

Thesis  
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**Living with the Urge: A Study Exploring the Experiences  
of People who Self-Injure**

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**This thesis is submitted in fulfilment of the regulations for  
the Degree of Doctor of Philosophy**

**University of Stirling**

**November 2004**

06/05

University of Stirling

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Submitted for the degree of Doctor of Philosophy

November 2004

#### Declaration

I declare that this thesis has been composed by myself and that it embodies the results of my own research. This work has not been included in any other thesis.

Signed: *Dianne Cameron*.....

Dianne Cameron

## **Dedication**

**In memory of my Gran, Helen Purves who died in February 2004:**

**“I’ve finally finished!”**

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## Acknowledgements

It gives me great pleasure to take this opportunity to thank the people who helped make it possible for me to complete this thesis. Firstly, I would like to thank my principal supervisor and friend, Dr Siobhan Sharkey, for her sound advice, encouragement and guidance. I could not have asked for a better supervisor and would never have submitted this year without her support. Professor Tricia Murphy-Black, though based in Stirling also provided supervision and encouragement. I would like to thank her for her positive contribution.

Many thanks to Professor Immy Holloway for her friendly advice and hospitality but most of all for helping me navigate through grounded theory.

The participants in the study deserve special thanks for their willingness to share their personal experiences with me. This can not have been easy and I warmly acknowledge their courage and insight. The Gatekeepers and Independent Advisor greatly assisted me in finding participants. Without them there would have been no study.

I would like to express thanks to Maimie Thompson, my office-mate, friend and personal chauffeur! Maimie's help, sense of humour and advice was very much appreciated and made the past year much easier to get through.

Thankfully, my friend Elaine was by my side to complete the final sleep deprived task of putting the thesis together. Terry Veitch provided practical support and clinical expertise which informed many aspects of the study. This was very much appreciated.

Without the love, practical support and understanding from my mum, dad and brother it would not have been possible for me to finish this thesis. I am eternally grateful.

My final thoughts are for James. He has shared this journey with me, the good times and bad. His love, strength and encouragement allowed me to carry on during long nights spent at the computer and he instilled in me the self-belief needed to see this thesis through to the end.

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## Abstract

Increasing rates of self-injury in the United Kingdom coupled with the apparent lack of understanding, highlights a need for research to be conducted in this area. A dearth of research illuminating the experiences of self-cutting, together with increased awareness of the differences in perspective between people who self-injure and professionals, also provides a rationale for this study. This study aims to explore the experiences of people who self-injure in order to identify and understand the processes involved in self-cutting, and develop a theory which aids this understanding.

A grounded theory approach is used to meet the aim of the study, generating data through in-depth interviews with 10 people who engage in self-cutting. Participants shared their experiences of self-injury emphasising both the meaning and function of cutting for them, and the struggle they face living with the behaviour. Although the experiences of participants were unique to each individual, clear commonalities in experience emerged during data analysis and were explored with subsequent participants, in keeping with the grounded theory method. As data generation and analysis developed, the aim of the study became more focused, resulting in an exploration of the urge to self-injure and how people who engage in self-cutting respond to this urge.

Findings relate to the core category, *living with the urge* and main categories of experience namely *underlying urge*, *triggering the urge*, *satisfying the urge* and *resisting the urge*. Discussion of the findings offers a substantive theory, asserting

that people who self-injure face a paradox of finding it very difficult to live with self-cutting, while simultaneously facing the challenge of living without the behaviour. This paradox can be understood within the context of the core category, *living with the urge*, a process which begins before the participants start self-injuring, continues while they are cutting, through to when they are trying to live without cutting. The discussion contributes knowledge relating to commonalities between self-cutting and the experience of addiction; issues for prevention; repetitive nature of cutting; the relationship between people who cut and their cutting tools; and ultimately highlights how difficult it is for the participants to break-free from the world of cutting. Implications of the findings for health and social care practitioners, and education and training are discussed, and recommendations for research are made.

## Prologue

*“We are all individuals and no two people think alike, no two people react to a situation in the same way and.....people...society has a lot to answer for you know erm, this pigeon-holing and labelling business is not helpful at all. All it does is it victimises the people who are going through it because you know I just, I’ve had it up to here with mental health people (laughs) because erm I’ve tried you know erm explaining erm like for instance I mean about the self-harm and the cutting and I tried with a CPN, actually she is my current CPN and I had a conversation with her one day and I was trying to explain the reasons why I personally self-harm and she would not take it on board at all.*

*She used to go – I think you’ll find you self-harm because you get a sense of release you know – and I think really whether I get a sense of release or not is not, not the actual issue. The actual issue is why are you doing this in the first place? A lot of it is because it’s trauma in life, in childhood and in adulthood as well and erm if these problems within society are not addressed then the same things are going to carry on and it is a lot easier for people – you know I’ve noticed it all through my life with different things that have happened to me erm....*

*It's a lot easier to blame the individual person than to say now hold on a minute there's a problem in society here you know, whether it's school or whatever you know?"*

Quote taken from a Participant in the Study



# Chapter 1

## Introduction

*“I started to cut the soles of my feet, because it was somewhere nobody could see. I used scissors, nail clippers and razor blades. But you make it look like it is an accidental thing. My self-harming was completely secret” (Naysmith, p.18, 2000).*

### Background to the Study

This quote is from an article in the *Big Issue* about two young girls who engaged in self-cutting. As a starting point for thinking about self-cutting, this article highlighted the secrecy and lack of understanding about this behaviour and acted as a catalyst to explore further what is already known. It was clear that both girls in the *Big Issue* article were dissatisfied with the help they had received for their self-injury, whether this was from Accident and Emergency or from a psychiatrist. They both described how the professionals showed very little understanding about self-harm and how they found themselves socially isolated because of the stigma attached to the behaviour. These girls spoke out against the negative attitudes they had come up against, for example being labelled as attention-seekers and time-wasters by professionals who were supposed to be helping them. The quote used for the Prologue was taken from a participant in the current study. It echoes many of the issues raised above and aptly sets the scene.

## **Significance of Problem**

Self-injury is a problem amongst young people living in the United Kingdom today (Harris, 2000). It is surprising that there is limited research into self-cutting despite statistics demonstrating the prevalence of the behaviour. For example it has been reported that every half an hour a young person self-injures or takes an overdose (Samaritans, 2000). In England and Wales there are approximately 150,000 self-harm presentations at Accident and Emergency departments each year (National Institute for Clinical Excellence, 2002) and in Scotland each year more than 7000 people receive treatment in hospital for non-fatal deliberate self-harm (Scottish Executive, 2003). Most of these cases are for self-poisoning and the figures do not take into account the number of people who self-harm (e.g. self-cutting) and do not seek medical attention. Hawton (2000) states that compared with other European Countries there is a very high rate of self-harm in young females living in the United Kingdom, and this rate has been increasing over the past ten years (National Institute for Clinical Excellence, 2002).

Further evidence for this increase was recently obtained from ChildLine (2004) as part of a National Inquiry into self-harm. Telephone calls from children who disclosed self-harm to ChildLine were analysed between April 2002 and March 2003, and in total 3345 (3032 girls and 313 boys) discussed self-harm with a telephone counsellor. Over the last decade there has been an annual average increase of 23% in telephone calls to ChildLine about self-harm. Cutting was the most common form of self-harm disclosed by the child callers with 62% of those being counselled on self-harm having engaged in



cutting. It is difficult to establish the true incidence of the problem but it is clear that it is on a very large scale (Walsh & Rosen, 1988; Babiker & Arnold, 1998).

People who self-harm are 100 times more likely than the general population to commit suicide in the subsequent year (National Institute for Clinical Excellence, 2002), highlighting the significance of the problem. The relationship between cutting and suicide is complex, with many people who self-injure claiming that they do not cut to kill themselves (Pembroke, 1994; Harrison, 1995; Arnold, 1995a; Spandler, 1996).

However Thompson and Miah (1999) state that it is of no surprise that people who self-harm may end up killing themselves either intentionally or accidentally, given the huge psychological damage that often underlies their need to self-harm. It is important to understand why and how increasing numbers of young people are relying on cutting to help them deal with their problems, and furthermore what happens to them once cutting becomes a feature in their lives.

### **Policy Issues**

In March 2004, in response to the worrying increase in rates of self-harm amongst young people in the United Kingdom, the Camelot Foundation and the Mental Health Foundation jointly launched a National Inquiry into self-harm in young people. The inquiry will run for two years and it aims to discover why so many young people are turning to self-harm to cope with problems. Evidence is requested from people with personal experience of self-harm in addition to those working in health, education, social care, research and voluntary organisations who encounter self-harm. The aim of

the inquiry is to base recommendations for policy change and service delivery in research and the views of young people who self-harm, that will make an impact within the United Kingdom both locally and nationally (The Camelot Foundation and Mental Health Foundation, 2004).

The Scottish Executive (2003) recently launched a National Strategy and Action Plan to improve Scotland's higher than average suicide rate. The '*Choose Life*' campaign aims to reduce the suicide rate by 20% by the year 2013. The campaign acknowledges that a complex relationship exists between self-harm and suicide and they propose that if strategies to reduce suicide are to be effective they should take into consideration the link between self-harm and suicide. There are a variety of risk factors related to suicide, one of which is self-harm, however the National Strategy rightly points out that not all self-harming behaviours are intended to result in death. The strategy explains that most people who self-harm do not end up committing suicide so the strategy only includes acts of self-harm which might be indicative of suicidal risk (Scottish Executive, 2003). This implies that the scope of the strategy will include targeting groups of people who self-harm through overdosing but unlike the National Inquiry (The Camelot Foundation and Mental Health Foundation, 2004) will not focus on people who injure themselves, for example through cutting.

Self-harm is increasingly receiving the attention it deserves with the media beginning to recognise the importance of the topic. Recently self-cutting has been featured in soap operas, newspapers, magazines and BBC Radio One regularly offers advice and raises

awareness of the problem in their 'Sunday Surgery' broadcast. This growing interest in self-harm highlights the demand for more understanding about the behaviour and furthermore this could help reduce the stigma attached to self-cutting.

As a result of reports that people who self-harm often receive poor care when they seek help for their self-injury, the National Institute for Clinical Excellence (2004a) has introduced guidelines for NHS healthcare professionals in England and Wales.

Recommendations have been made for the physical, psychological and social assessment and treatment of people both in primary and secondary care within the first 48 hours after an episode of self-harm. The guidelines encourage good practice and were created by healthcare professionals, people who have experience of self-harm, patient representatives and scientists (National Institute for Clinical Excellence, 2004b).

A booklet which explains the NICE guidelines has also been produced for people who self-harm, their carers and the public (National Institute for Clinical Excellence, 2004b). It is too early to establish whether or not the guidelines will improve the treatment which people who self-injure receive. It is however an important step in acknowledging the lack of understanding on self-harm amongst some healthcare professionals, and any attempts to improve the relationship between people who self-injure and healthcare professionals is welcomed.

### **Rationale for Exploring Self-Cutting**

The increasing rates of self-harm in the United Kingdom coupled with the apparent lack of understanding about the behaviour emphasises the need for research to be conducted

in this area. Rodham et al. (2004) note that empirical research on self-cutting, particularly in the United Kingdom is however relatively rare compared to the large amount of studies on other self-harming behaviours such as self-poisoning. Numerous researchers have carried out studies on deliberate self-harm but they tend to focus more on self-poisoning (e.g. Reder, 1991; Norgate, 1996; Nadkarni et al. 2000). Although there is some overlap between self-cutting and self-poisoning, researchers should be cautious in making generalisations about these acts (NHS Centre for Reviews and Dissemination, 1998).

The literature on self-cutting comprises a wide number of review articles (Raine, 1982; Collins, 1996; Feldman, 1988; Kehrberg, 1997; Gratz, 2003) and psychoanalytic case reports (Daldin, 1988; Woods, 1988; Daldin, 1990; Woodruff, 1999; Anderson, 2000). In recent years however there has been an increase in the numbers of studies exploring self-cutting and given the growing publicity and interest in the behaviour, this problem will hopefully continue to attract research attention. Most of the studies on self-harm centre on trends in the behaviour and ignore attempts to seek individual root causes, or investigate the wide range of self-harming behaviours (Harris, 2000). Although identifying correlates, trends and clinical characteristics of self-injurious behaviour may be considered useful by healthcare professionals in predicting the onset and pattern of the behaviour, the perceptions of people who self-injure are being neglected. Pembroke (1994) states that self-injury draws minimal research attention, and she argues that “existing research reinforces the typical pejorative stereotypes; ‘maladaptive’, ‘deviant’, ‘a reduced capacity to regulate affect’, ‘immature responses’, ‘manipulative’,



and even, 'passive problem solving style' (p. 1). A number of researchers have called for more studies into self-cutting (Walsh & Rosen, 1988; Garrison et al. 1993; Arnold, 1995a; Spandler, 1996; NHS Centre for Reviews and Dissemination, 1998; Suyemoto, 1998; Harris, 2000).

The literature that provides the clearest insight into self-cutting includes personal accounts written by people who self-injure and studies which focus on the perspective of people who engage in cutting. Qualitative research studies into self-injury are however particularly scarce (e.g. Harris, 2000; Weber, 2002; Abrams and Gordon, 2003; Taylor, 2003; Hodgson, 2004). This view is congruent with Solomon and Farrand (1996) who also found that there are very few studies which involve interviews with people who self-injure, and Lindgren et al. (2004) who state that it is rare for self-harm to be described from the perspectives of patients'. Furthermore, Arnold (1995b) states that few researchers have spoken directly to people who self-injure about how they understand and interpret their self-injury, and calls for more research concentrating on the experiences and perceptions of people who self-injure. The present study aims to address the dearth of research in this area and emphasises the importance of representing the voices of people who self-injure. People who engage in self-cutting have stressed their dissatisfaction with how professionals conceptualise and understand self-injury. There is a need to listen to the experiences of people who self-injure in order to explore what the behaviour means to them.

## **Overview of Thesis**

The thesis constitutes ten chapters. Following on from the introductory chapter, chapter 2 contains a review of the literature on self-injury, focusing on differing perspectives on self-cutting, and highlighting the need for more understanding about the experiences of people who self-injure. Chapter 3 initially outlines the main features of grounded theory and justifies the selection of this research approach for the present study. The second part of the chapter describes the study's research method through discussing the ethical considerations related to researching a sensitive topic, sampling issues, data collection procedures, the strategy used for data analysis, the steps taken to ensure the trustworthiness of the findings and the limitations of the research. The findings of the study are presented in chapters 4 to 8, commencing with a description of the substantive theory and core category in chapter four with each subsequent chapter illuminating a main category related to the core category. Chapter 9 contains a discussion of the contribution of the theory to the knowledge on self-cutting and how it increases our understanding of the behaviour. The implications of the theory for the practice and education of health and social care practitioners and recommendations for future research are made in light of the findings. The final chapter reflects on the research process and presents a summary of how the substantive theory has the potential to increase understanding about self-cutting.

## **Chapter Summary**

The decision to research self-harm emanated from reading a magazine article which prompted further investigation into the behaviour. From initially knowing very little

about self-cutting it came as a surprise that the behaviour is a growing problem amongst young people in the United Kingdom. The lack of research into self-cutting coupled with reports of how people who self-injure feel misunderstood, highlighted the need for more studies which focus on the experiences of people who cut themselves. With growing interest in self-cutting through the media, national inquiries and policies, the present study comes at a time when the voices of people who self-injure are beginning to be heard.

## **Chapter 2**

### **Searching for Understanding: A Review of Medical and Personal Perspectives on Self-Cutting**

#### **Introduction**

The introduction highlighted self-cutting as a behaviour which appears to be misunderstood despite its prevalence amongst young people in the United Kingdom.

The purpose of this chapter is twofold: first, to critically review the medical perspective on self-cutting through raising questions about its effectiveness in meeting the needs of people who self-injure, and how it contributes to misunderstanding of the behaviour.

Second, the chapter highlights the contribution made by studies exploring the personal experiences of people who self-injure in comprehending self-cutting. Finally studies attempting to explore the relative perspectives of people who self-injure and professionals are examined.

#### **Terminology**

An examination of the literature has revealed that there is a range of terms used to describe the act of cutting. These include: delicate self-cutting (Pao, 1969; Doctors, 1981), self-cutting (Ghaziuddin et al. 1992; Suyemoto & MacDonald, 1995), self-mutilation (Raine, 1982; Bennun, 1984; Walsh & Rosen, 1988; Favazza & Conterio, 1988; Scott & Powell, 1993; Zila & Kiselica, 2001; Ross & Heath, 2002), self-injury (Solomon & Farrand, 1996; Crowe & Bunclark, 2000; Huband & Tantam, 2000;



Machoian, 2001), wrist-cutting (Clendenin & Murphy, 1971; Rosenthal et al. 1972), self-inflicted violence (Alderman, 1997), self-abuse (Weber, 2002), self-inflicted wounding (Moffat, 1999), self-destructive behaviour (Van der Kolk et al., 1991), and deliberate self-harm (Pattison & Kahan, 1983; Hawton et al. 1997; Melville & House, 1998; Hurry, 2000). It was decided that the term, self-harm was too broad as it might have caused confusion as to what kinds of self-harming behaviours the present study was focussing on. This view is in agreement with McAllister (2003) who states that using self-injury and self-harm as synonymous terms can create misunderstanding about the relationship of cutting to self-poisoning and suicide attempts. She therefore recommends that the terms are kept apart in order for clear statistics to be collected and effective treatments discovered for both. The lack of consensus of definition of terms used to describe self-harm behaviours prevents the emergence of a clear picture of the scale of the problem (Russell-Johnson, 1997).

It appears that people who engage in self-cutting prefer the use of the terms, self-injury and self-harm to define their behaviour (e.g., Pembroke, 1994; Arnold, 1995a; Harrison, 1995, Lynn, 1998), and also refer to “cutting” when talking specifically about the act (Himber, 1994). For the purposes of this thesis, the terms self-injury and self-cutting have been used interchangeably. Arnold and Magill (1996) define self-injury as “any act which involves deliberately inflicting pain and/or injury to one’s own body, but without suicidal intent” (p. 2). Self-injury is often used to refer to the act of self-cutting in addition to other behaviours, such as burning, skin-picking and hair-pulling. The reason for choosing ‘self-injury’ relates to the fact that it is also one of the terms

preferred by service-users (Babiker & Arnold, 1998) and their perspectives are of importance to the present study. The term, self-cutting was also chosen, as it is more specific in relation to describing the behaviour of interest in the present study.

### **Self-Cutting**

In order to set the scene for this chapter it is pertinent to give a brief introduction to the behaviour of self-cutting, outlining the main features of the act as reported in the literature. Cutting is the most common form of self-injury (Favazza & Conterio, 1988; Hawton & Catalan, 1987; Arnold 1995a; Herpertz, 1995; Briere & Gil, 1998; Hawton, 2000) and most people who engage in self-cutting started during their adolescent years (Favazza & Conterio, 1988; Pattison & Kahan, 1983; Arnold 1995a; Kehrberg, 1997; Babiker & Arnold, 1998; Anderson, 2000). Self-injury has generally been found to be more common in females (Favazza & Conterio, 1988; Ghaziuddin et al. 1992; Rosen et al. 1990; Herpertz, 1995; Rosen & Heard, 1995) however some studies have found the reverse (Taylor and Cameron, 1998; Horrocks et al. 2003) or no difference between females and males (Gratz et al. 2002). Most research studies on self-injury tend to focus on clinical populations (Gardner & Gardner, 1975; Simpson, 1975; Nijman et al. 1999; Osuch et al. 1999; Nijman & Campo, 2002; Paul et al. 2002; Conner et al. 2003) and this could be because it is easier to identify and recruit people in hospitals as opposed to locating people who self-injure and live in the community. However recently there has been an increase in the number of studies into self-cutting using community samples (e.g. Gratz et al. 2002; Ross & Heath, 2002; Abrams & Gordon, 2003; Nada-Raja et al. 2003; Tyler et al. 2003; Alexander & Clare, 2004).

There are a number of functions of self-cutting reported in the literature, for example control (Shearer, 1994; Arnold, 1995a; Suyemoto, 1998; Solomon & Farrand, 1996), and expression of feelings (Suyemoto and MacDonald, 1995; Solomon and Farrand, 1996). One of the most commonly cited functions of self-cutting is the release of tension (Pao, 1969; Gardner & Gardner, 1975; Simpson, 1975; Shearer, 1994; Arnold, 1995a; Barstow, 1995; Haines et al. 1995; Herpertz, 1995; Spandler, 1996; Harris, 2000). The sight of blood is often reported as significant in relieving this tension (Rosenthal et al. 1972; Simpson, 1975; Shearer, 1994). Empirical research on the functions of self-injury is limited and this area requires further investigation (Babiker & Arnold, 1995; Gratz, 2003).

There is a preponderance of psychoanalytic case reports in the literature which offer various theories for the function of self-cutting behaviour. For example, Daldin (1988) proposes that self-cutting in adolescence is related to the significance of masturbation during this stage, which he reports is consistent with most psychoanalytic case studies in the literature. Daldin suggests that his client's self-cutting behaviour gave her an orgasmic-like relief however he fails to explore other possible precipitators of self-injury for the girl. Given her chaotic background there could be a number of reasons for why she behaves in the way she does, other than for purely sexual reasons. Woods (1988) shares a similar view to Daldin (1988). Studies which have investigated self-injury, however, found little evidence to support sexual gratification as a function of self-cutting (Favazza & Conterio, 1989; Suyemoto & MacDonald, 1995). Other psychoanalytic theories include using cutting to make a distinction between the self and

others. For example, when faced with separation in a relationship, cutting can combat feelings of loss by marking the boundary between the self and others (Woods, 1988). This is where the skin can hold special significance in the form of marking a physical boundary (Raine, 1982). Bennun (1984) argues that the psychoanalytic theories are pure speculation, which contain a lack of testable hypotheses. Babiker & Arnold (1998) note that people who self-injure often find the interpretations provided by psychoanalytic writers to be offensive or inappropriate.

