-harm in their process of recovery. In other words, participants described the discovery of a community of fellow-travellers as key to their ability to "change."

It is also intriguing that some participants described the discovery of DSH as occurring in the context of observing the behaviour in other people. The data indicated, however, that peer-influence was not a necessary factor for the discovery of self-harming behaviours, while the majority of participants experienced recovery in the context of what could be conceived of as positive group influence. It is interesting, nevertheless, to highlight that, to some degree, peer influence was implicated in both the discovery of, and recovery from DSH. In both discovery and recovery, the peer group appears to have offered a means of regaining control.

The finding that participants in this study reported their recovery as taking place without intervention from professional clinicians would appear to contradict existing
models of change which all assume the necessity of some level of professional involvement. It could also, however, be seen as partially supportive of the two most prominent therapeutic models for people with self-harm, in that both emphasize groups as the locus of change. The first major therapeutic program is Conterio and Lader's (1998) S.A.F.E. program which uses a residential “therapeutic community” modality to work with people living with self-harming behaviour. The second is Linehan's (1993), Dialectical Behaviour Therapy (DBT). Both the S.A.F.E. program and the DBT model require clients to have a personal psychotherapist with whom to work on crises and emotional concerns, while the group acts as a training forum. In explaining the utility of the group modality from the DBT perspective, Ivanoff, Linehan, & Brown (2001) stated that:

The group format has several advantages over individual skills training: participants learn from each other and practice skills with others engaged in the same tasks; skills practice coaching and feedback are available for a variety of members’ responses; and group membership often decreases isolation and increases clients’ sense of connection. (p.165)

In other words, the authors recognized the importance of “decreasing isolation” and increasing “connection” in working with people living with DSH. DBT considers therapeutic collaboration to be core to facilitating an environment in which change can take place (Swenson, Dulit, Sanderson, & Linehan, 2001). Nevertheless, both models lay out particular, “manualized” intervention strategies, and DBT has been listed as an empirically-validated method of intervention by the APA (Linehan et al., 2006). Rigid intervention strategies might well be important as tools for developing new strategies to
deal with emotions and urges which underlie DSH (Conterio & Lader, 1998), but this study suggests people with DSH might be more likely to engage in therapeutic endeavours when their participation was voluntary and people providing therapeutic interventions appeared genuinely knowledgeable about DSH. The implication is that therapeutic resources might be more efficiently directed at facilitating opportunities for peer-group interventions.

This is, thus far, the first study to document a group of people who (largely) overcame DSH without professional intervention. It would appear to validate Hubble, Duncan, & Miller's (1999) assertion regarding the primacy of relationship factors in facilitating consumer “change.” Simply put, most participants in this study considered themselves to have recovered despite medical or therapeutic intervention, and often in the context of finding a community of people with similar experiences to themselves. Thus, social validation by a community, conceptualized in the present model as “Inclusion,” was described by participants as the most important variable in their recovery.

Implications for Research

The experience of people living with DSH remains an under-researched area in the literature. While there are studies that focus on the experiences of people living with DSH, from the direct perspective of such people, this is the first study to utilize the grounded theory methodology to build theory via utilization of direct reports of people with personal experience of DSH. It is certainly the only attempt at developing a model to explain the experience of DSH from prior to transitioning towards this behaviour, until recovery. The very nature of grounded theory research, however, assumes limitations in
models deriving from such research; that is, theories are assumed to require ongoing modification and refinement.

The following section will discuss future research in recognition of this study's findings.