Various life events are reported to contribute to the onset of self-injury. In addition to adolescence, distressing events in adulthood can also contribute to the emergence of self-cutting behaviour however this area has attracted less research interest (Babiker & Arnold, 1998) perhaps because it is less common for people to begin self-injuring in adulthood. Life experiences associated with the onset of self-cutting include sexual abuse (Favazza & Conterio, 1989, Van der Kolk et al. 1991; Ghaziuddin, et al. 1992; Shearer, 1994; Arnold, 1995a; Spandler, 1996; Briere & Gil, 1998; Santa Mina & Gallop, 1998; Low et al, 2000), neglect (Van der Kolk et al. 1991; Arnold, 1995a) and interpersonal loss (Walsh & Rosen, 1988; Rosen et al. 1990).

Biological theories have been generated which propose that self-injury is linked with low serotonin levels (Winchel and Stanley, 1991; Simeon et al. 1992; Favazza, 1996). Johnstone (1997) finds it hard to believe that a sudden fall in serotonin levels in the female population could account for a rise in the rates of self-injury. More trials are needed to test this relationship and until then results of such studies should be



interpreted with caution (Babiker & Arnold, 1998).

Self-cutting behaviour tends to be explained in different ways depending on the framework which is used to comprehend self-cutting. For example within a medical framework people who self-injure are labelled as mentally ill (Temple & Harris, 2000). The person who self-injures can be perceived as a mixture of 'symptoms' whose management and treatment is governed by healthcare professionals, and Temple and Harris (2000) argue that this results in them not being viewed as an individual, situated within a broader social context. The following section discusses the way in which the medical model 'understands' self-cutting.

### **Self-Injury within a Medical Framework**

The medical model appears to be the dominant framework in research conducted into self-cutting with the behaviour being viewed in this context as a symptom of a psychiatric disorder. A variety of diagnoses have been given to people who self-injure for example posttraumatic stress disorder, dissociative identity disorder, bipolar affective disorder, depression and psychosis (McAllister, 2003). The psychiatric diagnosis most often given to people who self-injure is borderline personality disorder (Walsh & Rosen, 1988; Feldman, 1988; Favazza & Conterio, 1989; Ghaziuddin et al. 1992; Babiker & Arnold, 1998), which was introduced as a diagnosis in 1980 by the Diagnostic and Statistical Manual of Mental Disorders (DSM), the official diagnostic system used widely in the field of mental health (Davison & Neale, 1998). Self-cutting is listed as one of the diagnostic criteria along with personality traits such as being

argumentative, irritable, sarcastic, quick to take offence and very difficult to live with (Davison & Neale, 1998). Collins (1996) highlights the danger of perceiving self-injury within the medical model because the act is viewed as the 'symptom', which is then interpreted as being manipulative in nature instead of a communication of distressing experiences. Rather than being seen as someone in desperate need of help, the person is believed to be attention-seeking, receiving negative responses such as silence, punishment or ignoring an injury (Collins, 1996).

Ghaziuddin et al. (1992) point out that because self-cutting is a feature of borderline personality disorder there is the tendency for people who engage in the act to be labelled with this disorder. Self-cutting occurs in 70-80% of patients who meet the criteria for borderline personality disorder (Bohus et al. 2000). Once people who cut are labelled as borderline, other symptoms which they exhibit may be ignored or dismissed as part of their borderline diagnosis (Ghaziuddin et al. 1992). Based on their findings that the majority of the patients who cut were clinically depressed and suffering from an affective disorder Ghaziuddin et al. (1992) argue that self-cutting among inpatients should not immediately be perceived as a symptom of a personality disorder. Instead they propose that cutting should be viewed as a cry for help or a sign of depression. The adolescent inpatients in their study however were not given the opportunity to explain why they were cutting, and instead of attributing their behaviour to psychiatric disorders it is suggested that it would have been illuminating to explore their reasons for cutting.

Based on a review of 220 cases of self-inflicted injuries, Van Moffaert (1990) states that self-cutting is an expression of personality problems and suggests that people who engage in cutting demonstrate a strong wish to take on the patient role and this is part of their 'disturbance'. This highlights how a deeply distressed person who cuts to help cope with unbearable feelings is perceived via a medical model as someone who is mentally disturbed.

### *A Separate Diagnosis for Self-Cutting*

There have been proposals for the inclusion of an exclusive diagnostic category for people who self-injure. Pattison and Kahan (1983) called for a separate DSM IV classification for what they termed 'deliberate self-harm'. This is another illustration of the medical model being used to attempt to explain and understand self-injury. Pattison and Kahan (1983) analysed 56 case-reports of self-harm, revealing common features, and consequently proposed deliberate self-harm as a syndrome starting in late adolescence, of low lethality, and continuing repetitively over a number of years. Pattison and Kahan's analysis relied on indirect reports from the literature rather than empirical or primary data. They admit that they had problems comparing data accurately, reporting that some of the terms used in the literature to describe suicide and deliberate self-harm were unreliable. Pattison and Kahan (1983) found that the 'deliberate self-harm syndrome' met all the diagnostic criteria for DSM-III axis 1 'disorders of impulse control not elsewhere classified' and therefore called for its inclusion as an axis 1 diagnosis in the DSM IV.

Other disorders of impulse control recognised by the DSM IV include kleptomania (stealing), pyromania (fire-starting), pathological gambling and intermittent explosive disorder (Davison & Neale, 1998). Simeon et al. (1992) also support the inclusion of self-cutting as an impulse control disorder and they go on to suggest that the disorders should be separated into aggressive and non-aggressive types (self-cutting and kleptomania respectively), a classification which has the potential to stigmatise self-cutting even further.

Similar attempts to categorise self-injurious behaviour have been made by other researchers. For example, Favazza and Rosenthal (1993) propose that self-mutilation can be categorised into three basic types. The first type is major self-mutilation such as limb amputation and eye enucleation (plucking out eye), and is often associated with psychosis. Secondly, stereotypic self-mutilation involves acts that are most commonly seen in people with learning difficulties, for example, head-banging, finger-biting and eyeball pressing. The third category is superficial or moderate self-mutilation which refers to acts which are of low lethality and result in little tissue damage, that take place repetitively or irregularly and are the most common type seen in psychiatric settings. This view is not shared by Pembroke (1994) who argues that the classification of self-injury into three types is like proposing that there are only three ways through which a leg can be broken. Pembroke acknowledges that the risk and intent in self-injury is often assessed by the severity of injury, however she suggests that the relationship is not so clear-cut. She states that the underlying emotions may be the same whether the injury is a superficial scratch or a deep cut.



However, Favazza and Rosenthal (1993) highlight the clinical utility of their classification of self-mutilation based on the likelihood that each type of mutilation is related to particular psychiatric disorders, thereby helping with the formulation of diagnoses. For example, they have identified a syndrome which is associated with superficial self-mutilation. The syndrome is called 'repetitive self-mutilation' and describes a pattern of self-cutting behaviour which begins in adolescence, and may continue intermittently for many years along with problems with eating, alcohol and substance abuse. Often the person alternates between self-mutilation, eating disorders and substance abuse but the destructive behaviours can also occur simultaneously. Favazza and Rosenthal (1993) report that the key feature of the repetitive self-mutilation syndrome is "recurrent failure to resist impulses to harm oneself physically without conscious suicidal intent" (p. 137). This is in agreement with Pattison and Kahan's (1983) call for the inclusion of their 'deliberate self-harm syndrome' as a disorder of impulse control in the DSM IV.

It is interesting to note that Favazza and Rosenthal (1990) justify their proposal for the inclusion of 'repetitive self-mutilation syndrome' as an axis I disorder by stating that clinicians will be able to pay more attention to the self-cutting behaviour itself. Furthermore, they state that there have been no consistently successful psychiatric treatments for axis II personality disorders. This implies that by diagnosing people with 'repetitive self-mutilation syndrome' instead of borderline personality disorder there is more chance of cutting being successfully treated. It is difficult to ascertain whether Favazza and Rosenthal (1990) are suggesting that people can be diagnosed

with both disorders or either one or the other. Although there would be less stigma attached to the new diagnosis, it is not clear how this new label would be advantageous for people who self-injure, as in Pembroke's (1994) view feelings are crucial and often ignored.

Lacey and Evans (1986) go further than this and suggest that impulsivity problems represent a distinct group of patients who suffer from a 'multi-impulsive personality disorder'. They propose that the impulse problem doesn't apply to just one behaviour and that significant numbers of patients exhibit impulse disorders in relation to a variety of problems such as substance abuse, eating disorders and self-harm. Lacey and Evans argue that treatment should focus on the variable nature of the symptoms because if patients receive help to overcome substance abuse there is the chance they could then develop problems in relation to self-harm or eating.

Furthermore, Zlotnick et al. (1999) found that self-cutting was significantly related to axis 1 disorders such as substance abuse, posttraumatic stress disorder and intermittent explosive disorder independent of borderline and antisocial personality disorders. They suggest that there could be a neurobiological reason for impulse aggression, which is the defining feature of axis 1 disorders. Zlotnick et al.'s medical perspective fails to consider the possibility that people who self-injure might also abuse substances as another way of coping with feelings associated with distressing past experiences (posttraumatic stress disorder).

Rosen and Heard (1995) also attempted to classify self-injury and looked at self-injury in adolescents with the aim of providing a system for mapping self-harm, by severity of the injury and cutting site. The proposed purpose of this system was for accurately recording variation in acts of self-injury. The sample was selected from students attending a school for adolescents who were described as emotionally disturbed. There were 128 incidences of self-injury during the four years of data collection, with 32 students having at least one incident. Whilst attending to the injury, the school nurse recorded the site of the injury on the body, the severity of the injury and the method used to cause the injury. The severity of the injury was recorded on a system with 4 levels of severity, with level 1 being the least severe. Most injuries (86.7%) were superficial and hence level 1 in nature.

Rosen and Heard (1995) state that the rating system is effective at distinguishing between a superficial injury and a severe wound, and claim that the seriousness of the injury usually determines the extent of the crisis intervention. They also report that the cutting site is significant too because the lethality can be assessed and the treatment planned accordingly. It appears as if Rosen and Heard (1995) made assumptions regarding the relationship between severity/site of injury and mental state. They claim that there is a huge difference between a minor cut and a serious, disfiguring injury, however they do not state what this difference relates to. It is not clear if they are implying that the meaning of the act for the person is different for less severe acts of self-cutting, or if they are assuming that the more severe the injury is the more emotionally distressed the person is. By focussing on the nature of the injury, Rosen &

Heard (1995), neglected the adolescents' interpretations of their injuries. It would have proved more revealing and informative if they had also asked the students about the circumstances surrounding the episode of self-injury, and how they felt at the time of the incident.

Pembroke's (1994) view is that "these categorisations serve only to trivialise the 'lesser' injuries whilst leaving the more 'serious' injuries equally condemned to another stereotype" (p. 2). Indeed it does seem that some researchers (e.g., Pattison & Kahan, 1983; Favazza & Rosenthal, 1993; Rosen & Heard, 1995) are more interested in using categorisation as a means of arriving at a diagnosis instead of listening to the person who self-injures in order to find out what their needs are.

Walsh and Rosen (1988) also failed to demonstrate how a person who self-injures would benefit from the classification of self-cutting behaviour. Walsh and Rosen's classification of self-injury opts for the use of the term, self-alteration of physical form, to refer to self-injurious behaviour. Their reasoning for this choice was to avoid encompassing such acts as nail-biting as self-mutilations. They suggest that there is a wide range of human behaviour which involves a change in physical appearance, however there are various dimensions which determine whether such alterations are self-mutilative or not. The proposed dimensions are severity of physical damage, psychological state at the time of the act, and the social acceptability of the behaviour (Walsh and Rosen, 1988). They state that within their classification system, behaviour will be defined as self-mutilative when all three dimensions are in some way considered



deviant. Such behaviours are referred to as Type III and Type IV and include wrist and body cutting, self-burning, interfering with wounds, amputation, self-enucleation (plucking eyeball out) and self-castration. Types I and II are not considered self-mutilative by Walsh and Rosen (1988) because such acts are perceived to be “beauty-enhancing or symbolically meaningful within a specific subculture” (p. 8). Examples include ear-piercing, cosmetic surgery and ritualistic scarring. Harrison (1995) interprets Walsh & Rosen’s (1988) classification of self-cutting, to mean that anyone who changes their body in any form, in isolation and outside the realms of social acceptability, runs the risk of being psychiatrically labelled.

#### *Meaning of Diagnosis for People who Self-Injure*

It is difficult to ascertain the benefits for people who self-injure of creating a “deliberate self-harm” or “repetitive self-mutilation” syndrome, or a “multi-impulsive personality disorder”. These labels do not enhance understanding of the specific experiences or needs of people who self-injure. Although diagnoses can be helpful in terms of planning treatment there is the danger that once individuals are given a label they are seen as a disorder and their experiences and interpretation of their behaviour are disregarded.

Johnstone (2000) makes an important point about psychiatric diagnoses in that they are based on social judgements and not on objective scientific assessment. A psychiatrist’s beliefs about what constitutes ‘normal’ or acceptable behaviour has an impact on the decision made about a person’s symptoms. For example Pembroke (1994) claims that



by disrupting treatment, being difficult or disliked can result in the diagnosis of personality disorder. She describes this diagnosis as “the clinical term for arsehole” (p. 46). This process is further highlighted in the following quote from a woman who has experienced self-injury and who demonstrates what it feels like to be labelled with a psychiatric disorder. “Borderline Personality Disorder, that’s how the great wisdom of psychiatry eventually labelled and objectified my distress. Something was basically wrong with my personality, I was told – very enlightening and helpful; I felt as if I had been cast into the dustbin of science” (Harrison, 1995, p. 2). As a contrast to the ‘diagnostic’ trap, exploration of the behaviour and feelings of people who self-injure within the context of their life experiences may provide a basis for understanding his or her actions. By way of example, people who have suffered sexual abuse often report feeling dirty or bad inside and they engage in self-cutting to release this ‘badness’ (Arnold, 1995a, Spandler, 1996; Harris, 2000). This helps to illuminate the logic behind the behaviour and provides a more comprehensible explanation than linking self-injury solely to borderline personality disorder.

It is understandable that people who self-injure have a fear of being labelled with the borderline personality disorder diagnosis as it conveys a very negative picture of a person. Living with a label such as borderline personality disorder and its resulting stigma can have all sorts of negative consequences for a person in relation to employment, housing and insurance (Johnstone, 1997). Very few studies have explored what it feels like for someone to live with a diagnosis of borderline personality disorder. Nehls (1999) interviewed thirty people who were diagnosed with

borderline personality disorder and discovered that the participants did not have a problem with the diagnosis itself but it was the consequences of living with a negative label that had an adverse effect upon them. Their self-cutting behaviour was often perceived as being manipulative and this was attributable to their diagnosis of borderline personality disorder. The participants perceived their self-cutting as being related to living with emotional pain and they wished that healthcare professionals were able to understand their experiences. Wilkins and Warner (2001) question the logic of understanding the coping behaviours used by some people as symptoms of pathology. They illustrate how the symptoms related to the borderline personality disorder diagnosis can be perceived as a response to difficult early relationships, trauma, and abuse and highlight the importance of understanding the impact of distressing early experiences on an individual.

Horfsall (1999) reviewed nursing responses to complex behaviours. In this paper he acknowledges that psychiatric diagnoses and clinical terminology are employed by healthcare professionals to develop common understandings of specific groups of symptoms, and possible treatment interventions. He states that medical and clinical terminology become an essential part of a mental health professional's daily routine, but argues that such jargon does not necessarily help the comprehension of a client's experiences and fears. Furthermore, Horfsall states that although healthcare professionals may perceive clinical terms as harmless and neutral, the opposite is often the case with some service users who experience the language as accusatory or

offensive. According to Horfsall (1999) these differences in perception could hamper the development of an effective therapeutic relationship.

Pembroke (1991) describes her dissatisfaction with psychiatric services and she reveals that her distress was only acknowledged within a medical framework. She highlights how her world view and experience of living were considered not important by the psychiatric services. Pembroke learned that she did not need a medical framework to define herself and her experiences, realising she could own her experiences and find meaning in them. “I do not pursue the twin gods of ‘cure’ and ‘normality’ anymore. I embrace my distress, continue to experience it, learn from it, finding it life-enriching as well as painful” (p. 32). Similarly, Johnstone (1997) argues that the problem (self-injury) somehow comes to belong to the professionals, leaving the people who self-injure feeling powerless in relation to defining their behaviour, explaining what it means to them, and how they would like to be helped. Clarke and Whittaker (1998) echo this view and assert that clinical philosophising by healthcare professionals about self-injury adds little to our comprehension of it. Instead they suggest that it is the people who self-injure that we should be listening to because they could provide a valuable insight into cutting behaviour and effective approaches to care.

### *Section Summary*

Although diagnostic labels or classification systems can be helpful for healthcare professionals when deciding on treatment they reveal little about a person’s unique situation and specific needs.

- Viewing cutting within the medical model results in the behaviour being interpreted as a sign of mental illness with the person who self-injures often feeling misunderstood and stigmatised. In addition to having to live with the consequences of cutting they also have to cope with the label of being mentally ill.
- A number of researchers believe that there should be a separate psychiatric diagnosis for people who self-injure, however this is a further example of how experience and meaning are ignored in favour of pathologising the behaviour.
- There are few studies which focus on how people who self-injure feel about being labelled with psychiatric diagnoses.

The impact of psychiatric diagnoses on the lives of people who self-injure is another area that warrants further research. Exploring how their lives change once they receive a diagnosis is one such example. One important way forward is to examine and understand how people who self injure define and interpret their own behaviour.

### **Exploring the Experiences of People who Self-Injure**

Adhering solely to a medical model fails to contribute to the understanding of individual experiences of self-injury in terms of context and meaning, and lessens the likelihood that the needs of people who self-injure will be met. Solomon and Farrand (1996) propose that in order to design effective treatments, research into self-cutting needs to move beyond the tendency to identify correlates of the behaviour towards an understanding of the meaning and context of the act. Within the last decade there has been an increasing contribution from service-users and voluntary organisations to the



literature on self-cutting (e.g. Pembroke, 1994; Arnold, 1995a; Harrison, 1995; Spandler, 1996; Smith et al. 1998). This reflects the need and demand for an alternative perspective on self-cutting which takes personal experience into consideration.

In a recent historical review of girls' and women's self-injury, Shaw (2002) reports that the idea of self-injury as meaningful has largely been ignored, and this is more noticeable in the modern literature. She argues that the roots of self-injury in girls and women should be explored and discussed within the context of their experiences of being female instead of pathologising their behaviour. This section will discuss the literature which has attempted to give people who self-injure the opportunity to voice what self-cutting means to them.

Abrams and Gordon (2003) explored the motivations, functions and meanings of self-injury for six young women from two different social contexts: an urban, working-class and mainly ethnic-minority community and a suburban, mainly white, affluent community. Abrams and Gordon emphasise the need to understand self-injury in the words of young women who engage in the behaviour within their own contexts and life experiences. The experiences which motivated the participants to self-injure all related to past family traumas such as losing parents, violence, financial problems and divorce or current relationship problems. All three suburban participants disclosed past sexual assault whereas none of the urban girls reported sexual abuse. Abrams and Gordon (2003) state that although this was highlighted as a difference between the groups it



was not clear if the urban girls had decided not to disclose such information. Self-injury was seen as a temporary relief from overwhelming emotional pain and distress for the suburban girls and as a relief from anger for the urban participants. This small-scale study has highlighted the importance of taking social context into consideration when exploring self-injury and it would be worthwhile to conduct a larger study exploring the meaning of self-cutting in different contexts.

Alexander and Clare (2004) provide another example of a study which looked at self-cutting within a specific context in order to highlight the meaning of the act. They explored the experience and meaning of self-injury for 16 women who identified themselves as being either lesbian or bisexual. Self-injury had been a feature in the lives of the participants from as little as 18 months to as long as 41 years emphasising a wide range of cutting experience amongst the women. The findings of the study reported that the onset of self-injury was influenced by societal and contextual factors, many of which could be relevant for any woman who self-injures. For example most participants loathed themselves and often suppressed their emotions as a result of suffering from negative and distressing childhood and adulthood experiences.

Other findings were more meaningful for lesbian and bisexual women such as feeling different because of their sexuality. The women reported experiencing negative responses because of not conforming to society's expectations in relation to gender (Alexander & Clare, 2004). Some participants believed that there was a strong association between issues with their sexuality and the onset of self-cutting whereas

others had not given thought to the potential relationship between the two factors.

Alexander and Clare (2004) warn professionals of the potential danger of contributing to the maintenance or escalation of self-cutting if attitudes reflect the negative social factors associated with the onset of the behaviour.

Taylor (2003) investigated the experiences of men who self-injure, another area which has been largely unexplored in the literature on self-injury. This could be because the behaviour is perceived to be more common in females, although it is not known how many males are cutting within the privacy of their own homes, choosing not to seek help for their behaviour. Conterio and Lader (1998) state that men are more likely to deny that they are experiencing emotional distress whereas women on the other hand tend to seek help for their problem. More men than women keep their self-injury hidden because the act is more socially unacceptable for them (Taylor (2003)). The findings of his study show that only one participant identified childhood experiences as a contributing factor to his self-injury whereas two men identified rejection in adulthood as a cause of their behaviour. Taylor (2003) states that low self-esteem appeared to be a common feature amongst the reported causes of self-injury, and furthermore cutting seemed to help manage the participants' feelings, experiences and lives. More studies are needed which explore the experiences of men who engage in cutting in terms of the meaning and function of the behaviour and the factors which motivate them to keep the behaviour hidden.

Spandler's (1996) research gave adolescents the opportunity to talk about their experiences of self-injury. Individual and group interviews were conducted with fifteen young people who have attempted suicide or engaged in self-injury. The participants were recruited from a community mental health resource for young people. Some of the participants identified past experiences or events which they thought could have contributed to their self-cutting behaviour. For example, childhood physical or sexual abuse, bullying, rape, a damaging adult relationship, adverse reactions to lesbian/gay sexuality, loss, and suppression of emotions such as anger and sadness. One girl talked about her cutting in relation to past sexual abuse: "I know there's a connection because I know what was going through my head when I wasn't cutting up. When I was cutting up it was how to get away from the abuse...none of that (the abuse) helped and I think that is the reason I cut up, and I think that if none of those things had of happened to me, I wouldn't have started and definitely wouldn't have been carrying on..." (p. 49). However other interviewees could not identify any life events which they thought caused them to self-injure. Links with past events and self-injury can sometimes become confused which may be unconscious or subconscious (Spandler, 1996). The findings also reported that many of the young people used very negative words to describe themselves such as bad, evil, disgusting and worthless. They often blamed themselves for their past experiences such as abuse or bullying and perceived such situations as their fault.

Solomon and Farrand (1996) explored the meaning and function of self-injury in small sample of young women. They report that there appear to be two features of self-injury

which seem significant in relation to why people find this behaviour more effective than other self-destructive acts – physical damage and pain, and the act of cutting and release of blood. Solomon and Farrand propose that physical pain is often easier to deal with than emotional pain because it is less distressing and complex and the source of the pain is evident. They also describe how two of the women emphasise the importance of seeing the blood, and the connection between the bleeding and the release of tension or anger. The authors further suggest that because some people who self-injure find it difficult to release their emotions through crying, cutting (blood-loss) could be seen as a replacement (Solomon and Farrand, 1996).

Similarly, Harris (2000) sought to find the meaning of the act of self-cutting through qualitative research. She received detailed letters from 6 women who self-injure in which they wrote about a range of issues surrounding their self-injury. The issues that emerged in this study were very similar to that of Solomon and Farrand (1996). For example, the letters revealed that self-cutting served the function of relief from emotional pain, and the sight of blood was also significant in contributing to the relief, in terms of getting rid of the anger and anguish which was being experienced.

Arnold (1995a) highlighted the contrasting range of functions reported by the women in her study with those that are frequently linked to self-injury by clinicians. For example, she states that very few women perceived their self-injury as serving the function of a means of communication with others. This is in agreement with the participants in the studies of Solomon and Farrand (1996) and Harris (2000). Two girls in Abrams and



Gordon (2003) study, however, reported using cutting as a means of communicating underlying distress to their families. In conclusion, Arnold (1995a) suggested that these findings support the view that self-injury is not attention-seeking or manipulative. Rather, it serves many important survival functions for women who engage in the behaviour.

It is, therefore of clear importance for healthcare professionals to listen to a person who has engaged in self-cutting before assuming that he or she has attempted suicide.

People who self-injure may need to discuss what precipitated the incident so that they can confirm for themselves that their motive was not death, but instead to cope with their deep distress (Arnold, 1995a). Similarly, a participant in Solomon and Farrand's (1996) study, acknowledged healthcare professionals' power to change the meaning of self-injury for both themselves and the person who self-injures. Solomon and Farrand suggest that this could create incorrect assumptions about self-injury at a time when people who self-injure are not in a position to challenge such assumptions, due to their vulnerability and sensitivity to other peoples' interpretations of their behaviour.

### *Section Summary*

Qualitative studies enable a more in-depth account of the meaning of self-injury. When such studies are considered alongside each other, similar themes (e.g. relief of feelings, suffering distressing life experiences, secrecy of self-injury and significance of blood) emerge with clear resonance for people who self-injure. Potentially these themes ought to come to the attention of health care professionals. The research studies reviewed in



the section “Exploring the experience of people who self-injure”, raise a number of important issues regarding the meaning of self-cutting in different contexts. An appreciation and understanding of the social contexts of people who self-injure provides an opportunity for exploring how factors within society can affect feelings and contribute to self-cutting behaviour. Instead of viewing cutting as a symptom of a psychiatric disorder, it would be more beneficial for it to be interpreted in terms of an interaction between individuals and their social context.

- Experiences such as sexual, physical or emotional abuse, neglect, interpersonal loss and lack of communication are often present in the past or current lives of people who self-injure. The majority of studies look at the relationship between childhood experiences and self-injury and more research is needed into adult experiences which can lead to the onset of self-cutting.
- It appears that certain feelings associated with the negative life events still remain in people who self-injure despite the fact that the traumatic events which occurred in the past are no longer present in their lives. For example, feelings of badness, guilt and dirtiness associated with sexual abuse, feelings of hatred towards the self as a result of emotional abuse, and feelings of anxiety, anger or hurt as a result of past interpersonal losses. In some people such feelings may be deeply buried, but for others the feelings may be at the forefront of their mind. It would be interesting to explore how people discovered or became aware of self-cutting for the first time and whether they associated the behaviour with traumatic past experiences.
- There is a lack of studies from the perspective of people who self-injure, which explore stressors in the social world which could precipitate or trigger a cutting

episode. It is also important to find out which situations or circumstances generate the intense feelings associated with the period before a self-cutting episode, and furthermore how a person's life changes when they become someone who self-injures.

- Although there were similarities between the perceptions of the participants in the qualitative studies (e.g. Arnold, 1995a; Solomon & Farrand, 1996; Spandler, 1996; Harris, 2000) it is also clear that self-injury can mean different things for different people at different times in terms of how they live their lives. It is therefore important for health and social care practitioners to be aware of the diversity of contexts in which self-cutting can continue to be triggered and the variety of meanings the behaviour can have for people who engage in the act.

### **Focusing on the Differences**

Research focusing on the medical perspective of self-cutting and studies which explore the experiences of people who self-injure have highlighted how self-cutting can be interpreted in different ways. Some studies have attempted to understand more about the competing perspectives of people who self-injure and healthcare professionals.

This section will review studies which focus on how people who self-injure perceive treatment responses from professionals, and conversely how professionals feel about people who engage in cutting.

### *The Perspectives of People who Self-Injure*

Warm et al. (2002) reported that from a group of 243 people who self-injure 178 had sought help in the past for their behaviour. The professionals most frequently contacted were psychiatrists, counsellors and psychologists and the participants reported being least satisfied with the response of the psychiatrists, nurses and doctors. Interestingly the medical model is associated with those professions which created most dissatisfaction amongst people who self-injure. Participants reported feeling the most satisfaction when receiving help from voluntary organisations and self-harm specialists. If front-line workers were provided with accurate information about self-cutting, Warm et al. (2002) suggest that this would facilitate the provision of more appropriate services. It is not clear why the participants were satisfied or dissatisfied with the responses of various professionals. This information could prove valuable in designing education and training for professionals who encounter people who self-injure.

Arnold (1995a) conducted a similar study however unlike Warm et al. (2002) she interviewed the participants about the responses they had experienced in relation to their self-injury. Again, the participants were most dissatisfied with psychiatrists and psychiatric hospitals. Unhelpful responses included negative attitudes, ignorance, misunderstanding, failure to listen or to deal with underlying issues, inappropriate or substandard treatment and being subject to excessive or abusive power or control (Arnold, 1995a). Counselling was the service which the participants reported most satisfaction with. This was found to be most helpful when staff were sympathetic and

supportive and this was combined with the provision of effective and appropriate treatment.

Warm et al. (2003) explored perceptions of self-injury through an internet-based questionnaire with 243 people who engage in cutting. There was strong agreement with the false statements which said that 'people who self-injure should be kept in psychiatric hospital', 'self-injury is a sign of madness' and that 'people who self-injure should be made to stop cutting themselves'. This again emphasises that self-cutting has a different meaning for people who self-injure compared to those who use a medical framework to understand the behaviour. Warm et al. (2003) state that they are not suggesting professionals should necessarily accept the perceptions of people who self-injure in relation to the causes of their behaviour, but instead should be aware of what they regard as correct and incorrect perceptions of self-injury. Although there was considerable agreement amongst the responses of the participants, Warm et al. (2003) highlight the importance of professionals giving each person the opportunity to put forward their experiences and perceptions about self-cutting and furthermore regarding them as meaningful.

Harris (2000) analysed letters written by women who self-injure about their experiences, and she centred on the differences in logic between people who self-injure and healthcare professionals. She suggests that this is why many women feel humiliated, guilty and misunderstood when they attend Accident and Emergency or are admitted to a psychiatric facility. She proposes that doctors and nurses find self-injury



difficult to understand because they are trying to “apply a rational scientific logic instead of a situated internal logic to the issue” (p. 169). Harris found evidence of situated internal logic in the women’s letters. She uses the example of the release experienced by the women when self-cutting, and the subsequent relief that the damage to the self is minor. She then contrasts this with a professional rationalist view which fails to comprehend how a woman could cut herself and then feel relieved. Harris (2000) noted that it is perfectly logical for the women to feel relieved that although they engaged in self-cutting, they had not done it so severely that they would endanger their life. She states that professionals would perceive this behaviour as irrational because in their opinion it is putting the woman’s life at risk. Furthermore they may also see self-cutting as a sign of mental illness, and being out of control.

### *The Perspectives of Healthcare Professionals*

There are few studies which give healthcare professionals the scope to talk in-depth about their experiences of working with people who self-injure and furthermore how they feel about people who cut themselves (Huband & Tantam, 2000). Crawford et al. (2003) examined knowledge, attitudes and training needs in relation to self-harm amongst a mixture of professionals who work with adolescents who engage in the behaviour. Knowledge about self-harm was found to be adequate but with some important gaps, for example in relation to social groups most at risk of self-harm and also the relationship between self-harm and suicide. Doctors demonstrated the most knowledge and psychiatrists reported more worry about the behaviour compared to the other professions. Crawford et al. (2003) suggested that this could be related to the



level of responsibility because interestingly non-psychiatric nurses who have limited responsibility regarding patients who self-harm showed the lowest levels of knowledge and worry (Crawford et al. 2003). The study also found that the staff who felt more effective were less negative about people who self-harm and this has implications for training.

This is consistent with McAllister et al. (2002) who found that if Accident and Emergency nurses perceive themselves as being suitably skilled to help people who self-harm they are more likely to feel that their work with this patient group is worthwhile, and are less likely to display negative attitudes towards them. McAllister et al. however report that generally there was a negative attitude and a feeling of helplessness from the nurses towards self-harm. This suggests a need for training and education in order to increase knowledge and learn skills for effectively dealing with people who self-harm. Both Crawford et al. (2003) and McAllister et al. (2002) focussed on self-harm (self-harm and self-poisoning) and no distinctions were made between the behaviours so it is therefore not possible to specifically relate the findings to self-cutting.

Huband and Tantam (2000) did however focus on the attitudes of professionals to self-cutting specifically. They reported that the attitudes of staff members who had extra qualifications in counselling or psychotherapy were significantly different in relation to self-injury compared to those who had no counselling experience. For example in response to vignette about a woman who engaged in cutting, they demonstrated more

understanding about her behaviour and perceived that she had less conscious control over her actions. This is consistent with Arnold (1995a) where the participants reported feeling most satisfied with the counselling service. The medically trained staff perceived the woman as more likely to be a difficult patient (Huband & Tantam, 2000) and this perhaps explains why people who self-injure reported being most dissatisfied with psychiatrists. The vignette technique employed by Huband and Tantam was administered through a postal survey and this limited the opportunity to explore further the responses of the participants. Furthermore it might be difficult for professionals to assess how they would feel about a patient they have not interacted with in the real world. Contextual information could be missing from the vignette which might influence how the professionals understand and respond to her behaviour.

### *Comparing the Perceptions of Healthcare Professionals and People who Self-Injure*

Research which directly compares the perceptions of healthcare professionals and people who self-injure towards the act of self-cutting, is scarce. Studies which focus on the two perspectives provide the opportunity for exploring the same issues with the groups in order to illuminate differences in knowledge and understanding about self-injury. For example, Smith (2002) interviewed fifteen mental health workers from a variety of professions in addition to exploring the experiences of three service-users who self-injure. Issues which emerged from the interviews with people who self-injure were used as topics for exploration with the professionals. Key findings included people who self-injure reporting that they were never asked why they cut themselves, feeling misunderstood, being seen as a failure by staff and finding it helpful to talk to

other patients who self-injured. Half of the professionals stated that they thought people who self-injure were treated negatively, and most staff members felt under pressure and anxious about self-cutting, which made them reluctant to explore the behaviour with patients. Most staff members recognised the need for more training and education on self-injury and furthermore more support in helping patients who self-injure. The staff felt under pressure from government policies to reduce suicide and this then had an effect on their relationships with patients (Smith, 2002). Although the sample of people who self-injure was small there was some consistency in themes. The findings of this study suggest that it could be beneficial for people who self-injure to be involved in the training and education of staff members.

Jeffery and Warm (2002) devised a questionnaire which included statements taken from the literature on self-cutting, ten of which were considered accurate accounts of self-injury, and ten which were viewed as representing common myths about the behaviour. The questionnaire was completed by general practitioners, nurses, psychiatrists, psychologists, counsellors, mental health support workers and a group of people who self-injure who all had to rate the statements on a five point scale ranging from “strongly agree” to strongly disagree”. The authors found support for their hypothesis that medical workers and psychiatrists have a poorer understanding of self-injury than workers from the fields of psychology and social care (Jeffery and Warm, 2002). Interestingly there were no significant differences between the group of people who self-injure with those with psychological or social care/community training, in relation to their understanding about the behaviour. Jeffrey and Warm (2002) suggest such

differences in understanding could be linked to the focus of their work. Professionals whose work requires the formation of a therapeutic relationship with people who engage in cutting may have more of an understanding of the behaviour, than those professionals who focus on assessment and treatment. These findings highlight the need for an evaluation of training needs of various professionals in relation to self-cutting (Jeffrey and Warm, 2002).

### *Section Summary*

These studies have confirmed the existence of a barrier between people who self-injure and health and social care practitioners, and a number of issues appear to have contributed to this. The lack of understanding about self-cutting amongst some healthcare professionals could be partly due to their specific occupational training. Some studies have pointed to the benefit of learning counselling skills, in that people who self-injure reported their satisfaction with counselling, and healthcare professionals trained in counselling demonstrated less negativity towards self-cutting. This could explain why in the literature, people who self-injure were most dissatisfied with the treatment received from psychiatrists and they showed more negativity towards this profession. Occupations where there is less emphasis on the importance of counselling could struggle in terms of meeting the needs of people who self-injure. Talking and being listened to have been reported as being important to people who engage in cutting when seeking help for their problems (Weber, 2002). This however does not appear to fit within a medical framework where the emphasis is on assessment and diagnoses. More research is needed to explore how counselling skills can help



healthcare professionals work more effectively with people who self-injure. Lack of confidence and anxiety appear to affect the relationship between practitioners and people who engage in cutting and this is understandable given the often distressing nature of the behaviour.

Training and education strategies are needed for improving the confidence levels of healthcare professionals in terms of their ability to help people who self-injure.

Service-users with experience of self-cutting should be involved in these strategies because they can provide a unique insight into the behaviour in terms of helpful and unhelpful responses. Furthermore more time and resources should be devoted to self-cutting in the training of nurses, doctors, psychologists, social workers and other professions who work with vulnerable people. The nature of the training should also be closely looked at given the current clashes of perspectives between people who self-injure and those trained within a medical framework. Ultimately all of these issues call for increased understanding of experiences of self-cutting and ways of hearing the perspectives of those who cut.

### **Limitations of the Literature**

This chapter has reviewed the literature on the medical perspective towards cutting compared to the perspectives of people who self-injure. However a number of limitations are apparent in the literature, particularly in relation to understanding the experiences of people who self-injure. The present study hopes to contribute to further understanding on self-cutting in light of these gaps in the knowledge.



### *Lack of Focus on Experience and Meaning*

The few qualitative research studies in the area of self-cutting give a unique insight into the ways in which self-cutting affects a person. For example we know from qualitative studies that people who self-injure usually make a clear distinction between self-injury and suicide; that self-injury is used as a coping strategy; it is generally a private act to an individual; it may be a means of getting rid of intense feelings; it is not usually used to communicate feelings to others; and that it is perceived as a form of survival in that some people who self-injure describe feeling relieved that they have not severely damaged themselves. The sight of blood in the act of self-cutting appears to hold some significance in providing relief from intense feelings. Further elucidation of these issues is necessary. In order to build on these studies, more focused insight is needed into the feelings which precipitate self-injury; how these feelings are triggered in the everyday social world of a person who cuts and how self-cutting functions to regulate their emotions. Exploration of the symbolic meaning which the sight of blood has for this group of individuals is also necessary. Of particular interest is how these experiences come together for people who self-injure. Providing a more detailed holistic representation of 'lived experience' would potentially lessen stigma and misunderstanding created by diagnostically based treatment approaches.

As people who self-injure have stressed their dissatisfaction with the medical perspective on self-cutting, people who engage in cutting should have the opportunity to explain and define self-injury in their own words. People who self-injure can provide a valuable insight into what it is like to engage in this behaviour, and their stories could

inform healthcare professionals about the meaning and function the act has for them. This would give healthcare professionals a deeper understanding of their particular needs, and treatment could then be negotiated accordingly, instead of on the basis of what clinicians think they need. A lot can be learnt from people who have actually experienced a phenomenon like self-injury because they can offer a subjective account unlike healthcare professionals, who can only look at self-cutting objectively.

There is the need for a theory of self-injury which explains the behaviour, and the conditions surrounding self-cutting from the point of view of the people who experience it, using language which is accessible to all. Psychoanalytic theories are based on case reports and are formulated from the therapist/clinician's point of view, where the language used is often difficult to understand and the interpretations are at times confusing, and the same applies to the biological theories.

### *Need for Diversity in Sampling*

The majority of studies on self-injury involve psychiatric inpatients, general hospital admissions or adolescent care homes. Very few studies recruit participants from the community. This is understandable given the secrecy which surrounds the act of self-cutting thus making it difficult to find participants. However this fact should not deter researchers from using a community sample. Indeed there might be some people who self-injure who have never come into contact with healthcare professionals in relation to their self-cutting. It is important to find out how self-injury helps people function and get through daily life, and also how people who cut interpret and define their own

behaviour. Indeed, Gratz (2003) calls for future research into self-injury to include more diverse groups of people such as both clinical and non-clinical samples which incorporate both men and women. Furthermore, Ross and Heath (2002) suggest the need for research into what happens to people who start self-injuring in adolescence in relation to whether the behaviour becomes long-term. Similarly, Suymeoto (1998) states that it would be beneficial to try to compare people who have been self-injuring for many years with those individuals who have managed to stop cutting themselves.

### **Contribution to Knowledge**

It is important to justify the reason for conducting a research project in terms of what the findings will add to the current body of knowledge, how it goes beyond what is already known, and what the benefits of the research will be. We know that self-cutting is the most prevalent form of self-injury, there is a higher prevalence in females and the onset is usually in middle to late adolescence. There is consensus in the literature as to the life events/experiences which may lead to self-cutting, for example, sexual abuse, neglect, loss, and lack of communication. Researchers have identified a number of functions which self-cutting serves for a person such as, release of tension, control, numbing emotional pain, and cleansing the body. However, research and practice lack theory which helps understand the process of self-cutting in an accessible way from the perspective of people who self-injure. The literature review has revealed that self-cutting can mean different things to different people at different times. This, however needs to be explored in detail using appropriate qualitative research. Without such a

model of self-cutting, care and treatment run the risk of never fully meeting the needs of people who self-injure.

The current culture, strongly advocates that user involvement should be integral to designing and developing services sensitive to their needs (Scottish Executive, 2002; 2003). It is unacceptable that an area such as self-cutting is so poor at engaging with people who self injure, and much more needs to be done to develop their perspective and help them take some control over their own care.

There do not appear to be any studies which highlight the processes that are operating in situations where the need to self-cut is triggered. Furthermore it would be interesting to explore the personal and social consequences of engaging in self-cutting in order to appreciate what everyday life is like for people who self-injure. Like Spandler (1996) this research will go beyond medical and clinical approaches and definitions of the problem. Self-injury is an under researched area and any new research into this misunderstood phenomenon is to be encouraged.

There is a need for clarification and explanation as to what is happening within the personal and social world of a person who self-injures. A model which elucidates this personal and social world would enhance the understanding of not only healthcare professionals, but also people who self-injure. If the meaning of self-cutting to people who self-injure is explored in context, it could provide valuable information about the different functions cutting serves. Such understanding would have implications for



treatment provision, identifying alternative coping strategies, and addressing conditions which cause particular distress for people who self-injure, providing a more negotiated model of care based on real experiences.

Arnold (1995a) points out that the comparatively small amount of literature which exists on self-injury is diffuse and not widely accessible, but it does contain theories developed by academics and clinicians, ultimately guiding treatment approaches.