Suggestions for Future Research

I have the following suggestions for further research:

1. As an educated white, male from a middle-class background, I was immediately removed from the experience of most participants in this study. That is, most participants in this study were female. It could be argued that this provided me with a unique perspective, given that most of the literature in the direct area of DSH appears to be written by women. On the other hand, I remain suspicious that all but one participant denied sexual abuse in their histories, this despite a literature which emphasizes such abuse as a central causative factor. Follow-up meetings with those participants who were asked to critique my emerging theoretical analysis, produced overwhelming agreement with my understandings, prompting me to wonder if my perceived status as an “expert,” or as someone within the health-care system (I met with most participants at my office in a community mental health team) acted to intimidate participants into agreeing with my perspectives, or from challenging me in a more substantive sense. If I were to continue to refine this research, I would find it useful to invite current or additional participants to attend focus groups, led by women, in which my hypotheses could be discussed under conditions more conducive to a free-flow of ideas and debate.
2. It would be interesting to expand the research sample to include people outside of the British Columbian and even North American sphere. More men who have lived with DSH should be included in future sampling. In addition, people who have not yet “recovered” from DSH would be an interesting source of data to further expand upon the existing model. For example, by limiting participation in this study to people who self-reported as having “recovered” from self-harming behaviours meant I applied my own concept of recovery. It would have been interesting to further explore the experiences of people who continue to self-harm, as a broader understanding of the concept of “recovery” might have been achieved.

3. For ethical reasons, this study did not include participants under the age of 19. It would be useful, in future research projects, to include more age-diversity in the sample or people interviewed.

4. Negative experience with the health care system emerged as an important finding of my study, and it would therefore be interesting for further research to examine the attitudes and perspective of health-workers themselves as a means of developing more insight into their perspectives. This would be helpful in terms of the development of a broader model of DSH that could be used to build educational and treatment programs.

5. It would be interesting to examine the experiences of people who have experienced exclusion/intrusion but who did not discover self-harming behaviours as a coping mechanism as this would provide further insight into the process by which DSH develops.
6. It would be useful to examine a broader range of people who consider themselves to have recovered from a "mental illness," but who do not consider their recovery to have been facilitated by collaboration with mental health professionals.

7. There is currently no epidemiological data available regarding DSH in the British Columbia context. As noted above, people with self-harm appear not to receive adequate care in the Lower Mainland of British Columbia. This is probably, in large measure, due to a lack of clear information defining DSH, as well as prevalence data and methods of prevention and intervention. This study suggests that such studies are urgently required.

Implications for Practice and Policy Making

Several concepts emerged from this study that have implications for counselling (as well as general medical/mental health) practice and policy making.

The first implication concerns treatment reported by people living with DSH when interacting with the mental health care and health care systems. It appears that professionals, be they nurses, physicians or counsellors, would benefit from further education around the needs and experiences of people living with DSH. In addition, emergency rooms would benefit from specific protocols concerning the treatment of people with DSH. Hospitals and other health-care centres would benefit from the compilation of a list of resources, as the ability to refer patients to more appropriate resources would cut down on visits to the ER, as well as providing staff with the sense they are actually able to provide people living with DSH with positive options that go beyond merely stitching people up.
With that in mind, more community resources for people living with DSH need to be developed. Based on the results of this study, such resources need not be staffed by professional practitioners. Rather, they should be locations where people living with DSH and their friends/family can go for further information on an informal or semi-formal basis. Where possible, the peer support model of intervention should be implemented. For people living with DSH who require personal therapeutic intervention, for example, in dealing with crises, a list of counsellors with knowledge of, and experience with, people living with DSH should be compiled; preferably by people who have lived with DSH themselves.

Student physicians, nurses, social workers, counsellors, etc. should be exposed to information concerning DSH during their training. Having at least a basic understanding of self-harming behaviour, would be greatly helpful in reforming professional interaction with people living with DSH.

Prevention strategies should be implemented in schools and health-care centres. In the case of schools, students could be exposed to visiting educators, and school counsellors could receive specific training. Physicians, especially GPs should be made aware of “early warning” behaviours that might develop into DSH. Favazza (2006), for examples, recommends that physicians inquire about recent episodes of DSH during initial mental health status examinations; taking note even when such behaviour has not been repetitive. The results of this study suggest that health-care professionals should be aware of the potential for DSH in people who have experienced trauma in the form of abuse or neglect, and who continue to experience social isolation.
Concluding Remarks

This study has begun the process of building a substantive theory concerning the experience of people living with deliberate self harm. The model was conceptualized as a transitional journey for these participants – a journey that included discovering self-harming behaviours as a coping mechanism, living with self-harm and eventual recovery. The model suggests that self-harming behaviours occur in the context of constant interaction between the person and his/her environment. Themes that emerged as central to an understanding of DSH were Exclusion/Intrusion and Inclusion. Such experiences lead to a sense of loss of control over self and the environment, which in turn leads to cutting as a form of temporarily regaining this sense of control. Continued experiences of Exclusion and Intrusion lead to maintenance of these behaviours, and a sense of Inclusion, or the discovery of a community that accepts the person, appears to be necessary for recovery from deliberate self-harm.