Solomon and Farrand (1996) propose that in order to discover effective treatment strategies, a move towards an understanding of the meaning and context of the act of self-injury is needed. They propose that this is only achievable through in-depth interviewing of people who self-injure. The aim of this study is to explore the experiences of people who self-injure in order to identify and understand the processes involved in self-cutting.

## **Chapter Summary**

The dominance of the medical model as a framework for interpreting self-cutting has resulted in people who engage in self-injury feeling misunderstood, marginalised, silenced and ultimately powerless. Viewing cutting as a symptom of a psychiatric disorder ignores the wider social context within which the behaviour takes place. The reasons why people engage in cutting vary from person to person as does the meaning and function of the act, and the consequences of the behaviour. By grouping people who self-injure together under one diagnosis, the meaning of the behaviour is ignored and individual experiences are replaced with a label. There is a need for greater



understanding about the lives of people who self-injure in relation to how they interpret and understand their behaviour. The next chapter will describe how the present study was designed in order to explore the experiences of people who self-injure.

## **Chapter 3**

### **Research Approach and Method**

#### **Introduction**

The literature review presented in Chapter Two highlights a dearth of research which describes the subjective perspectives of people who self-injure. This provides a rationale for the broad aim of the study, namely to explore the experiences of people who self-injure in order to identify and understand the processes involved in self-cutting, and develop a theory which aids this understanding. The first part of the chapter outlines the main features of grounded theory and justifies the selection of this research approach. The second part of the chapter describes the study's research design including the ethical considerations related to researching a sensitive topic, sampling issues, data collection procedures, the strategy used for data analysis, the steps that were taken to ensure the trustworthiness of the findings and finally the limitations of the study. The first person is used when describing some aspects of the method in particular relating to reflective aspects. Through the development of the design and execution of the research, this chapter traces the study's evolution from research aim to substantive theory.

#### **Philosophical Perspective**

Annells (1996) states that "the actual formulation of the research question arises from the researcher's notions about the nature of reality, the relationship between the knower

and what can be known, and how best to discover reality” (p. 379). Having gained insight into self-cutting from reading in-depth accounts of the behaviour it was evident that more studies illuminating the experiences of people who self-injure were needed. As researcher, I wanted to explore what was important and meaningful to people who engage in self-cutting with a view to jointly constructing an in-depth and true-to-life description of their experiences. The positivist approach, widely used in self-cutting research, is therefore not appropriate for meeting the aim of this study, given it focuses on objectivity and maintains distance between the researcher and participants (Holloway and Wheeler, 2002). Harris (2000) argues that quantitative studies on self-harm fail to generate an in-depth explanation for the behaviour because they do not take context and culture into account. She claims that the quantitative perspective has been widely used “because it appears to satisfy the medics’ overweening positivist obsession with validity, reliability, and generalisability, but also because, more than these it speaks in the commonly understood language of statistics” (p. 165). Harris’ viewpoint could be perceived as biased, failing to acknowledge that researchers must choose the most appropriate method to suit their research aims.

Creswell (1998) suggests that it is the task of the qualitative researcher to present multiple realities of all individuals within the research context, for example those of the researcher and the participants. Denzin and Lincoln (2000) define qualitative research as “involving the studied use and collection of a variety of empirical materials – case study; personal experience; introspective; life story; interview; artefacts; cultural texts and productions; observational, historical, interactional, and visual texts – that describe

routine and problematic moments and meanings in individuals' lives" (p. 3). Given its emphasis on meaning and describing problem situations, qualitative research potentially allows the exploration of the realities of people who engage in self-cutting behaviour.

### **Research Approach**

There are a variety of qualitative approaches available to the researcher, for example phenomenology, ethnography and grounded theory and although they share some similarities (Strauss & Corbin, 1994) they also have features which make them individually unique as research approaches. For example, the main difference between grounded theory and the other qualitative research approaches is its focus on the development of theory (Strauss & Corbin, 1994). Having chosen grounded theory as the approach for this study, this section will present a description of its theoretical roots and main features followed by justification of its use for exploring the experiences of people who engage in self-cutting.

#### *Theoretical Roots of Grounded Theory*

The development of the grounded theory method was influenced by the diverse research backgrounds of Glaser and Strauss. Charmaz (2000) describes how Glaser's training in quantitative research brought rigour to the development of qualitative analysis, whereas Strauss used grounded theory to introduce the study of process, meaning and action given his experience of field research and grounding in pragmatism and symbolic interactionism.

## Pragmatism

MacDonald (2001) comments that although pragmatism was important to Strauss, researchers appear to ignore the pragmatist roots of grounded theory and instead focus on symbolic interactionism as the method's theoretical underpinning. The following quote from Corbin and Strauss (1990) highlights the influence of pragmatism on their method of grounded theory: "Thus, grounded theory seeks not only to uncover relevant conditions, but also to determine how the actors respond to changing conditions and to the consequences of their actions" (p. 5). Pragmatists highlight how conditions in the environment or immediate situation can disrupt routine action, causing people to assess their circumstances before deciding on an option and carrying on with the altered action (MacDonald 2001). Corbin and Strauss (1990) not only emphasise the importance of incorporating change and process into grounded theory, but also that people have the ability to determine what happens to them through their responses to varying circumstances.

## Symbolic Interactionism

Grounded theory also has roots in symbolic interactionism, a framework which emerged from the pragmatist perspective (Schwandt, 1994) and "focuses on the meaning of events for people in natural or everyday settings" (Chenitz & Swanson, 1986, p. 4). George Herbert Mead, regarded as the founder of symbolic interactionism, proposes that individuals respond to stimuli in the social environment by thinking about the meaning of certain stimuli, and by then choosing a behaviour that they deem



suitable for the specific circumstances they find themselves in (Layder, 1994). Mead argues against the behaviourists' view that people automatically respond to external stimuli, and instead highlights the importance of the mind and self in responding to situations (Layder, 1994). Herber Blumer was a student of Mead's and he created the term 'symbolic interactionism' (Layder, 1994). For Blumer (1969) the three basic premises of symbolic interactionism are: firstly that "individuals behave towards things (e.g., physical objects, human beings, institutions or the activities of others) on the basis of the meanings that the things have for them; secondly that the meaning of such things is derived from social interaction, and thirdly the meanings are managed through an interpretative process by the individual" (p. 2). Blumer (1969) explains that it is essential for researchers to see 'things' as their participants perceive them in order to understand the actions of a group of people. Chenitz and Swanson (1986) state that the use of a symbolic interactionist approach in grounded theory enables the examination of human behaviour and interaction, and is particularly effective in situations which are complex.

### *Grounded Theory*

Glaser & Strauss (1967) published 'The Discovery of Grounded Theory' in response to requests from people who had read their studies on dying and wanted a detailed description of the method they used (Glaser, 1992). At that time the field of sociology was dominated by quantitative research where researchers focused on obtaining accurate facts and testing theory (Glaser & Strauss, 1967). The aim of 'Discovery of Grounded Theory' was to emphasise the importance of generating theory, as well as

verifying it, through guiding researchers to discover concepts that were relevant to their research area (Glaser & Strauss, 1967). Glaser and Strauss (1967) define grounded theory as “the discovery of theory from data which fits empirical situations and is understandable to sociologists and layman alike and most important, it works - provides us with relevant predictions, explanations, interpretations and applications” (p. 1).

Grounded theory is an inductive method, in that a theory emerges after data collection begins (Glaser, 1978). However, thinking moves between induction and deduction during the grounded theory process when the researcher creates statements of relationships from the data and then sets out to verify them by collecting further data (Corbin, 1986). The theory develops through the continuous interaction between data collection and analysis (Strauss & Corbin, 1994). Analysis can result in two different types of theory, substantive or formal. Substantive theories are developed for a substantive area of enquiry such as delinquency (Glaser & Strauss, 1967) whereas formal theories apply to broader areas of inquiry and have less relevance for a specific group of people (Strauss & Corbin, 1998).

It is essential in a grounded theory study for researchers to have theoretical sensitivity (Strauss & Corbin, 1998). This is the ability to identify what is important in the data, giving it meaning (Morse & Field, 1996). Theoretical sensitivity can develop over time from a number of sources such as reading literature, and professional and personal experience, all of which create awareness and encourage the researcher to be open and flexible when examining the data (Holloway & Wheeler, 2002). Theoretical sensitivity develops through working with the data, making comparisons, asking questions and

collecting additional data. This circular process of data collection and analysis allows meaning to become clearer (Strauss & Corbin, 1998). Principal features of grounded theory are therefore asking questions, the making of comparisons and theoretical sampling (Glaser & Strauss, 1967; Glaser, 1978; Strauss & Corbin, 1998). These features distinguish grounded theory from other methods and are essential for developing theory (Strauss & Corbin, 1998).

### Asking Questions

Asking various types of questions during analysis is deemed essential by Strauss and Corbin (1998), for example:

- Sensitising questions which point the researcher to what the data might be suggesting, for example, ‘What is going on here?’ and ‘Who are the actors involved?’
- Theoretical questions which assist the researcher in identifying process, variation and relationships between concepts, for example, ‘What is the relationship between one concept and another?’
- Practical questions which provide guidance for sampling and promote the generation of the structure of the developing theory, for example, ‘Which concepts are well developed and which are not?’
- Guiding questions which guide the interviews, observations and their analysis. Guiding questions begin broad and open-ended at the start of the research process but become more focused as the research progresses (Strauss & Corbin, p. 77, 1998).

Charmaz (2000) acknowledges that Strauss and Corbin's (1998) asking of questions has the potential to assist beginning researchers develop their data generation skills but she advises researchers to be aware of Glaser's (1992) warning that questions can result in forcing of the data into preconceived categories.

### Making Comparisons

Glaser and Strauss (1967) introduced the term, comparative analysis to describe a method for generating theory. The making of comparisons is considered to be an essential feature of grounded theory (Glaser and Strauss, 1967; Strauss & Corbin, 1998). Benton (1996) describes the constant comparative method as involving the comparison of incidents with incidents, enabling categories to develop from the data. Benton (1996) explains that incidents in the data are then compared with categories and this process enables the characteristics of the category to be identified. If irregularities appear when comparing incidents with categories then Benton (1996) suggests that researchers should note down their thoughts on the issue in the form of a memo. At each step of the analysis, irregularities and similarities are used to establish boundaries and relationships between categories. Holloway and Wheeler (2002) explain that constant comparison is helpful in looking critically at concepts because each concept is highlighted by the new data which has been collected. Because each incident of a category is compared with other incidents for similarities and differences, this promotes the discovery of properties (characteristics) of categories (Holloway & Wheeler, 2002).



During this process the researcher will become aware of a category that repeatedly occurs in the data and which appears to link other categories together and this is known as the core category (Schreiber, 2001). The researcher then restricts coding to variables that relate to the core category (Schreiber, 2001). Glaser (1978) explains that the core category can be for example, a basic social process (BSP), a condition or a consequence and that additional criteria apply when it is a process. All BSPs are core categories however not all core categories are BSPs. What differentiates BSPs from other core categories is that BSPs include a process and have two or more stages (Glaser, 1978). Baker et al. (1992) define the core process as “the guiding principal underlying what is occurring in the situation and dominates the analysis because it links most of the other processes involved in an explanatory network” (p. 1357).

Olshansky’s (1987) study into the meaning of infertility to people who experience it, provides a good example of a core process as described above. She found that people who experience the distress of infertility adopt a central identity for themselves as infertile. Olshansky (1987) highlights the core process as one of taking on and managing this new identity. This captures what Hutchinson (1986) believes to be the essence of grounded theory and that is people who share similar circumstances (for example infertility) experience shared meanings and behaviours. She proposes that grounded theorists assume that such groups have in common a specific social psychological problem that is not usually expressed (for example adopting a central identity as infertile). It is through social psychological processes (for example, taking on and managing this new identity) that the problem is alleviated (Hutchinson, 1986).



## Theoretical Sampling

Making comparisons and asking questions direct data generation during theoretical sampling (Strauss & Corbin, 1998). Glaser and Strauss (1967) define theoretical sampling as: “the process of data collection for generating theory whereby the analyst jointly collects, codes and analyses his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges” (p. 45). Further on in the data collection/analysis process when the researcher has a number of categories, sampling becomes more specific and it is aimed at developing, densifying and saturating the categories (Strauss & Corbin, 1998). Theoretical saturation of categories occurs at the point when no new properties (characteristics) emerge from incoming data or when the researcher notices that the same properties keep occurring again and again (Glaser, 1978).

### *Glaser and Strauss Debate*

Since the first publication on grounded theory by Glaser and Strauss in 1967, there has been controversy surrounding the development of the method, centring on the differing viewpoints of Glaser and Strauss, so much so that researchers in the field have identified two different grounded theory approaches; the Glaserian and the Straussian (Stern, 1994). Although both Glaser and Strauss seemingly thought that they were using the method in the same manner, their students in the 1960's and 1970's clearly identified differences between the work of the pair (Stern, 1994).

Reportedly, Glaser only become aware of such differences when in 1990 Strauss and Corbin published the 'Basics of Qualitative Research' (Stern, 1994). In response to this, Glaser published the 'Basics of Grounded Theory Analysis' (1992) in which he corrected what he thought was wrong in Strauss and Corbin (1990). Stern (1994) describes how Glaser clearly highlights what the differences are and even suggests that the Glaserian and Straussian methods should have different names: 'grounded theory' for Glaser's method and 'conceptual description' for Strauss'. Melia (1996) suggests that Glaser is accusing Strauss of developing a new method which fails to sufficiently acknowledge their earlier collaboration.

Glaser's main criticisms relate to the nature of research questions, initial coding processes, and that Strauss and Corbin's (1990) method is aimed towards description and not discovery (Melia, 1996). The main criticism regarding the method of Strauss and Corbin (1990) is that it is too proceduralised, with Glaser arguing that in Strauss' full conceptual description the data is forced, and there is a preconceived approach to analysis (Melia, 1996). Given it is outwith the scope of this section to fully describe Glaser's criticisms of Strauss and Corbin, further information can be obtained from Glaser (1992).

Strauss and Corbin (1998) defend their set of procedures by stating, "why provide a set of procedures and techniques if these are not meant to be approached in a step-by-step fashion? Just as painters need both techniques and vision to bring their novel images to life on canvas, analysts need techniques to help them see beyond the ordinary and

arrive at new understandings of social life” (p. 8). In this, it appears that they are responding to Glaser’s criticisms that their method involves too many rules and procedures which result in the theory being forced instead of emerging naturally. Furthermore, Strauss and Corbin (1998) emphasise that their analytical techniques can be selected, rejected or ignored depending on the needs and preferences of the researcher, and they advise people who want to generate new theory to employ methods like the one presented in their publication.

A quote from a paper written by Strauss and Corbin (1994) is interesting in light of Glaser’s criticisms that they deviated away from what he regards as grounded theory. They state that, “The features of this methodology which we consider so central that their abandonment would signify a great departure are the grounding of theory upon their data through data-theory interplay, the making of constant comparisons, the asking of theoretically oriented questions, theoretical coding, and the development of theory. Yet, no inventor has permanent possession of the invention – certainly not even of its name – and furthermore we would not wish to do so. No doubt we will always prefer the later versions of grounded theory that are closest to or elaborate our own, but a child once launched is very much subject to a combination of its origins and the evolving contingencies of life. Can it be otherwise methodology” (p. 283)? This quote does seem to be an attempt to justify their version of grounded theory and suggests that they think Glaser has laid claim to ‘grounded theory’ in that anything which differs from his interpretation is not worthy of being called grounded theory.

### *Why Grounded Theory?*

How does grounded theory facilitate achieving the aim of this study? Self-cutting is an area where there is a lack of understanding and there have been calls for more research, particularly studies which explore the experiences of people who engage in the act.

Grounded theory is appropriate for researching topics where more understanding is needed and a fresh outlook could prove advantageous (Schreiber, 2001). There are a lack of adequate theories which explain or predict the behaviour of people who self-injure, which according to Hutchinson (1986), is where grounded theory is particularly useful as a research approach. As mentioned in Chapter Two the theories that exist in the self-cutting literature are not accessible or understandable to all, and they are often based on the assumptions of clinicians instead of being grounded in the experiences of people who engage in self-cutting. This study aims to move beyond description of the experiences of participants to look for patterns and relationships between categories (Holloway & Wheeler, 2002).

The theoretical roots (as discussed above) of grounded theory are suited to the present study in that process, social interaction and meaning appear to play an important role for those who cut themselves. In order to understand the meaning of self-injury to the people who engage in it, it was important to try to see the world as perceived by them (Blumer, 1969). Glaser (1978) explains that the purpose of grounded theory is “to account for a pattern of behaviour which is relevant and problematic for those involved” (p. 93); thereby fitting the aim of this study because experiencing and coping



with self-injury is a pattern of behaviour which causes difficulties for the people who engage in it.

Benoliel (1996) conducted a search of grounded theory journal articles and research reports and found that generally they focused on the social psychological processes of individuals who were going through significant changes in their lives. Similarly Schreiber (2001) recommends that grounded theory is “useful when we want to learn how people manage their lives in the context of existing or potential health challenges” (p. 57). Schreiber comments that through using grounded theory researchers can learn how people understand and cope with what has happened to them over a period of time and in varying circumstances. Examples of such studies which mainly focus on health issues include: coping with profound hearing impairment (Hallberg et al. 2000), spiritual dimensions of people with terminal cancer (Thomas & Retsas, 1998), women who repeatedly acquire sexually transmitted diseases (Redfern-Vance & Hutchinson, 1995), and cue sensitivity in women living with cardiac disease (Miller, 2000).

Furthermore, McCann and Clark (2003a) highlight the utility of grounded theory for exploring people who share similar illness experiences which are at times not understood by themselves or other people, for example mental illness. With its focus on process, meaning and experience grounded theory is therefore appropriate for exploring the lives of people who cut themselves in terms of how their behaviour varies over time. For example, how they cope and respond to the day to day experiences of being someone who self-injures and furthermore what cutting means in their lives.



### *Why Strauss and Corbin (1998)?*

Wilson and Hutchinson (1996) report that researchers are now obliged to identify which grounded theory method they choose to follow, whether it be the original 1967 Glaser and Strauss version, the 1990 (or the more recent 1998) Strauss and Corbin version or the 1992 Glaser interpretation. In contrast, Annells (1997b) suggests that researchers should not be limited to these choices and she provides a few more options for them to consider. One suggestion involves combining the procedural steps of the original Glaser and Strauss (1967) version with that of Strauss and Corbin, for example adhering to Strauss and Corbin's form of coding, memoing and theoretical sensitivity but choosing a theoretical coding family from Glaser (1978). Annells (1997b) states that there are many variations available within this option.

Melia (1996) is a well-established grounded theorist, who also teaches the method. She claims to belong to the Glaserian school, however she states that she has on occasion recommended that her students consult the procedure-oriented works of Strauss and Corbin to assist them in comprehending the intricate details of grounded theory. Melia (1996) confesses that she always has a few reservations about encouraging her students to consult the work of Strauss and Corbin because she finds their method too restricting with its volume of categories, subcategories, properties, dimensions and array of rules. However, Melia (1996) also acknowledges that her initial impression on first reading Strauss and Corbin (1990) was that it was very similar to Glaser and Strauss (1967) except that it was perhaps set out more clearly for the benefit of researchers new to grounded theory. However it was only when she became aware of Glaser's criticism in

which he argued that Strauss and Corbin (1990) had developed a completely different method that she reconsidered her feelings towards the more technical nature of their approach.

This study followed Strauss and Corbin's (1998) method of grounded theory because it was felt more suitable for meeting the practical needs of the study. Strauss and Corbin's approach provides a structured, comprehensible and practical set of guidelines compared to Glaser & Strauss (1967) which is less explicit. Although aware of the criticisms levelled at Strauss and Corbin (1990), it was anticipated that their method would provide an appropriate level of accessibility. In adopting this approach some of Strauss & Corbin's (1998) analytical procedures were utilised, though not rigidly, providing a means of ensuring progression and rigour without restricting dialogue with the data during analysis. In the words of Strauss and Corbin (1998), "Techniques and procedures are tools only. They are there to assist with analysis but never should drive the analysis in and of themselves" (p. 58). In addition, the underlying philosophical perspectives of Strauss and Corbin (1998) fitted with this study. Strauss & Corbin's work is reflective of the constructivist paradigm in that they consider theory to be jointly constructed or developed by the researcher and the participants instead of it emerging from the data (Annells, 1997a). Strauss and Corbin (1994) describe their work as interpretive and that these interpretations must incorporate the perspectives and voices of the study participants. In order to comprehend the behaviours or actions of a collective group of participants, interpretations are sought, and researchers must accept responsibility for interpreting what is heard, read or observed (Strauss & Corbin, 1994).

They explain that, “As researchers we are required to learn what we can of their (the participants) interpretations and perspectives. Beyond that, grounded theory requires, because it mandates the development of theory, that those interpretations and perspectives become incorporated into our own interpretations (conceptualisations)” (p. 280). This is ultimately how findings are therefore presented.

### **Research Method**

The design of the present study developed with a great deal of consideration given the sensitive nature of the research area, and this had implications for the final shape of the study and how it was carried out. There are various definitions in the literature as to what constitutes a “sensitive” research topic. Interestingly the term, ‘sensitive’ is also used quite loosely as if its meaning was obvious to the reader in the absence of a definition (Lee and Renzetti, 1990). Lee and Renzetti (1990) define a sensitive topic as “one which potentially poses for those involved a substantial threat, the emergence of which renders problematic for the researcher and/or the researched the collection, holding, and/or dissemination of the research data ” (p. 512). Examples of research areas which this definition would cover are; bereavement, marital problems, deviance, mental illness and terminal illness. The sensitive nature of these research topics is clear. However another view is that most research could be perceived as sensitive to the individuals involved (Sque, 2000), in keeping with Lee and Renzetti (1990) who claim that depending on the context, any topic could be considered sensitive.