The model developed through this research constitutes a “beginning,” or an hypothesis. More research would need to be carried out, particularly in the British Columbian context, to build a more inclusive understanding of the lives and experiences of people living with self-harming behaviours. What does emerge from this study is that people with DSH report troubled interactions with professionals in the medical and mental health care systems. These interactions serve to take away from people living with DSH that which they most lack, and which might be an important underlying source of their behaviours; a sense of control.

In addition to further studies, people with DSH would be best served by healthcare workers who are better educated about their experiences and needs. This would
entail not only learning more about these behaviours, but taking time to listen to the person presenting with a self-inflicted wound. Too much is made of the wound itself, and little of the experience represented by the injury.
References


Harris, J. (2000). Cutting the bad out of me. *Qualitative Health Research, 10*(2), 164-173.


This letter is an invitation to consider participating in a study I am conducting as part of the requirements for my Doctoral degree in the Department of Education and Counselling Psychology and Special Education at the University of British Columbia under the supervision of Dr. William Borgen. I would like to provide you with more information about this project, which is entitled “The Experience of Recovery from Deliberate Self Harm: A Grounded Theory Study,” and what your involvement would entail if you decide to take part.

Most studies that examine treatment and recovery from various psychological “disorders” tend to do so from the point of view of the “professional.” In other words, such studies concentrate on what clinicians can do to influence change in their clients, based on theories of change and recovery developed by clinicians. I am interested in developing an understanding of how people living or labeled with deliberate self-harm, as well as professionals, and family members, make sense of the experience of recovery – no matter whether they continue to self-harm, or have stopped for whatever reason. The purpose of this study, therefore, is to explore self-harm as a journey, from the vantage points of people who have lived with deliberate self-harm and others closely involved in their lives.

Participation in this study is voluntary. It will involve an interview of approximately two hours in length to take place in a mutually agreed upon location. There is a possibility that I might need to contact you for a follow-up interview. You may decline to answer any of the interview questions if you so wish. Further, you may decide to withdraw from this study at any time without any negative consequences by advising the researcher. With your permission, the interview will be tape-recorded to facilitate
APPENDIX C

Consent Form for Audio-taping Interview

I understand that the interview will be audio taped to facilitate the collection of information with the understanding that all information that I provide will be held in confidence and I will not be identified in the thesis, summary report, or publication. I understand that I may withdraw this consent at any time without penalty by advising the researcher.

Please circle one: I do/I do not consent to this interview being audiotaped.

Participant Name (Please print): ________________________________

Participant Signature: ________________________________

Witness Signature: ________________________________

Date: ________________________________
APPENDIX D

Initial Interview Guide

1. I use the term self-harm, and have my own understanding of what that means.
   What do you understand by the term self-harm?

2. Can you tell me about your own experience with self-harm?

3. (If answer to 2 above does not include this point, prompt with) Do you remember how your self-harming behaviour started?

4. Why do you think you self harmed?

5. How did self-harming make you feel?

6. Did you approach another person’s (for example, a friend/family member, a psychologist, a physician, a minister) for help with your self-harming behaviour?
   If so, what was that experience like? What was helpful about what that person did for you? What was less helpful about what that person did for you?

7. Did you take part in a formal therapy program for people living with self-harm? If so, what was helpful and less helpful about that program?

8. Looking back as someone who has stopped self-harming, what do you miss (if anything) about self-harming behaviour?

9. What advice would you offer to mental health professionals about how best to help people living with self-harm?

10. Is there anything we haven’t discussed that might add to my understanding of the experience of living with self-harm?
APPENDIX E
Revised Interview Guide

1. I use the term self-harm, and have my own understanding of what that means. What do you understand by the term self-harm?