In terms of the present study, the topic of 'self-cutting' was regarded as sensitive because this behaviour is often kept hidden from other people (Pembroke, 1994; Harrison, 1995; Herpertz, 1995; Spandler, 1996) implying that it is an area of experience which people who self-injure find difficult to disclose to others.

Furthermore, people who self-injure have often suffered distressing life events or are susceptible to low moods which increases their risk of harm when participating in a study. Not surprisingly it was felt there was a high chance that participants could have found describing their experiences to be emotionally painful.

The meaning which the term 'sensitive topic' had for the present study is similar to that of Brannen (1988) who highlighted how research on sensitive topics differs from other types of research. Firstly, the risk of participants being identified in written work related to the study, not only by themselves but by others too and this is because the data is usually highly personal and unique. Secondly, related to the identification issue is the possibility of stigma, and thirdly there is the risk that participants will find sharing their experiences with a stranger to be quite stressful (Brannen, 1988). To minimise the risk of harm to the participants in the study a number of strategies and support systems were implemented in line with recommendations from both the University Departmental Research Ethics Committee (DREC) and the Local Research Ethics Committee (LREC). It is appropriate at this point to outline these ethical issues before describing the research design to give an appreciation of the complexities that were involved in designing the study.



### *Ethical Considerations*

Research on sensitive topics can raise important ethical issues which are often very complex. This was the case with the present study and the process of obtaining ethical approval took much longer than initially anticipated. This section firstly examines the main ethical considerations that were initially identified as important and the measures taken to address these issues are described. The process of applying for ethical approval is then outlined, highlighting the difficulties encountered and how they were eventually overcome.

### *Anonymity*

In any research study the issue of anonymity is important for protecting the identities of the participants. This was particularly pertinent in the present study given that self-cutting is an act which is usually concealed from others. Using code numbers instead of the names of participants on any written material relating to the study ensured anonymity. Both the transcriptions of the interviews and the labels on the interview tapes contained code numbers instead of participants' names. Furthermore, documentation linking participants' names with their assigned code numbers was stored on a computer file and the computer was password protected. Holloway and Wheeler (2002) state that the researcher should be the only person who can link the participants' names and identities with the tapes or written findings. Morse (1998) reports that it is becoming more common for participants in qualitative studies to reject anonymity in favour of having their contribution acknowledged. In this situation it is important for researchers to ensure that participants understand the implications of revealing their



identity. None of the participants in this study expressed a wish to have their identity revealed.

### Confidentiality

It is crucial to for all personal data to be kept confidential as the main form of protection against unwanted disclosure (Christians, 2000). In order to ensure confidentiality the interviews were personally transcribed and the audiocassette tapes and participant data were stored in accordance with the Data Protection Act (1998) in a locked filing cabinet. In qualitative research the words of participants are used as data, so full confidentiality cannot be guaranteed (Morse, 1998: Holloway & Wheeler, 2002). Ramos (1989) recommends that researchers should consult the participants if there are doubts over whether or not highly sensitive material should be made public or not. Participants were informed in the participant information sheet (see Appendix 1) that a written report would be produced in relation to the study, but that their names would not be linked to the information and code numbers would be used instead. On the basis of the above information the participants could decide whether or not they wanted to take part in the study.

### Informed Consent

Participant information sheets (see Appendix 1) explained the purpose of the study, the participants' rights, the possible advantages and disadvantages of taking part and the format of the interview were given to potential participants via gatekeepers. In order to make an informed decision about taking part in a study, participants need sufficient information about the aim of the study, the nature of their involvement, the risks and

benefits of taking part (Lipson, 1994). The informed consent process is situated within the principle of autonomy which states that participation should be voluntary and that participants should be aware of how taking part in the study could affect them (Holloway and Wheeler, 2002). It cannot be assumed that all people who are vulnerable or have a mental illness have reduced decision-making capacity for participating in research (Usher & Holmes, 1997).

If potential participants expressed an interest in taking part in the study, arrangements were usually made either directly or through a gatekeeper, to have an introductory meeting with them usually one week before a potential interview. The aim of the introductory meeting was to go through the participant information sheet with the participants, explain the study in more detail, outline the participants' rights and give them the opportunity to ask questions. An important aspect of the meeting was that the participants were given the chance to assess my personality and determine whether they would feel comfortable talking to a stranger about their personal experiences. A third party such as a support worker or nurse often introduced the participant and the three of us would engage in conversation until the participant felt comfortable to be left alone in my company. A good rapport was usually built up at the pre-interview meeting both through general conversation and research talk and this helped to lessen participants' anxieties about the study.

Informed consent was requested from the participants and the interviews only occurred if participants reported that they understood and agreed with the terms, and gave their

signature. They also had the right to withdraw at anytime and did not have to give a reason. The participants were given the opportunity to take their time in deciding whether or not to take part and they could discuss any questions with an independent advisor if they wished. Usually the participants wanted to sign the consent form (see Appendix 2) at the pre-interview meeting and a date was then organised for the interview. It was made clear to participants that this did not mean that they had to participate in the study.

On the day of the interview, the study was explained to the participants once more and their consent to take part was again requested. Qualitative research is flexible in nature so informed consent should be a continual process, allowing for re-negotiation if unexpected events should occur (Munhall, 1988). Participants had my contact details in case they needed to discuss in the months after interview any fears or worries about their interview data however this situation did not arise. Where pre-interview meetings had been possible, the participants had an idea of what to expect and more importantly who they were meeting on the day of the interview. The pre-interview meeting was also of personal benefit in terms of getting to know the participants. For example, some participants had opened up without prompting during this meeting and this gave an idea as to how the interview might progress. Pre-interview meetings were not always possible because some of the participants preferred to take part in the interview the day they first met me, but usually under these circumstances they had already discussed participation with either their support worker or community psychiatric nurse. A pre-interview meeting still took place in that I spent some time immediately

before the interview speaking to the participant either in a coffee room or with a third party present such as a nurse or support worker until such time as the participant felt relaxed.

### Support for Participants

There is a high chance of emotionally vulnerable people experiencing distress whilst telling their stories in an interview situation (Brannen, 1988). It was therefore explained to the participants both in the pre-interview meeting and in the information sheet that there was professional support available for them if they became upset during or after the interview. Participants were also made aware both verbally and in writing that if it became apparent during the interview that they were a risk to their self or others, contact would be made with the appropriate service in order to get professional support for them. Informing participants that they may become distressed and making provisions for follow-up intervention are common ethical activities (Cowles, 1988). A Mental Health Liaison Nurse offered to undertake the role of support person for the study participants given his extensive clinical experience of working with people who have cut themselves. Researchers are usually advised to request help from colleagues who can provide support and counselling to participants who are upset (James and Platzer, 1999). If participants had accepted the offer of support then they would have been given the option of receiving support from a professional whom they were already in contact with such as a community psychiatric nurse, or from the support person for the research study.



Fortunately none of the participants found the interview to be a distressing experience and there was no need to arrange professional support. Several participants stated that they enjoyed being listened to and speaking to someone who understood about self-injury and furthermore some participants hoped that their responses would educate people about self-injury. Hutchinson et al. (1994) reported the benefits of participating in research interviews through looking at a large number of qualitative studies. They found that catharsis, self-acknowledgement, sense of purpose, self-awareness, empowerment, healing and providing a voice for the disempowered were the main positive aspects (Hutchinson et al. 1994).

### Support for the Researcher

It is not only the participants who could become upset and need support after taking part in a research interview; the researcher is also at risk. Due to the sensitive nature of the research topic it was deemed important that in addition to the participants, a personal support system was made available. Interviewing vulnerable people often involves listening to in-depth accounts of distressing life events (Anderson & Hatton, 2000) and indeed this was the case with the present study. Novice researchers need to be aware of the emotional pain that they may suffer as a result of fieldwork (Dunn, 1991). From her experiences of interviewing people with depression, Moyle (2002) highlights the importance of debriefing, emphasising the need for support not only after interviews but during the many hours spent transcribing and analysing data. In the present study, two supportive colleagues were available for debriefing and it was a relief to know that they were available to confide in if needed. Cowles (1988) found



that having the opportunity to debrief with a few of her colleagues was the most effective way of dealing with her emotions in relation to the sensitive topic she was researching. In the present study reflective writing was the other strategy which helped in coping with the distressing nature of the interviews. After each interview thoughts and feelings were recorded in a journal and this helped to release the emotional burden of the interview, illuminating the issues which had the most emotional impact. Dunn (1991) also benefited from reflective writing in helping her ventilate her feelings and she recommends researchers use this strategy after each interview. The issue of reflexivity will be discussed more fully at the end of this chapter, highlighting further the impact of the research on the researcher.

The above information was incorporated in a proposal which was submitted to the Departmental Research Ethics Committee. The feedback received from the committee included some recommendations and requests for clarification on a few issues which impacted on the timeline of progress.

### Disclosure of Sexual Abuse

The most important issue which the committee raised involved devising a strategy for dealing with the disclosure of sexual abuse. Given that histories of sexual abuse are prevalent in people who self-injure, some thought had been given to the issue, but the implications of such a disclosure had not been operationalised in the design over and above the acknowledged need to pass on 'risky' information. It was timely that the suggestion was made by the DREC and contact was subsequently made with a number

of international researchers who would have possibly come across such a situation in their research activity. They provided helpful advice which was incorporated into the strategy. Discussions also took place with various healthcare professionals who had experience of dealing with victims of sexual abuse. From the information and advice received, the following strategy for the disclosure of sexual abuse was devised:

**Figure 3.1: Strategy for Dealing with Disclosure of Abuse**

- I will share my concerns with the participant and offer support for the person to seek help from the appropriate service.
- If they would like me to notify the appropriate service then I would try to do this there and then in the presence of the participant.
- If participants do want support then I would refer them to a Mental Health Liaison Nurse who has great experience of which services are available in the local community for people who have been abused.
- If the participant refused support and did not want me to disclose the abuse then I would leave contact information (e.g. telephone helplines) in case of a change of mind in the future, and I would respect such wishes and take no further action.
- If the person is a child under law – i.e. under 18 years old then I would have to report the situation, however this study is only recruiting participants aged 18 years and over.
- It is important that participants do not feel that control is being taken away from them, and they will be given the respect they deserve and kept fully informed. The decision regarding disclosure of sexual abuse will ultimately rest with the adult participants concerned.

The amendments were submitted to the DREC and the application for ethical approval was granted. Ethical approval then had to be sought from the LREC. Apart from the requirement to create a separate consent form (see Appendix 3) for the tape-recording of interviews, concerns over safety and legal issues dominated the response from the LREC and the issues raised were as follows:

### Personal Safety

The committee expressed concerns about personal safety when conducting interviews and suggested that there was an increased risk if interviews were conducted in locations such as the participants' homes. Whilst consideration had been given to the needs of the participants, my own needs had perhaps been neglected. It was important to hold the interviews in a location which was comfortable and non-threatening for the participants, and the participants' homes had been suggested on this basis. It had not been anticipated that there would be any real threat to my safety by entering the homes of participants but this was a concern for the committee. There were also implications for confidentiality as participants might want to keep their self-cutting behaviour a secret from the people they live with. There may be issues between family members, so perhaps interviewing in the home might not be a safe or private option for them either. Smith (1992) suggests that interviews which are held in participants' homes pose a greater risk to a researcher's personal safety than those conducted within a hospital or community facility, where help and support are usually available if needed. Kenyon and Hawker (1999) report that researchers often use avoidance strategies in order to

limit risk, for example not interviewing in the home and instead choosing institutional settings where people are around if help is needed.

Furthermore, Paterson et al. (1999) report that inexperienced researchers who are new to the field are more at risk than those who are very familiar with field research, because they do not know what to expect. This situation was very relevant in the context of the present study but through discussions with experienced researchers, an appreciation of the risks involved in interviewing was gained. In response to the LREC's concern over personal safety, a discussion took place with both supervisors and while not in full agreement regarding the level of risk, a safety protocol was designed. The safety protocol was as follows:

**Figure 3.2: Personal Safety Protocol**

- Interviews will be conducted in a private room at a clinical site, voluntary organization or at the University Campus. By doing this, healthcare professionals, support workers and experienced researchers will be close at hand in case their help, support or advice is needed either during or after the interview.
- My supervisor, a colleague, a support worker or a healthcare professional will be informed of the time which the interview will start, the location, the expected duration of the interview, and contact will be made with them when the interview has finished.
- A mobile phone will be carried in case of emergencies.



Although the perceived risk of personal safety was small it was still important to consider “worst case scenarios” and know how to handle them if such difficult situations did arise. Kenyon and Hawker (1999) note that the safety of lone researchers is largely neglected in the literature in that there are very few references to the use or development of safety protocols for researchers (e.g. Parker & Ulrich, 1990; Paterson et al. 1999; Langford 2000). Craig et al (2002) have developed a draft code of practice for the safety of social researchers which includes four main areas: assessment of the situation, prevention strategies, identifying and responding to a threat and follow-up. They suggest that researchers use such a protocol because at present there are few guidelines available which give advice to researchers on how to prevent or handle threatening situations.

#### Legal Implications of Disclosure of Sexual Abuse

Although a strategy had been developed for dealing with the disclosure of sexual abuse, the LREC recommended that the legal implications of such a revelation needed to be explored further. Discussions were held with healthcare professionals and experienced researchers and from these discussions the legal implications relating to the study were established:

- The legal definition of ‘who is a child’ is dependent on particular circumstances. According to the Children (Scotland) Act 1995, a child is defined as a person under the age of 18 years old. Therefore to avoid complex legal and moral issues it was decided to increase the minimum age for inclusion in the study from 16 years to 18 years old.

- There is no legal obligation in Scotland to report child abuse, however the Children (Scotland) Act 1995 is founded on a number of principles including, each child has the right to protection from all forms of abuse, neglect and exploitation.
- Certain professions for example education, and the health service, implement their own policies on the issue of reporting cases of sexual abuse.

In light of these legal principles the following protocol was designed:

**Figure 3.3: Updated Protocol for Disclosure of Sexual Abuse**

- Prior to giving consent, participants will be informed both verbally and in writing that confidentiality will be maintained except where there is concern for the safety or well-being of the participant or others e.g. children. This point will also be reiterated to participants prior to the commencement of the interview.
- If worrying information about the participant is discovered, e.g. victim/survivor of abuse and no one else knows about it then the participant will be informed of the concern and will be advised to seek support. If the participant refuses then his or her wishes will be respected, however the participant will be provided with contact numbers (e.g. telephone helplines) in case of a change of mind.
- If the participant reveals that he or she knows of a child who is at risk, then the participant will be informed that advice is going to be sought on the matter, and the authorities, for example social work or police may get involved.

Incidentally, no action had to be taken in relation to disclosure of sexual abuse.

Parker and Ulrich (1990) advise researchers to be aware of the law in relation to reporting abuse and to make sure that participants understand the implications of such a disclosure. In the present study it was difficult to establish a clear-cut answer from a variety of professionals regarding the reporting of abuse. It was through talking to a number of different organisations and professionals that a clearer picture began to emerge. This position appears to be in contrast to that of the United States where guidelines for researchers in relation to disclosure of abuse, appear to be more definitive than in the United Kingdom. Anderson and Hatton (2000) explain that Institutional Review Boards (US equivalent of research ethics committees) require researchers to include a clause in the informed consent form which states that they have a legal obligation according to mandatory state laws to report disclosure of current abuse of children, adults and the elderly.

#### Approval from Local Primary Care NHS Trust

The LREC suggested that because of the legal and safety implications of the study, approval should be sought from the local Primary Care NHS Trust. The Trust wanted to know what arrangements had been made for indemnifying all the people who would be involved in the study (the participants and the researcher). It was established that indemnity insurance ought to provide cover if any participants made a claim against me for whatever reason, and also conversely if I came to harm as a result of the actions of a participant. In response to the comments from the Trust, the LREC therefore requested that arrangements be made for indemnity insurance, and ethical approval was

subsequently granted on receipt of the appropriate insurance cover. Although the process of applying for ethical approval took approximately five months and was more complicated than expected, it was a valuable learning experience

### *Sampling Issues*

Researching a sensitive topic like self-cutting has the added problem of identifying participants who are willing to talk in-depth to a stranger about personal experiences which are often distressing. The sample of interest in the present study could be described as 'hidden' and 'hard-to-reach' and a great deal of thought was given to finding the optimum way for identifying potential participants. Self-cutting is usually a very private act and people who engage in the act appear to conceal their behaviour from others (Solomon & Farrand, 1996; Spandler, 1996; Arnold, 2000). Faugier and Sargeant (1997) report that sampling is likely to be more difficult, the more sensitive the research area is as there is a greater likelihood that potential participants will hide their activities. Examples of such participants include prostitutes and people who are addicted to drugs. The difficulties in obtaining access to participants obviously had implications for the sampling strategy adopted for the present study.

Theoretical sampling is the strategy of choice in grounded theory. Strauss and Corbin (1998) define theoretical sampling as "data gathering driven by concepts derived from the evolving theory and based on the concept of 'making comparisons,' whose purpose is to go to places, people or events that will maximise opportunities to discover variations among concepts and to densify categories in terms of their dimensions or



properties” (p. 201). In reality however, the sampling strategy which is most often employed by new, inexperienced researchers involves a very systematic approach where researchers often work through a list of potential participants/locations and accept whoever agrees to take part (Strauss & Corbin, 1998).

### Sampling in the Real World

As was the case with the present study, researchers usually find that it is often difficult to conduct a study in the ideal way and they often have to settle with what is considered the practical way (Strauss & Corbin, 1998). Due to the difficulties in finding people who were willing to take part in the study it was not possible to be as selective as initially anticipated about whom and from where participants were recruited. It would have been unrealistic to expect unlimited access to people who self-injure given the sensitive nature of the research area, and coupled with the strict ethical requirements, this was not attempted. Chiang (2001) also demonstrates a need to maintain methodological rigour coupled with an element of compromise in order to satisfy the ethical requirement of protecting vulnerable individuals. Coyne (1997) acknowledges that in a grounded theory study, initial sampling is purposeful where the researcher knows where to sample. In the present study sampling was however a mixture of:

- *Purposeful* – recruitment focused on places where people who self-injure were likely to be found, such as hospitals, community mental health team, mental health voluntary organisations, service-user groups. Sandelowski (1995) explains that in purposeful sampling, individuals participate in qualitative studies mainly by having experience and knowledge of an event such as illness, pregnancy or in the case of

the present study, self-cutting. Sampling is not based on demographic features of individuals unless for example age or gender emerge as an analytic variable (Sandelowski, 1995).

- *Snowball* - Although snowball sampling was attempted as a strategy for finding participants none of those who took part were recruited as a result of this technique. Faugier and Sargeant (1997) suggest that snowball sampling might be the only practical option for researchers studying hidden populations however this was not the case in the present study.
- *Theoretical* - Despite adopting a practical approach to sampling, rigour during analysis is crucial with capacity to make comparisons on the basis of concepts (Strauss and Corbin, 1998). Due to ethical and practical reasons there were no opportunities to sample specific people or locations according to the developing theory; however it was still possible to carry out a form of theoretical sampling whereby emerging concepts were explored with each new participant who came along. Furthermore in keeping with Strauss and Corbin (1998) it is not the participant who is the focus of sampling, but incidents or events. Strauss and Corbin (1998) report that in their experience, differences in data often evolve naturally and this is due to the natural variations that occur in various situations. Despite the need for compromise in selecting participants, the sample (described below) composes a variety of participants from different locations, with a differing range of backgrounds and experiences of cutting. Given the variation among the participants' experiences, potential existed for emerging categories to be explored within different contexts and for comparisons to be made between incidents and

categories. This in turn helped in identifying new properties (characteristics) of the categories. As Strauss and Corbin (1998) state, “when it comes to events and incidents, rarely will a researcher find two or more that are identical. Rather, there nearly always will be something different – be it conditions, actions/interactions, or consequences – that will provide the basis for making comparisons and discovering variations” (p. 210).

### **Inclusion Criteria and Sources of Recruitment**

The inclusion criteria for the study were people aged 18 years or over who engaged in self-cutting. Morse (1991) states that in addition to participants having experience of a certain phenomenon (e.g. self-cutting), interviewees should be able to reflect, critically examine and speak in detail about their experiences. Furthermore they must be willing to open up to the interviewer. Morse (1991) believes that interviewees who possess such features are ‘good informants’. The following table outlines the main recruitment sources and the procedure involved in recruiting participants for the present study. Out of the variety of recruitment sources detailed below, the participants in the study were recruited from a psychiatric hospital, mental health service user groups and voluntary organisations, although the community mental health team acted as a gatekeeper to potential participants. The recruitment period lasted for approximately 14 months interwoven with data collection and analysis.