2. Can you tell me about your own experience with self-harm?

3. (If answer to 2 above does not include this point, prompt with) Do you remember how your self-harming behaviour started?

4. What do you remember about your home life when you were a child?

5. Do you consider yourself to have been abused in any way at any time in your life?

6. What was your life like before you first began to self-harm? Do you recall any life changes at that time?

7. Some people describe self-harm as a way of helping themselves to cope. Would you agree with that idea? (Additional probe) Have you ever tried any other form of coping besides self-harm?

8. Could you tell me more about how you felt at the time of self-harming? For example: What would be going through your mind before you began to self-harm? Did it hurt? Did you feel “better” afterwards?

9. Thinking back on your life, who have you felt closest to? Who were you most able to share thoughts and feelings with? (Probe) Did you let this person/these people know you were self-harming?

10. What would you do after a self-harming session?
11. Did other people, for example friends and family, know about your self-harming behaviour? If yes, did you tell them that you were self harming? (If yes) How did they react?

12. Did you seek help from any other people (for example, a friend/family member, a psychologist, a physician, a minister) for your self-harming behaviour? If so, what was that experience like? What was helpful about what that person did for you? What was less helpful about what that person did for you?

13. Did you ever go to a hospital or ER for help with your self-harm? (Probe) Was this voluntary? How would you describe that experience?

14. Did you take part in a formal therapy program for people living with self-harm? (prompt) That is, a program specifically set up to help people living with self-harm as opposed to a generic counselling/therapy session. If so, what was helpful and less helpful about that program?

15. I have been told that people who self-harm “find other people who self harm.” Is that your experience? Can you help me to understand how that happens? What was helpful about contact with other people living with self-harm in your eventual decision to stop self-harming? What was less helpful about contact with other people with self-harm?

16. Looking back, do you think you could have stopped self-harming without help from other people?

17. As someone who has stopped self-harming, what do you miss (if anything) about self-harming behaviour?
18. Thinking back, what do you regard as most important in helping you to stop self-harming?

19. What advice would you offer to mental health professionals about how best to help people living with self-harm?

20. Is there anything we haven't discussed that might add to my understanding of the experience of living with self-harm?
APPENDIX F

Interview Guide for Tattoo Artist

1. What is your own experience with cutting?

2. When interviewing people for my study, I have used the term self-harm to
describe people’s cutting behaviour. Can you comment on my use of this term?

3. What, if anything, do you see as the difference between harmful and aesthetic
cutting? (Probe) Have you ever met/worked with a person who cuts in what you
considered harmful as opposed to aesthetic reasons? How would you tell the
difference?

4. If a client came to you to for a piece of skin art, and you considered their
motivation to be self-harm as opposed to aesthetic, what advice would you give
that person (if any)?

5. You are only the second male I have met as part of this study. Can you comment
on that?

6. Is there anything we haven’t discussed that you believe might be useful for me to
know?
APPENDIX G

Interview Guide for Psychologists/Counsellors

1. What do you understand by the term self-harm?

2. Can you tell me about your own experience working with people living with self-harming behaviour?

3. What reasons do your clients give for their self-harming behaviour? (Prompt)
   Why do you think people self-harm? (Prompt) Do your clients report experiences of sexual and/or physical abuse?

4. Do you follow a therapeutic model designed particularly for people living with DSH? (If yes) What do you think is helpful about this model? What do you think is less helpful about this model? (If no to the first part) What therapeutic model(s) or technique(s) do you find useful for working with this population? What models/techniques are less useful?

5. What advice would you offer to other mental health and health-care professionals about how best to help people living with self-harm?

6. Is there anything we haven’t discussed that might add to my understanding of the experience of living with self-harm or the experience of working with people living with self-harm?
Participant’s Initials: ____________________

Gender: ____________________

Date of birth: ____________________

Place of birth: ____________________

Primary language: ____________________

Level of education completed: ____________________

Current Occupation: ____________________

Approx. date of ceasing self-harm: ____________________