**Table 3.1: Recruitment Sources and Procedure**

<b>PROCEDURE</b>	<b>SOURCE OF RECRUITMENT</b>	
	<b>Healthcare Professionals (HCP)</b> Community Psychiatric Nurses Community Mental Health Team Mental Health Liaison Nurses Psychiatrists Accident & Emergency Psychologists	<b>Service User Groups/Voluntary Orgs.</b>
<b>Step One</b>	Letters and study info sent to HCPs	Posters/letters/study info advertising study and inviting participation sent to user groups and voluntary orgs
<b>Step Two</b>	HCP informs patient/client about study and asks if they would like to speak to me about the study.	Support workers/project managers inform users about study and ask if they would like to speak to me about study.
<b>Step Three</b>	If patient/client gives consent to speak with me, HCP will contact me to arrange introductory meeting.	If users are interested they can contact me directly or request support worker to set up introductory meeting.
<b>Step Four</b>	Meet patient/client to discuss study e.g. what participation will involve and explain the rights of the participant.	Meet user to discuss study e.g. what participation will involve and what the rights of participant are.
<b>Step Five</b>	Client/patient given time to decide and opportunity to contact independent advisor if necessary.	User given time to decide and opportunity to contact independent advisor if necessary.
<b>Step Six</b>	Patient/client decides either not to take part or signs consent form and date is arranged for the interview.	User decides either not to take part or signs consent form and date is arranged for interview.
<b>Step Seven</b>	Interview takes place.	Interview takes place.



## Characteristics of the Participants

The study took place in the Highlands of Scotland and ten people who self-injure formed the sample. The following characteristics describe the participants:

*Gender:* Six women and four men participated in the study.

*Age:* The participants were aged between 29 and 40 years old. The mean age of participants in the study was 35.3 years.

*Marital Status:* Four of the participants were married, four were single and two were divorced.

*Employment Status:* Most of the participants were not in employment. Four participants stated they were unemployed, two described themselves as homemakers, three reported that they were not fit to work and only one participant was employed full-time.

*Age of onset of self-injury:* The age at which the participants first self-injured ranged from 9 to 37 years, and the mean age was 18.4 years.

## Recruitment

A number of sampling problems were encountered in the present study. This was not surprising given the hidden nature of self-cutting behaviour and the fact that it is a taboo subject which most people will avoid talking about. In this study it took a considerable length of time to find participants who expressed a willingness to share their experiences and who subsequently went on to take part in an interview, and this is similar to Chiang (2001) who took 2 months to recruit her first participant. For example, in the present study the first three potential participants identified did not take

part in the study. Following initial contact, one participant had taken part in a pre-interview meeting where he had given consent to take part and a date had been arranged for the interview, however the person did not attend at the agreed location. It emerged that various personal issues had prevented the person from attending and that it had been a particularly difficult period of time for that person. A decision was then made by the person to withdraw from the study. Although this was disappointing, this emphasised how difficult life can be for people.

Further on in the recruitment process another potential participant decided to cancel the interview after a seemingly positive pre-interview meeting. This person was an inpatient in a psychiatric hospital and she did make clear at the pre-interview meeting that if she did decide to withdraw then I was not to think it was because of anything I had said or done. She informed me that she could not predict how she would feel on the morning of the interview and asked me to phone the ward to find out whether she still wanted to participate. Indeed this participant did not feel up to taking part and it was left up to her to make contact either directly or through her primary nurse if she changed her mind however no contact was made. This demonstrates insight on the participant's part as to how cutting and her mood can affect her and the amazing concern she showed for the researcher. Given the recruitment problems it was necessary to widen the geographical area from which to recruit potential participants, a strategy which proved successful.

In addition to the vulnerable state of people who self-injure causing withdrawals from the study, one other recruitment issue centred on the strict ethical guidelines which were adhered to, to protect the participants. Two potential participants were excluded from the study because they would only participate if the interview could take place in their home. This was understandable because their home environment would probably make them feel more comfortable and relaxed. Unfamiliar surroundings could add to their anxieties about taking part in the interview. Unfortunately the local research ethics committee would not give approval for interviews to take place in the homes of participants partly due to concerns about safety.

### **Data Generation**

An important feature of a grounded theory study is that data generation and analysis do not occur in a linear fashion but instead the researcher alternates between the two processes (Strauss & Corbin, 1998). For example, the first few interviews or observations are analysed before conducting more interviews or observations proceeded by further analysis (Strauss & Corbin, 1998). This results in more refined data analysis and provides a focus for data generation (Olshansky, 1987). The process of theoretical sampling, as explained above, is a feature of data collection/analysis because the analysis and the emerging theory guide sampling.

### *Unstructured Interviews*

It was decided to use in-depth, unstructured interviews as the main source of data in this study due to the sensitive nature of the topic. Fontana and Frey (2000) describe



interviewing as “one of the most common and powerful ways in which we try to understand our fellow human beings” (p. 645). Milliken and Schreiber (2001) suggest that for highly personal and sensitive issues like sexual abuse individual interviews may be the optimum method of data collection. In the present study it was felt that it would be more empowering for participants if they were given the opportunity to talk freely about their self-cutting at their own pace as opposed to facing a series of structured questions. Furthermore, unstructured interviews are very flexible and enable researchers to explore new areas as they emerge during the interview. Occasional probing questions were asked in terms of seeking clarification or further understanding about a particular issue, or for the purpose of keeping the participant focused.

Observation was not appropriate for this study because it was not practical and more likely that ethical approval would not have been granted to observe people who self-injure in their natural environments, for example in a psychiatric hospital or in their own home. In a hospital setting it would not have been obvious which patients were cutting themselves as usually the behaviour is kept hidden, and it would have been unethical to ask the staff for this information. Furthermore given the vulnerable nature of this group of people it would have been potentially distressing for them to have a stranger watching them interact in the hospital environment. Nonetheless notes were taken about interesting observations such as the participants’ non-verbal behaviour during the interview or the setting in which the interview took place. The notes were always recorded as soon as possible after the interview on specially designed documents (see Appendix 4). This information provided a clearer understanding of the



context of the interview situation. Strauss and Corbin (1998) suggest that the types of data chosen for inclusion in the study should have the greatest potential to yield the types of information required.

### *Interview Training*

Carrying out in-depth interviews can be challenging, particularly for novice researchers (Roulston et al. 2003) and furthermore, given that the qualitative researcher is the instrument in an interview context, the knowledge, sensitivity and empathy of the interviewer has the potential to determine the outcome of the interview (Kvale, 1996). For these reasons it was decided that it would be beneficial to receive training in interviewing techniques. This was carried out in the form of role-play with an experienced mental health liaison nurse which helped increase understanding of the importance of phrasing questions in certain ways in order to yield fuller, richer information, instead of one-word answers. There was also an opportunity to shadow the mental health liaison nurse while he interacted with patients in vulnerable states. This was an invaluable experience in terms of understanding how to engage with a person who is emotionally fragile, both in knowing what “warning” signs to look for, and what body language is most effective and non-threatening when interacting. Anderson and Hatton (2000) identify being a sensitive, willing listener as important factors when interviewing people who are vulnerable. In relation to this, although having minimal clinical experience, being a good listener, empathic, understanding and sensitive to the needs of others, all of which are important qualities in an interviewer, are personal attributes which have developed through personality-shaping life

experiences. It is crucial to remember that counselling the participants was not my objective or role, nevertheless the interpersonal skills I possess helped to create an equal and trusting relationship with participants.

### *Demographic Information*

Demographic information was collected from the participants at the beginning of the interview because it was anticipated that this would help them to relax. The information requested from each participant was their age, sex, marital status, employment status, and age of onset of self-cutting, providing a profile of the sample.

### *Interview Guide*

Although the interviews were unstructured some general guidelines were followed, for example the interview began with a single and open question like, "I am interested in cutting and what this means for you. Can you tell me about the events or circumstances within which this occurs?" This type of question prompted respondents to open up the world of cutting. On the advice of Strauss and Corbin (1998) efforts were made to use questions which began with the following phrases; "Tell me what you think about....?" "What happened when....?" and "What was your experience with....?" They state that such questions give participants more scope to respond in terms of what is important to them (Strauss & Corbin, 1998). Usually most of the participants started the interview talking about the first time they cut themselves and then told their story from that point to the present day. Morse (2001) discovered that unstructured retrospective interviews, in which participants tell their stories in a sequence from start to finish, are a natural



foundation on which processes may be identified by the researcher. Morse learned that continuous narrative data are essential in incrementally constructing the processes and strategies required to develop a grounded theory. The researcher aims to follow the main problems or perspectives of the participants (Wimpenny & Gass, 2000) however an interview guide (see Appendix 5), which had a short list of general areas of interest, was used if the conversation exchange slowed during the interview. Schreiber (2001) advises novice researchers to have an interview guide to refer to in case of forgetfulness or nervousness, a situation which was occasionally experienced in the first few interviews in the present study. The interview guide was checked at the end of the interview to see if everything had been covered and if not then the topics were raised with the participants. Schreiber (2001) explains that this prevents researchers from using their own agenda or imposing their structure on the data.

The interview guide changed as the study progressed in that the questions became more focused in relation to emerging categories. Indeed, Glaser and Strauss (1967) point out that at the beginning of the research, the interviews usually take the form of open-ended conversations, and the researcher often just listens while the participants tell their stories. However, as the research progresses, interviews and observations are guided by the developing theory, and the researcher may ask direct questions relating to the categories. For example when it became apparent that the 'urge to cut' was an important experience for participants, questions relating to this were introduced into the interviews. Often it was the case that participants would bring up the 'cutting urge'

when talking about their experiences and it was at this point that the questions would be asked.

### *Recording Interviews*

The interviews were tape-recorded with the permission of the participants, and then transcribed for data analysis. It was thought that taking notes during the interview as opposed to tape-recording would perhaps make participants feel uncomfortable and disrupt the conversation exchange. There was also the concern that illuminating phrases and contextual information would be missed if the interviews were not tape-recorded. Opinion appears to be divided in relation to tape-recording research interviews. In keeping with the present study Schreiber (2001) prefers to use a tape-recorder because she finds it distracting to take notes during an interview and furthermore she feels she would lose important detail if she relied solely on note-taking. Similarly, Morse (2001) feels that by not using a tape-recorder, researchers are limiting their opportunities to use participant quotations and therefore the ability to truly ground the study.

On the other hand Stern (1985) found short note-taking to be her preferred strategy for recording data and she would write down key words and phrases during the interview, and then as soon as possible after each interview she would type up the data from her notes and memory. She feels that taping an interview is both a waste of time and resources because it can cost money to hire a typist and much of the transcribed data will be unimportant and meaningless parts of the conversation (Stern, 1985). The tape-



recorder used in the present study was small and did not appear to make the participants feel uncomfortable. The first interview was a learning experience in that it was not realised that the tape would not make a noise to indicate the end of the first side of the tape. As a consequence approximately ten minutes of the interview were not recorded. Notes were made about these ten minutes from memory after the interview. In subsequent interviews it was possible to avoid this problem again.

### **Closing the Interviews**

The interviews usually finished with the question “Is there anything else you would like to tell me?” and this gave the participants the opportunity to offer more information about their experiences or conversely they could decide to end the interview. The participants were also asked how they were feeling and how they found the experience of participating in the interview. The comments were all positive and some participants said they were surprised to find that they had enjoyed talking about their experiences. Efforts were made to make sure the interview ended on a positive note and time was spent talking to the participant, often about general conversation topics after the tape had stopped recording.

### ***Setting for the Interviews***

The setting in which the interviews took place is important given that the social context in which the interviews were constructed provides an important backdrop in shaping and interpreting experiences. The majority of the participants were recruited from voluntary organisations for people suffering from mental health problems. Each centre

had a quiet room which was kindly made available to hold interviews for the study. The rooms were an ideal setting because they were familiar to the participants and it perhaps felt like 'their territory' and were positioned away from the main activity of the centre. This was important in terms of privacy and keeping the contents of the interview confidential from other people. A further advantage of the setting was that the staff were available for support if needed for the participants. Three interviews were held in a private room at the university campus and this was because it was more convenient for the participants to meet at this location. Support was available from a mental health liaison nurse who was located nearby if needed. One participant was an inpatient at the local psychiatric hospital and she consented to being interviewed at the hospital. After being introduced to the participant in the smoking room the interview took place in the privacy of the spiritual room.

### *Other Sources of Data*

The research literature is another source of data which can be used in a grounded theory study. In keeping with Hickey (1997) the literature was used when themes emerged from the data and there was a need to clarify certain issues, and questions that arose were then incorporated into further interviews. Strauss and Corbin (1998) emphasise the importance of not letting the literature come between the researcher and the data because this could limit creativity. However they advise that if the literature is not used to drive the theory but is employed as an analytical tool instead, then it can help the process of conceptualisation (Strauss & Corbin, 1998). This process is evident throughout subsequent chapters. Newspaper articles, television programs and websites

which contained information relating to categories were used in the same way as the research literature in terms of finding support for the emerging theory.

### **Data Analysis**


Interviews were personally transcribed to enable immersion in the data, to facilitate familiarity with the issues and problems that were affecting participants and to acknowledge the sensitive nature of the data. Although data were analysed manually for practical and time reasons, I am aware of the advantages of using packages such as NU\*DIST. For example benefits include helping in the indexing of sections of documents, quickly locating words and phrases and retrieving segments of text and their corresponding memos (Buston, 1997). The possibility of using qualitative analysis software in the future is therefore not discounted. Nevertheless it is engagement with the research data which is crucial.

### *Overview of the Analytical Process*

An overview of the analytical process used in this study has been presented table 3.2:



**Table 3.2: Overview of the Analytical Process**

	<b>Analytical Procedure</b>	
Stage 1	Transcription of interviews	<b>Memos</b> 
Stage 2	Listen to tapes and check against transcription	
Stage 3	Open coding carried out through examining transcript line-by-line and writing concepts in the margin	
Stage 4	After coding first few interviews similar concepts collapsed into higher order categories through the making of comparisons. Properties and dimensions are specified (Strauss & Corbin, 1998).	
Stage 5	Further interviews guided by categories from previous interviews as well as remaining open to what participants had to say	
Stage 6	Open coding continues with new interviews. Axial coding begins putting the data back together through making connections between categories and subcategories (Strauss & Corbin, 1998).	
Stage 7	Core category identified and linked to the main categories (Selective coding)	
Stage 8	Further interviews focus on core category and its development and integration with main categories	
Stage 9	Saturation of categories reached after 10 interviews. Two final interviews carried out to ensure saturation and to check findings with participants.	

*Memos*

As illustrated in Table 3.2, memos were written throughout the analysis process starting from initial coding through to the stage at which saturation of categories occurred.

Memos enable the researcher to keep a record of the analytic process, and they are written on separate pieces of paper from the transcripts (Strauss & Corbin, 1998).

Memos were used for noting down thoughts and ideas about the data, for example in terms of the development of categories, their properties, dimensions and subcategories.

Questions about the data were also recorded for use in subsequent interviews. In



addition to their analytical purpose, memos were used to note down practical issues, in relation to interviewing or sampling for example. In keeping with Strauss and Corbin (1998) memos were dated and given headings which indicated the categories or concepts to which they related (Strauss & Corbin, 1998). Memos were stored in a folder which was sectioned according to category. The following figure is an example of an excerpt from a memo written during axial coding when trying to identify the subcategories of the category, Cutting Precipitator:

**Figure 3.4: Example of Memo**

**Memo**

**Cutting Precipitator – 24/08/03**

This memo is about the subcategory of “feeling depressed”. Feeling depressed is undoubtedly a cutting precipitator however there are other emotions and feelings that can lead to a cutting incident. I think it would be better to include these emotions/feelings in one subcategory. The broader subcategory will allow for variation in emotions and will show the range of emotions experienced by people before they injure themselves. I now have to think of a name for the subcategory. Possibilities are emotional feelings, emotions, feelings, and negative feelings.

As explained earlier, data analysis starts during data collection in a grounded theory study. In order to get from the data to the development of a theory, the data have to be coded at a number of levels. It is important to point out that the different levels of coding can be engaged in at the same time, for example some data might be ready to be coded axially whereas other data might be at an earlier stage of development and

require open coding. The following sections describe different levels of coding (open, axial and selective) in relation to the present study, providing examples from the data.

### *Open Coding*

Open coding using line-by-line analysis was carried out on the transcribed interviews and data were closely examined, phrase by phrase. Strauss and Corbin (1998) emphasise the importance of conducting line-by-line coding at the start of a study because it allows the researcher to produce categories quickly and to develop those categories through theoretical sampling. During open coding, words or phrases were underlined in various colours and their matching concepts were written in the right-hand margin in the same colour. The following figure is an example of line-by-line analysis from interview 04 in this study:

**Figure 3.5: Example of Line-by-line Analysis**

Interview Transcript	Open Coding
<p>04: because <u>I was..... and I was sexually abused</u> then  like and so.....i <u>carried it around with me</u> for about 20 years and <u>never</u>  <u>told anybody</u> and then when I first came to X, I was seeing  a woman called X and I started doing this work with her and  <u>talking about it</u> and everything and then she referred me to see a  psychologist and we started <u>doing some work which was quite deep</u>  and it was then that it <u>brought it all back to me.....and I started cutting.</u></p>	<p>suffering sexual abuse  carrying emotional burden  keeping abuse secret  disclosing abuse  talking in-depth  reliving past experiences  starting cutting</p>

Some of the concepts chosen were in the words of the participants (in vivo codes) for example “starting cutting” and others were created because of the meaning or imagery they conveyed, for example “reliving past experiences” (Glaser & Strauss, 1967; Strauss & Corbin, 1998). Generally, open coding involves breaking down the data into distinct parts, closely inspecting these parts, and comparing them for similarities or differences.

As concepts began to emerge and similarities appeared between them, they were grouped together. If events, happenings, objects and actions/interactions are discovered which are conceptually similar in nature or meaning, they are then grouped into ‘categories’ (Strauss & Corbin, 1998). For example through comparing concepts and asking questions such as “What is going on here?” and “What are the participants doing?” I became aware of similarities between certain incidents and feelings in that they all preceded an episode of cutting. Concepts such as “low mood”, “feeling depressed”, “self-loathing”, “feeling angry”, “problems with self and others”, “feeling frustrated” were grouped together into a category which was given the name “Cutting Precipitator”. Each concept had the interview number and page number noted next to it so that the original source and context could be located quickly. Strauss and Corbin (1998) define categories as “concepts derived from the data that stand for phenomena” (p. 114). Once categories are identified it is important to develop them in terms of their properties and dimensions (Strauss & Corbin, 1998)



## Properties and Dimensions

Strauss and Corbin (1998) define properties as “the general or specific characteristics or attributes of a category” (p. 117), and dimensions as “the location of a property along a continuum or range” (p. 117). The following figure is an example of some of the properties and dimensions of the subcategory “Going without Cutting”:

**Figure 3.6: Illustration of Properties and Dimensions of “Going without Cutting”**

<b>General Properties</b>	<b>Dimensions</b>
Stopping Cutting	wanting to stop $\longleftrightarrow$ not wanting to stop
Time without Cutting	months $\longleftrightarrow$ years
Motivation for Stopping	self $\longleftrightarrow$ others

With each new interview, further properties of this category (and others) were looked for in the data because with each extra property and dimensional variation, knowledge about the category was increased (Strauss & Corbin, 1998). The properties and dimensions in Figure 3.6 provided knowledge about the participants in relation to trying to go without cutting. For example some participants expressed a wish to stop cutting whereas other participants did not want to give up the act. Several participants had not engaged in the act for a number of years however for others it was only a few months since their last cutting episode. The motivations for stopping cutting included reasons relating to both the self and others. Strauss and Corbin (1998) state that it is



important to qualify a category in this way through establishing its properties and dimensions because patterns and their variations can be formulated.

After the first few interviews I began to contemplate the important issues which had emerged from the data to date. It appeared as though the participants talked quite frequently and in-depth about the cutting act itself and this suggested that it was something that was very important and meaningful to them. For example categories such as Cutting Process, Cutting Precipitator, Cutting Function, and Physical Consequences of Cutting had all developed from the data. I also found that there was a sense in the data of the struggle or difficulty in terms of being people who engaged in self-cutting and the impact it had on their lives. The categories which were pointing to this included Trying to Cope, Secrecy of Self-Injury, and Urge to Self-Injure. It was decided to pay closer attention to these categories and how they related to each other in terms of the analysis and future interviews, following elements of theoretical sampling.

### *Axial Coding*

The aim of axial coding is to start putting back together the data that were broken down in open coding, through relating categories to subcategories (Strauss & Corbin, 1998). Subcategories answer questions about categories such as where, when, why and how a phenomenon is likely to occur, and this further explains the categories (Strauss & Corbin, 1998). In the present study there was the sense that some of the categories overlapped and that some of them could become subcategories within categories. It was decided to examine the categories more closely to see if any of them had

similarities and could then be collapsed together. This prompted me to look at all the categories related to the cutting act; cutting process, cutting precipitator, cutting function, physical consequences of cutting and post-cutting feeling. It was decided to group them together under a category heading called “Cutting” with cutting precipitator, cutting function, physical consequences of cutting and post-cutting feeling as subcategories. The latter two were combined to create the subcategory ‘suffering the consequences’. These subcategories answered questions about the category of “Cutting” in terms of when it happens, how it happens, and the consequences of it happening. Categories relating to the struggles that the participants faced as a result of being a person who engaged in cutting, (for example, trying to cope, secrecy of self-cutting, urge to self-injure, stopping cutting and keeping well) were then grouped together. These were grouped under the category of “Trying to Cope” and the subcategories answered questions about this category. Furthermore the subcategory ‘secrecy of self-cutting’ was incorporated into the ‘suffering the consequences’ subcategory which included the physical, emotional and social consequences of cutting. “Cutting” and its associated subcategories appeared to be very important and meaningful to the participants and this related to “Trying to Cope” and its subcategories in that they all related to the difficulties of coping with life as someone who engages in self-cutting.

This is what Strauss and Corbin (1998) define as axial coding “the process of relating categories to their subcategories, termed ‘axial’ because coding occurs around the axis



of a category, linking categories at the level of properties and dimensions” (p. 123).

The main tasks involved in axial coding are:

- setting out the properties (characteristics) and dimensions of a category
- establishing the range of conditions, actions/interactions, and consequences associated with a phenomenon
- linking a category to its subcategories through statements indicating how they are related to each other
- searching for signs in the data that indicate how major categories might relate to each other (Strauss & Corbin, 1998).

Although aware of the paradigm which Strauss and Corbin (1998) suggest researchers use to assist with the process of establishing relationships between events and happenings, the data was not approached with the paradigm in mind, so as not to restrict exploration of the data. Parts of the paradigm: context, conditions, actions/interactions and consequences however were incorporated into my thinking in that it is quite natural to identify for example, the consequences of a phenomenon or the conditions under which something happens without specifically searching for them. Indeed Strauss and Corbin (1998) make it clear that their paradigm is basically just a perspective which can be taken towards the data and is supposed to help researchers think about the ways in which the categories are associated with each other (Strauss & Corbin, 1998). Strauss and Corbin (1998) emphasise that the paradigm should not be used in strict ways which prevent creativity, but should instead help to stimulate thinking. Furthermore there are some reports in the literature of researchers

experiencing difficulties when using the paradigm model. For example, Kendall (1999) found that she became so preoccupied with the paradigm that her thinking became restricted to the components of the model instead of exploring the data in relation to her research question. In the present study it became apparent that the participants talked about their experiences in terms of their lives before cutting, lives with cutting and their lives without cutting. The category of 'Cutting' and its subcategories related to the phase, life with cutting and the category 'Trying to Cope' contained subcategories which described the struggle which the participants experienced when trying to live without cutting, for example 'stopping cutting'. and 'urge to self-injure'. The category 'other self-harm' related to the phase life before cutting in that the participants described other self-destructive behaviours they had engaged in before the onset of cutting, but were not conscious of at the time. These issues were explored through further interviews and going back to the data.

### *Selective Coding*

Suspecting that the core experience for the participants had not been pinpointed, prompted the writing of a memo about the categories, with the aim of capturing what was really going on. Thinking kept returning to the 'urge to self-injure' and I realised that the struggle the participants faced in trying to cope with life without cutting revolved around the 'urge to self-injure'. Interestingly right from the beginning of the study, the first participant referred to an 'urge' and reported how he thought that the urge had always been there but that he had not acted on it in the past. The 'urge' became of increasing interest as other participants talked about it; particularly those



who had not cut for a long period of time but still described experiencing the urge to cut. The 'urge to self-injure' related to most of the other categories, for example the participants seemed to find it difficult to "stop cutting" because of the urge to self-injure. Furthermore the participants were reluctant to say that they had stopped cutting and preferred to talk in terms of the "last time they had cut". It was decided to rename this subcategory 'going without cutting'. It emerged that a property of the 'urge to self-injure' was 'triggering the urge' which was similar to 'cutting precipitator' and closer, in my view to the experiences of the participants with some of them referring to 'triggers'. Another property of 'urge to self-injure' was 'satisfying the urge' which again was very similar to the category "cutting". 'Triggering the Urge' and 'Satisfying the Urge' were chosen to represent the participants' experiences of cutting given the prominence of the 'urge' in the data. The aim of the research then became more focused, exploring the urge to self-injure and how people who engage in self-cutting respond to the urge. The stages life before cutting, life with cutting and life without cutting all related to the "urge to self-injure" in various ways.

This part of the analysis is known as selective coding and it involves the integration and condensing of major categories to generate a theory (Strauss & Corbin, 1998). The term, 'selected' is employed because the researcher has to select one aspect as a core category, to focus upon (Punch, 1998). The core category is also known as the central category and it represents the principal theme of the research.

## Identification of the Core Category

Through modifying, rejecting, and developing categories, the main problem for the participants emerged as '*living with the urge*' to engage in self-cutting. It appears that once people start cutting it is as if they will never be free from it again. They may be free of cutting in the sense that they have not injured themselves for weeks, months or even years however this does not mean that their lives are not still plagued with the desire and urge to cut. The urge may be less central to their lives but it still seemed to be lurking in the background.

The core category was therefore conceptualised as "*Living with the Urge*" which dominated and spanned the three stages of life before self-cutting, life with self-cutting and life without self-cutting. For example before the participants started cutting there were indications that the urge was present in their lives, however it was not acted upon suggesting the presence of an '*underlying urge*'. After the participants started cutting the urge was very much a part of their lives especially while they were actively responding to the urge ('*triggering the urge*') by engaging in cutting ('*satisfying the urge*'). The final phase was life without cutting and although at this point participants were not engaging in the act the data indicated that the urge to cut could still feature in their lives to varying degrees ('*resisting the urge*'). The main categories relating to the core category therefore emerged as "*Underlying Urge*", "*Triggering the Urge*", "*Satisfying the Urge*" and "*Resisting the Urge*". The core category pervades these main categories through its corresponding properties and dimensions which vary depending on the particular main category.



Strauss and Corbin (1998) state, “in an exaggerated sense the core category consists of all the products of analysis condensed into a few words that seem to explain what the research is all about” (p. 146). The core category in the present study meets the criteria set by Strauss (1987) in that ‘*living with the urge*’ is central to the study and relates easily to the main categories and properties, it appears frequently in the data, it has implications for a more formal theory (for example ‘*Living with the Urge*’ has resonance for people engaging in other self-destructive behaviours and within the field of addictions), and it explains variation within the main categories.

### Writing the Storyline

Strauss and Corbin (1998) describe a number of techniques which help with the process of integration such as writing the storyline, using diagrams, sorting and reviewing memos. Clarification was needed as to how the development and integration of the categories had changed and to get the feeling for how it all fitted together. By writing sentences about the categories, a story started to emerge confirming “*living with the urge*” as it came through as central to the story.

### Diagrams

Following writing the storyline, a need to “see” what was happening to the categories and how they related to each other was developed in a diagram. It made sense to construct the diagram in terms of the stages of life before cutting, life with cutting and life without cutting, with the main categories fitting within the various stages, and the core category spanning all three stages.

### *Saturation*

After ten interviews no new data emerged with which properties or dimensions could be created (Glaser & Strauss, 1967) and there were many similarities amongst the experiences of the participants. It was decided to cease data collection at this point as saturation appeared to have been reached. The term saturation is used to describe the stage of data collection where researchers begin to notice similar instances appearing again and again in the data, and they become confident that the category has reached saturation (Glaser & Strauss, 1967).

Charmaz (2000) states it is more likely that saturation will be reached in studies where there has been sustained data generation as opposed to data gathered from a small amount of cases. Furthermore some researchers may identify gaps or interesting relationships at a later stage when writing up. Morse (1995) emphasises that it is the richness of data in a category and not the quantity of data that renders the category saturated, with data collection finishing when the researcher has sufficient data to construct a comprehensive theory which is grounded in the experiences of the participants. This is what happened in the present study after interviewing the tenth participant. It was fortunate because it was unlikely any new participants would have been found, especially given the time and financial constraints of being a doctoral student coupled with the difficulties accessing potential participants.

Indeed, Strauss and Corbin (1998) acknowledge that researchers may have to cease data collection for financial and time reasons however they also point out that the theory



will be insufficiently developed and lacking density and accuracy unless researchers collect data until all categories are saturated. To make sure that saturation had been reached a further two interviews were carried out with participants from the original sample (Lincoln & Guba, 1985). In addition to confirming that the categories had been saturated, as described below, the participants were also asked to comment on a diagram representing the findings to see if it fitted with their experiences.

### **Trustworthiness of Findings**

In response to criticisms of qualitative research for not attending to the issue of validity and reliability in relation to the findings, efforts have been made to develop trustworthiness in qualitative research (Morse and Field, 1996). Janesick (2000) proposes that validity in qualitative research relates to “description and explanation and whether or not the description fits the explanation” (p. 393). In qualitative research there is no single correct way of interpreting an incident or experience, so in order to increase the credibility of an explanation, researchers may employ audit trails or member checks (Janesick, 2000). The following measures were taken to ensure trustworthiness of the findings in the present study:

#### *Member checking*

Lincoln and Guba (1985) propose that checking categories, interpretations and conclusions with participants from the original sample is the most important strategy for ensuring credibility of the findings. In the present study a verbal summary of the findings and a diagram depicting the core category and its relationship to the main

categories were presented individually to two of the original participants. They were keen to participate again, as they were interested in the findings of the study. This strategy is in keeping with the advice of Strauss and Corbin (1998) who suggest explaining findings to the participants and asking them their perspective on the story as to whether it fits with their experiences. Furthermore, Strauss and Corbin (1998) suggest that the major concepts of the theory should apply to the participants even though the theory might not be effective in explaining a participant's complete situation. Both of the participants in the present stated that they could identify with the findings and one of them said he really liked the categories. The participants also made recommendations for adjustments to the diagram in terms of representing more clearly how the categories linked together. This enhances the credibility of the findings which refers to making sure that the perspectives of the participants are presented as clearly as possible (Morse and Field, 1996).

### *Going back to the data*

I went back to the raw data and read through the transcripts in light of the theory that had developed. This was to check how well the theory fitted with the original data given its level of abstraction (Strauss & Corbin, 1998) by making sure that nothing important had been missed and establishing that it was grounded in the experiences of the participants.

### *Audit Trail*

An audit trail was kept throughout the course of the study so that a record could be kept of events and decisions that were made in relation to all aspects of the research process. The memos that were written during the analysis also formed part of the audit trail, as did the reflective diary. Lincoln and Guba (1985) state that an audit trail is one technique for establishing confirmability of the findings, where the researcher's interpretations can be traced back to the data. Cutcliffe and McKenna (2004) however suggest that there is too much emphasis on judging the quality of qualitative research studies by their method and design, and not enough focus on the application of the findings. They posit that the credibility of qualitative research findings is not necessarily compromised if an audit trail has not been employed, and this is especially so if an experienced researcher carried out the study.

### *Literature*

The literature was searched for other situations whereby the theory from this study might have relevance, for example in relation to '*living with the urge*'; literature in the field of addictions was searched. Chiovitti and Piran (2003) found that by presenting similarities between the findings of their study and previous theories and models in the literature, they were able to demonstrate how the phenomenon explored in their study could be transferable to other health care situations.



## *Reflexivity*

Interwoven with issues of trustworthiness is the relationship of the researcher with participants. This can have an impact on data collection and analysis (Finlay, 2002). The exploration of relationships is known as reflexivity and is defined by Lincoln and Guba (2000) as “a conscious experiencing of the self as both inquirer and respondent, as teacher and learner, as the one coming to know the self within the processes of the research itself” (p. 183). However qualitative researchers often do not report or even recognise how they can have an impact on the construction of reality (Sword, 1999). Furthermore Hall and Callery (2001) note that the main players in grounded theory have neglected the relationships between researcher and participants in the creation of data, which they argue is a criteria for rigour. Without disputing the importance of reflexivity, Fine et al. (2002) express concern that the voices of participants with marginalised experiences may be silenced as a result of the reflexive analysis of researchers in privileged positions. Following the structure of Finlay (2002) this section will present a brief reflexive analysis of the research process in the present study, beginning with the preliminary research phase through to data generation and analysis.

## **Pre-research Phase**

Finlay and Gough (2003) point out that both the researcher and the participant will start with their own unique expectations about the research process, which may or may not be shared with one another however attempts will be made by both in order to make the relationship work. This relates to the concept of relationality which addresses power



and trust relationships between participants and researchers” (Hall and Callery, 2001, p. 258). Given my lack of clinical and personal experience of people who self-injure, my initial expectations about the research process were coloured by the judgements and recommendations made by several healthcare professionals and research ethics committees. For example it was suggested that counselling skills were required in order to speak to people who self-injure and concerns were therefore expressed about my ability to interview the participants. Several healthcare professionals were apparently reluctant to allow me the opportunity to speak to their patients in case taking part in the research interview disrupted any progress they had made. Consequently, this affected my confidence as a researcher and my expectations of the participants, because I anticipated engaging with very vulnerable people who would get upset easily and require a lot of prompting to speak about their experiences.

In reality the situation turned out to be quite different and the participants responded positively to the research context. They often talked in-depth about their experiences, offering unique insight into their lives as people who self-injure. In addition to the lack of clinical experience, my research experience was minimal which caused me to worry about my ability to handle the interview situation effectively and generate rich data through interacting with the participants. Although interview training was undertaken, the real learning took place when engaged in the research process and confidence grew as data generation progressed. This is in keeping with Strauss and Corbin (1998) who state that the initial interviews can be haphazard however the skills of the interviewer develop over time yielding richer data in later interviews.

## Data Generation

Mallory (2001) states that the data generation process and the research findings can be influenced by differences in the social, ethnic, cultural, sexual and economic backgrounds between the researcher and participants. Mallory proposes that performing an 'analysis of the difference' between researcher and participants could potentially improve the credibility of the findings in a grounded theory study. In the present study considerable thought was given to the differences between my background and those of the participants. Many of the participants had suffered extremely distressing life experiences and it was often difficult to forget about this in the interviews. I was initially concerned as to how I would feel and react when hearing about such things as sexual abuse. The participants varied in relation to how much they talked about their traumatic life experiences and it was possible to assess if they wanted to avoid discussing these experiences further.

It was important for me to be able to show empathy and understanding towards the participants and from comments made by them, it would appear that they found participation to be a positive experience. After the first interview I began to relax and look forward to interacting with the participants, realising that they were people who felt misunderstood, silenced and in need of someone to listen to their perspective.

Given my position as being a young female, with no clinical experience this could have impacted on the data constructed with the participants. For example the participants often talked about self-injury in the context of their everyday lives, what cutting meant to them and how healthcare professionals often did not understand how they felt. They



perhaps perceived me as someone who was interested in their experiences and had no power or authority over them, thus creating an equal relationship. Some participants commented on how much they enjoyed speaking about their experiences to someone who wasn't a healthcare professional. One participant said that she had poor eye contact and could rarely look at her GP or counsellor and was surprised she was able to look at me. Another participant said after the interview that she would not have taken part if she had not felt comfortable, and even commented that the way I was sitting made her feel relaxed. I had not been aware of my sitting position and the participant's remark made me realise how the smallest signs or behaviours can have an impact on the relationship between researcher and participants.

This is a different situation to other studies whereby researchers may have concerns about role confusion in that they interact with participants who could also be their patients. For example, Carolan (2003) on listening to her first few research interviews discovered that she had reverted back to her role as a midwife when interacting with the research participants. On the other hand my age and gender could have made some participants feel uncomfortable but this did not seem to be the case with the participants who ended up being interviewed. A potential participant (young male) expressed anxiety to his support worker when he found out that I was young female and although the pre-interview meeting appeared to go well he withdrew from the study for personal reasons.

A diary was also kept throughout the course of data collection so that events, observations, feelings and thoughts could be recorded and referred back to if necessary. Hutchinson (1986) suggests that researchers might benefit from keeping a daily journal or diary in which they can express their feelings and reflections. She proposes that this is helpful in maintaining an increased level of awareness.

### **Data Analysis**

Research participants could also contribute to the process of reflexivity, informing researchers as to how they perceive their impact on the research process. In the present study the research findings were shared with two participants who commented on whether the construction reflected their experiences of self-cutting. This provided the opportunity for participants to see how their voices had been incorporated into the findings and they were in a position to comment if they could not identify with the construction. Smith (1994) included his participants as self-reflexive co-researchers and made great efforts to make them feel involved by affording them a major role in influencing what and how the data were gathered.

### **Limitations of the Research**

There were a number of limitations in the present study which mainly centre on the difficulties experienced in finding participants. It was anticipated that the recruitment process would not be straightforward due to the hidden nature of self-cutting and because of the sensitive nature of the research topic. As explained earlier in this chapter (Ethical Considerations) for ethical and legal reasons the proposed focus on



young people changed and the minimum age of inclusion was increased to 18 years old. Furthermore on the advice of a service-user who had experience of self-injury, it was decided to remove the upper age limit because she suggested it would increase the chance of finding people willing to take part. She said that she knew of more people in their thirties and early forties who engaged in cutting. Although at the time the changing of the age limits appeared like a limitation, on reflection it meant that the sample included people who had been cutting for many years and could offer insight into their experiences. Incidentally, someone who had just started cutting perhaps could not have offered this.

Despite numerous recruitment drives targeting a variety of different locations, both in the public and voluntary sectors, gaining access to people who self-injure was problematic. Relying on gatekeepers to inform potential participants about the study was a limitation in that there was no control over how the study was presented to them. Having said that several gatekeepers were very positive about the study and provided regular updates about recruitment. As described earlier, it was not possible to adhere to pure theoretical sampling given the recruitment problems. Rather than searching for people or locations, it was necessary to sample according to whoever came along expressing a willingness to participate (Strauss & Corbin, 1998). Similar difficulties with theoretical sampling have been reported in other studies researching sensitive areas (e.g. Chiang et al. 2001; Cescutti-Butler & Galvin, 2003). Although the sampling strategy is acknowledged as a limitation, best efforts were made to explore emerging categories with each participant. The sample ended up being composed of people from

a variety of backgrounds, with different life events and cutting experiences however they all appeared to share the same problem, 'living with the urge' to self-injure which became the core category of the study.

The sample could be considered as being biased because the majority of the participants were recruited from the community, and they felt willing and able to share their experiences of self-injury. It is however suspected that the theory would still have meaning for people who are in a more vulnerable state regarding their cutting behaviour and are inpatients in a psychiatric hospital and this is an area worth exploring. A further source of bias in the sample is the age of the participants, with the mean age being 35.3 years. It is unclear whether the substantive theory would have meaning for adolescents who have recently started cutting, again an area which warrants further research.

### **Chapter Summary**

This chapter has justified the selection of grounded theory for exploring the experiences of people who self-injure in order to identify and understand the processes involved in self-cutting, and has outlined the procedure chosen specifically for this study. The main features of grounded theory were outlined before going on to describe the design of the study, incorporating sampling, recruitment, data generation and analysis, and techniques for establishing trustworthiness of the findings were discussed. As acknowledged in the 'limitations for research' the ethical considerations arising from the sensitive nature of 'self-cutting' undoubtedly made the research process more

complex, lengthy and challenging. Nevertheless, this was counteracted by the immense value of gaining access to the experiences of people who self-injure. In addition, the evolution of the core category, '*Living with the Urge*' was described. Participant experiences appeared to revolve around an urge to cut which dominated their lives whether they were cutting or not. The following five chapters present the findings of the present study, beginning with this core category.



## Chapter 4

### Core Category: Living with the Urge

#### Introduction

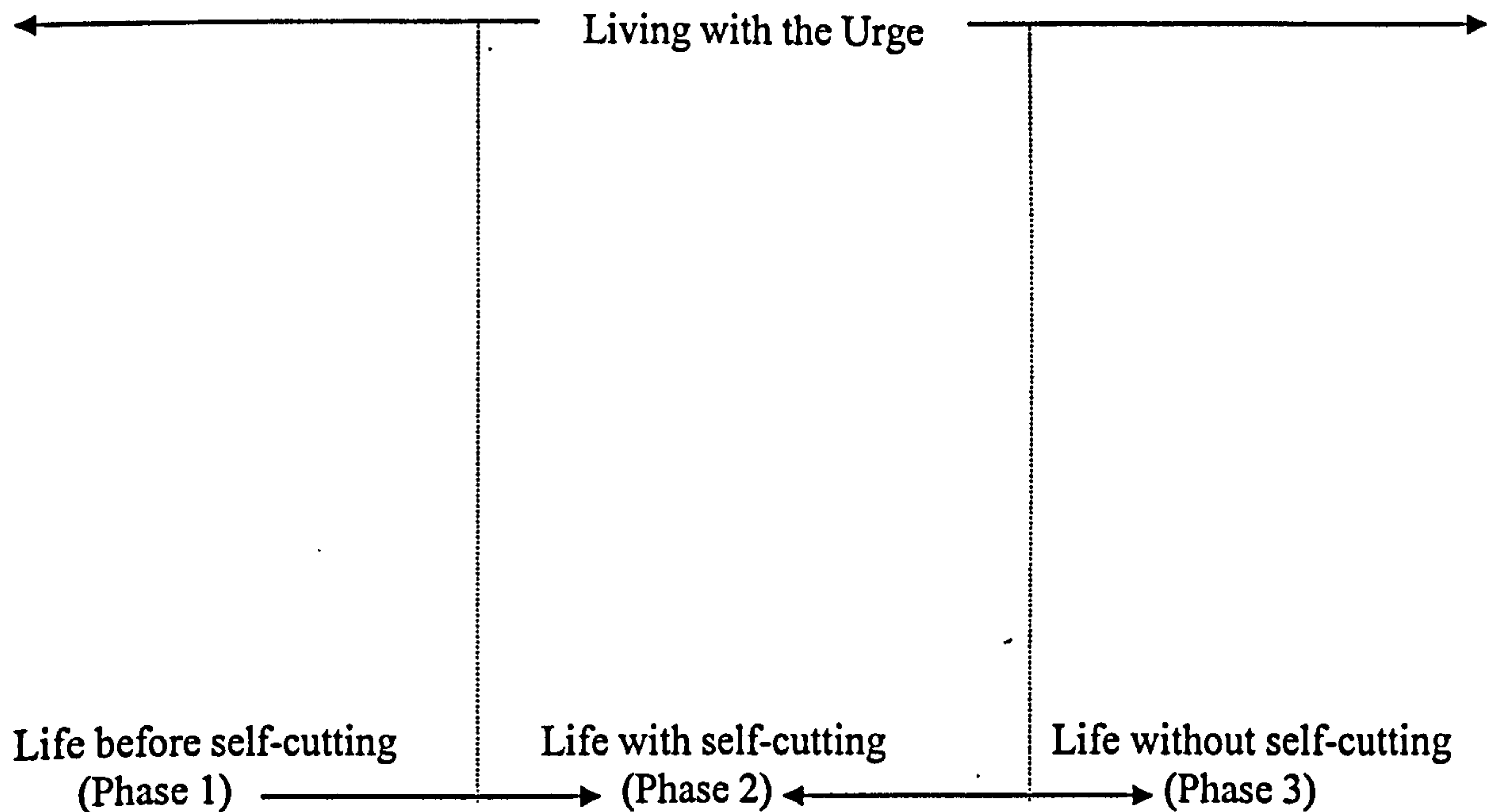
This study broadly set out to explore the experiences of people who self-injure in order to identify and understand the processes involved in self-cutting. As highlighted in Chapter 3, thinking kept returning to the 'urge to self-injure' which emerged as meaningful across the participants' experiences of self-cutting. The broad aim subsequently became more focused turning into an exploration of the urge to self-injure, and how people who engage in self-cutting respond to this urge. The findings demonstrate that the lives of the participants were never the same once they started cutting in that to varying degrees, they struggled with urges to engage in the behaviour. Over time the participants' lives were affected in various ways by the urge to self-injure. Participants not only talked about their lives when they were actively cutting, but most of the participants also referred to the period of time before they started cutting, and they all talked about trying to live without cutting.

Figure 4.1 demonstrates how the urge spanned all three phases from before the participants started cutting to when they were living without cutting. Once the participants moved from phase 1 – life before self-cutting, to phase 2 – life with self-cutting then it was impossible to move back to phase 1, however they could progress to phase 3 – life without self-cutting. There was a high chance that they would find it difficult to cope without cutting and move back to phase 2. Moving back and forth



between phases 2 and 3 was a common experience for the participants and the time spent in phase 3 varied from a few weeks to a few years at the time of interview.

**Figure 4.1: The three phases of Living with the Urge**



Analysis indicated that the urge related to all three phases of cutting and that a central experience for the participants was '*living with the urge*', which emerged as the core category. 'Living with' the urge was chosen as the phrase to conceptualise the core category, in order to emphasise how the urge stayed with the participants over time.

The evolution of the core category was discussed in the previous chapter. This chapter will describe the core category, '*Living with the Urge*' in more detail, defining what the urge is, how it varies in intensity and how it appears and disappears over time in the lives of the participants. Subsequent chapters will highlight what it was like for the participants to *live with this urge* by describing each of the main categories of the core category: *Underlying Urge, Triggering the Urge, Satisfying the Urge and Resisting the*

*Urge.* These categories are situated in the phases – life before self-cutting, life with self-cutting and life without self-cutting, and illustrate how the properties of the urge and the participants' responses to this urge developed and varied depending on the particular phase (see figure 4.2).



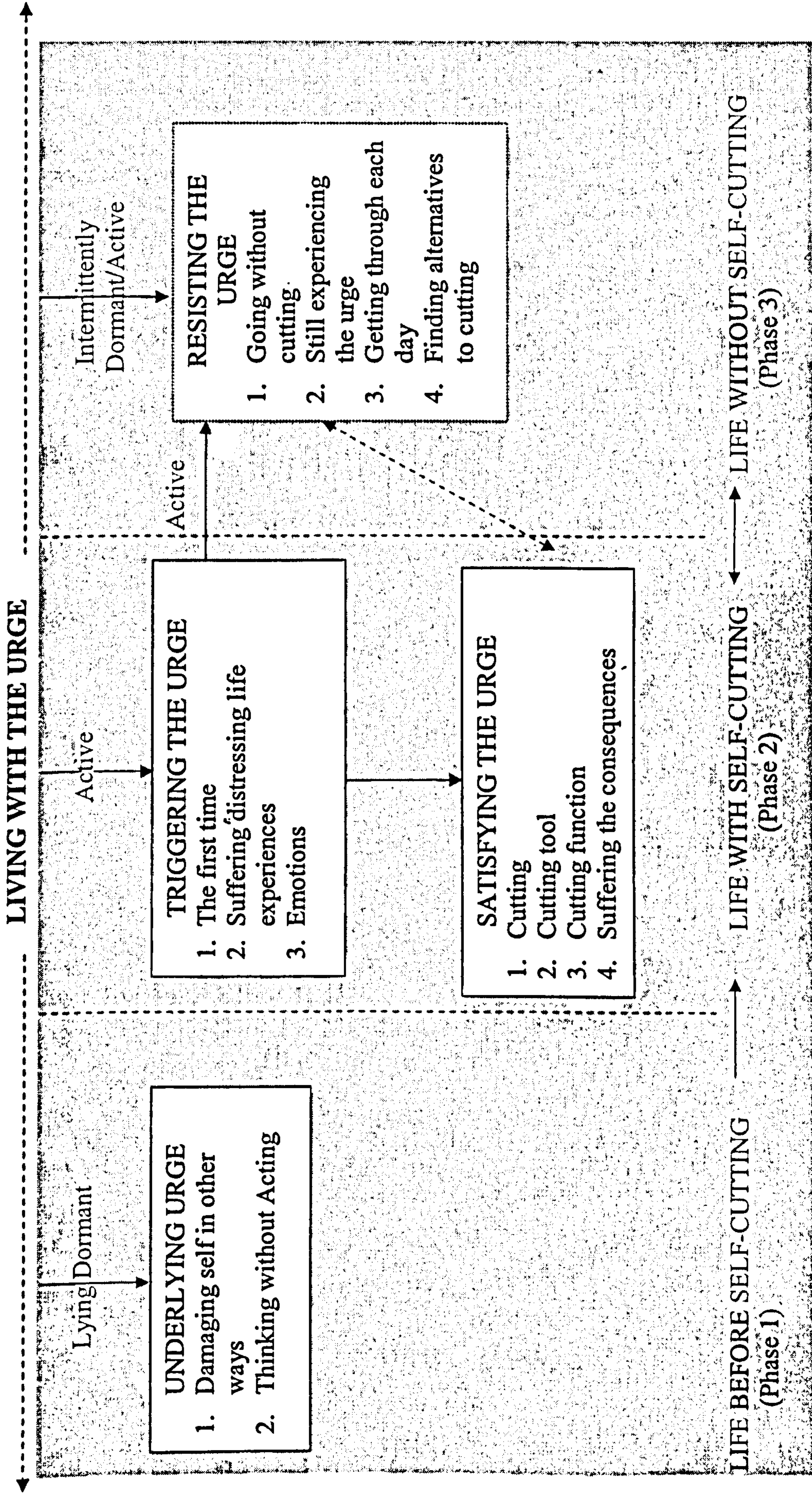


Figure 4.2: Living with the Urge.



## **Living with the Urge**

Prior to describing the main categories of the core category, it is necessary to describe the properties of '*Living with the Urge*': 'type of urge', 'nature of urge', 'intensity of urge' and 'intermittency of the urge'. These properties define the core category's particular characteristics, which in turn give the category precision (Strauss and Corbin, 1998). The core category pervades the main categories through its corresponding properties and dimensions which vary depending on the particular main category. For example, some of the participants reported being able to resist the urge when it was weaker in intensity. Similarly the type and nature of urge experienced often determined the way in which the urge was satisfied, in terms of severity of cutting or choice of tool. Holloway and Wheeler (2002) liken the core category to a thread which should be woven into the entire study and provide the story line. Through reading the subsequent chapters which represent the main categories of the core category, it should become apparent how the '*living with the urge*' thread is woven through the main categories.

The dictionary definition of urge is "a strong impulse, an inner drive or compulsion" (Cassell Concise English Dictionary, 1998, p. 1448). There are urges which are familiar to everyone, for example the urge to satisfy hunger or the urge to have a drink of water, and most people understand what it feels like to experience these urges. Urges which are less common and relate to negative behaviours or actions can be difficult to comprehend if they have never been a feature in your life. People who drink alcohol know what it feels like to experience the urge to go to the pub or to



maybe have a glass of wine after a busy day. However, they are perhaps less familiar with this urge to drink when it interferes with daily life and occurs at unusual times such as first thing in the morning or whilst at work. The urge to engage in self-cutting is a feeling which is even more alien to the average person, particularly because most people strive to stay healthy and want to avoid hurting themselves. The only way of knowing what it really feels like to have the urge to cut is to experience it first-hand. Nevertheless the participants in this study were able to express their experiences clearly and gave good insights into the properties of 'type', 'nature' 'intensity' and 'intermittency' of the urge. The properties and dimensions are presented in figure 4.3:

### *Type of Urge*

The property, 'type of urge' describes what the urge felt like for the participants whether it was experienced as an emotion, thought process or voice. Several participants were familiar with more than one type of urge whereas others experienced just one type.

For example the urge comprised a number of strong emotions for the following participant who gave a powerful description of what the urge to cut felt like for him:

# Living with the Urge

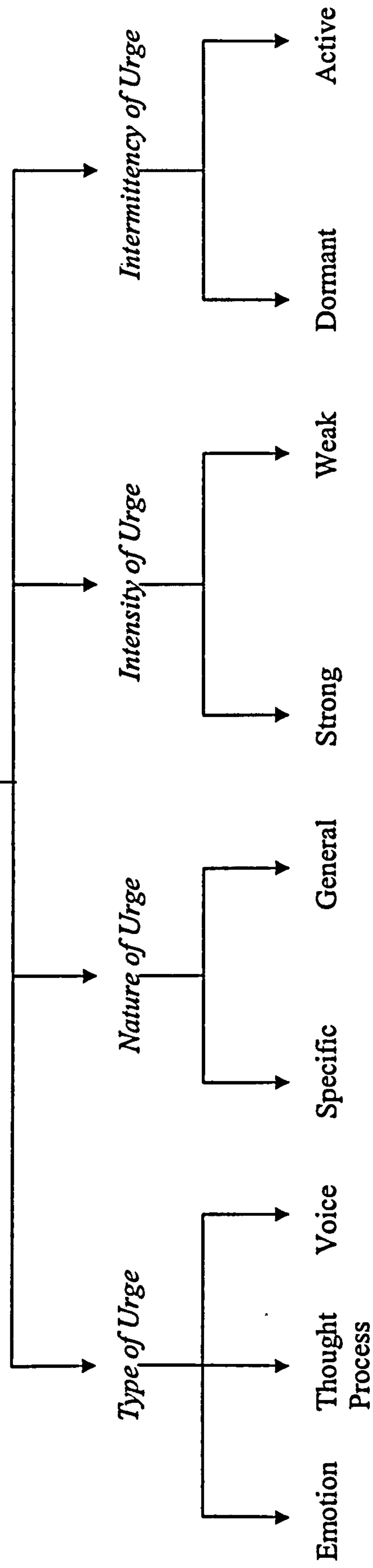


Figure 4.3: Living with the Urge (properties and dimensions)

*08: I think erm...when I was actually acting on it – I talked about it in something I wrote once – it was very frightening – it was – I sort of called it a white fear, like a white and icy fear, like you had gone hollow inside – you were very, very frightened inside, very trembly erm...fairly disgusted in yourself at the same time so that was when I was actually about to cut myself...*

Similarly, another participant described experiencing the urge to cut as an emotion:

*14: it is such an intense emotion you know and impulse...*

This suggests the urge was a powerful feeling within participant 14 however participant 05 did not feel that he cut himself compulsively:

*05: I believe for most people it is a compulsion – it was less so for me – it was more a thought loop...urge is the best word...*

Participant 05 seemed to experience the urge as a thought process and would make a decision to cut, and even if the urge lessened by the time he found some blades he still carried out the act:

*05: I also remember noticing once, em sometimes I wouldn't have blades handy, I'd have to get one out of a disposable razor or something....and it*

*would take time to get out.....I seem to remember on occasions I had made the decision to do it but by the time I got the blade out, blade out I wasn't, wasn't feeling too bad but....I, I did it because I'd made a decision...yeah I wouldn't question it at any point, there was no question of second thoughts....*

Once set in motion participant 05 never experienced any second thoughts and this could be because the urge was like a carefully thought out plan which he continued to completion devoid of urgency. He explained why the urge was not impulsive for him:

*05: I never had the feeling that - oh if only, and I never found myself thinking afterwards – oh if only I had thought about it a bit longer I wouldn't have. It is quite the reverse, if it was impulsive on those occasions where I had satisfied the urge before actually getting around to doing it – I wouldn't have done it...*

Participant 08 experienced the urge in a similar way in terms of it not being impulsive. Again the urge appeared to be like a thought process and he treated cutting as a reward for coping with the day:

*08: At other times when it was just a possibility so you thought – in the evening I might harm myself it was almost a solace – the urge was completely*



*different – if I can get through today then I can cut myself...does that make sense?*

Knowing that he could cut in the evening gave him comfort and security which helped him face the day ahead. This is comparable to people who are on a diet but allow themselves an occasional treat as a reward, or people trying to give up smoking who might limit themselves to one cigarette per day. This lack of impulsiveness was also apparent in the case of ‘Sally’ (Turp, 2002), who reported to her therapist that although she had not cut for one year she suddenly felt compelled to cut again. She claimed that she thought she had managed to resist the compulsion despite even handling a knife, however later after returning from the shop she allowed herself to engage in self-cutting. Sally engaged in cutting because she wanted her family to have a pleasant evening and she knew the act would stop her from lashing out at her children (Turp, 2002). Novotny (1972) describes a patient who made the decision that he would cut later on in the day as a reward for keeping his composure while his parents visited. Like participant 08, knowing that he could cut appeared to give him comfort.

Participant 08 distinguished between the type of urge he described earlier and another type of cutting urge (referred to as a “weirdness in his life”), which he experienced when he was psychotic. The following quote further highlights the lack of impulsivity in this participant’s cutting urge. Once he got the urge to cut he went through a specific routine or ritual as he called it:

*08: So that was different but yes when it was a feature of my life instead of some weirdness in my life it was very much a thing with rules almost about what you were to do. It was like a ritual, the only thing that wasn't a ritual – is, I think at that time I always wanted to cut deeper than I could and so I couldn't do what I was intending to do...*

Simpson and Porter (1981) studied 20 young people with histories of self-cutting who were inpatients in a psychiatric unit and discovered that most cases of self-cutting had been planned hours or days in advance and the severity of the act appeared to be carefully controlled. This lack of impulsiveness could be explained by the fact that opportunities for cutting might have been restricted due to being in hospital. Planning their cutting episodes in advance might have increased their chances of successfully engaging in the act. In contrast to this, Shearer (1994) found that approximately half of the 41 female inpatients in his study never planned their cutting behaviour and instead acted on impulse. Only 9 of the women reported that they usually planned their cutting episodes.

The urge has so far been described as an emotion or thought process however the urge was also experienced as a voice/voices or bizarre thoughts where some participants could hear the urge as well as feel it. When the urge was in the form of a voice, the participants were instructed by the voice to inflict damage upon themselves. This is similar to Favazza and Conterio (1989) who discovered that 20%

of the 240 women in their study reported hearing voices which instructed them to cut themselves. Experiencing the urge to engage in self-cutting in the form of a voice was both intrusive and distressing for the participants involved:

*04: this might sound funny but it's not me that's doing the cutting...it's, it's the...I, I get the uh, I get voices from the perpetrators.....it's, it's the...I, I get the uh, I get voices from the perpetrators, and they, they tell me, they tell me to do the cutting, they tell me to hurt myself like you know. It's like they tell me to either cut my arms or take an overdose, do some damage to yourself like you know.*

The voices were recognisable to the above participant and they were meaningful because he identified them as the people who sexually abused him in the past. Honig et al. (1998) compared auditory hallucinations between patients and non-patients (no psychiatric history), and found that significantly more participants in the patient group experienced voices which were negative in content. They defined negative voices as having “a critical or restricting content, and a negative emotional impact that potentially enhanced maladaptive or destructive behaviour” (p 650). Compared to the non-patients, the patient group was more scared of their voices and found they interfered with their lives. In Honig et al. (1998), histories of sexual abuse were more common in the patient group and in particular in the group of patients diagnosed with dissociative disorders. The content of the voices in the non-patient group was mainly positive and supportive and they were more able to keep the voices under control.



All of the participants who heard voices in the present study described the content of the voices to be negative, with the voice mainly telling them to do bad things to themselves:

*14: well you can imagine hearing voices and you know – first of all they were saying – you’ve got to cut yourself you know because you are a complete whatever, you know erm and then you cut yourself and they criticise you for not cutting yourself properly you know...*

The above description of hearing voices is consistent with Honig et al’s (1998) definition of the content of a negative voice. The voice not only instructed her to cut herself but also criticised her for failing to cut properly. Experiencing the urge in the form of a voice was reported by a participant in Nehls (1999) who said: “I know there’s not this little guy in my head pulling levers saying do this, do that, but it feels like it” (p. 287). In the previous examples the voices were ‘external’ to the participants however in the following case the participant did identify the voice as part of herself. The urge to cut manifested itself in the form of the voice representing the bad part of her self:

*13: I have, it’s not, it’s not voices in the schizophrenic voices – I think they call it your alter ego and my X calls it X – the bloody evil one, and it comes along sometimes, it says come on do this, do that, do the other (speaking very quietly)... It’s part of me this voice, it is actually part of me, it is the bad part.*



Participant 08 earlier described how he distinguished between a ritualised urge and the urge to cut when he was psychotic. This provides a further example of the range of meaning which the urge to cut can have for a person. This participant had in the past suffered bizarre beliefs about himself when psychotic and the urge to cut had dominated his thoughts:

*08: ...rapidly I became psychotic so I began to think...that, well my initial thoughts were that I had become an evil person and that there were spirits and devils inside my body and what not, um what I did then was just before I went into hospital I told (wife) that I was an evil, that I was full of evil spirits and that I was going to go to the woods and I was going to cut my wrists to get rid of the evilness....so that's what I did, I went into the woods, I cut myself but not, not deeply, and came back.*

The urge to cut was fuelled by his belief that he was evil and he needed to cut himself to release the evil. Understanding the context for cutting in this situation is crucial because for participant 08 the urge to cut offered a means of protection for himself and the people close to him. This urge differed to the other more ritualised urge in that there were no rules involved and his cutting was more severe as a consequence. The idea that cutting deeply could be risky did not enter the reality he was experiencing at that time:

*08: It wasn't too nice (laughs), lots of things happened and I ended up on the ward, and central to my thoughts I had to electrocute myself or cut myself to get rid of these devils that were going to destroy all those people around me, and I had to do that somewhere like the woods where I thought the evil that was in me would be neutralised. So...that was...that was the time when I self-harmed the most severely I think and was most at risk to myself. I had no intention at all of killing myself then, the concept that cutting my wrists might be dangerous didn't occur to me really...*

Favazza and Conterio (1989) reported that the urge to get rid of evil spirits was experienced by 12% of the women in their study.

### *Nature of Urge*

The property, 'nature of urge' describes how participants experience their urge in terms of how and where to cut. For example, specific urges related to the manner and sometimes 'tool' by which the participants carried out the cutting act. The following three participants all experienced the urge to specifically cut their arms, with two of the participants specifically using razor blades as their cutting tool:

*07: Yes it comes (the urge) from nowhere and very specific, I mean for me it's so specific it has to be the forearms...*

*08: For me it was – if it is what I see when I look at self-harm, if it is what I see when it is the normal self-harm then it will be very specific – I will use a razor blade or I would cut my forearm and so on, erm*

*14: No with me it's very specific erm my arms erm....I....also....I have been struggling for years with the urge to cut my face....erm although I haven't done that and I also always used to use a erm, a razor blade*

For participant 14 the urge was so specific that on one occasion she had to cut a certain amount of times during one cutting episode:

*14: I mean there was one time I cut myself 100 times you know because...100 seemed a very important number at the time (laughs)...*

Participant 08 appeared to experience a more general urge when he suffered from a psychotic episode:

*08: ... when I was psychotic it wouldn't have been (specific tool) – I would've just chosen whatever instrument that would have seemed to have fulfilled that reality...*



### *Intensity of the Urge*

The participants reported urges of varying intensities. Generally, the stronger the urge the more likely it was that the participants would engage in cutting however this did not appear to be the case for participant 05:

*05: ....and what I don't understand and that it must be different factors, is that there were times when I would have a stronger urge and not do it than, than, when, that when I did it...Yeah so it's, so it's, so it's not clearly dependent on the strength of urge...*

Participant 05 could not give a reason for why this was the case, however he did not feel compelled to cut and the urge he experienced involved an element of thought instead of being impulsive. This could explain how he managed not to cut when he experienced a strong urge but yet still went through with the act when the urge was weak. Some of the participants managed to resist strong urges to cut themselves and this will be explored further in relation to the main category 'Resisting the Urge' (see chapter 8). For example, the following participant thought about the consequences of his actions and this stopped him satisfying the urge:

*08: it is often a very strong wish to damage myself but equally I've reached the point where I know I can't....*



Similarly, participant 14 experienced very strong urges to cut herself and whether or not she satisfied this urge depended on the particular philosophy she believed in at the time:

*14: But I mean it is a very, very strong urge and you know – you go through your life – a lot of changes going through life and we all think one time I'm going for this philosophy, next time I will go for that philosophy and you know and...depending on what philosophy you are particularly going for at the time it's believing at the time – you are going to react differently to different....to cutting*

The urge seemed to increase in strength the longer the following participant refrained from cutting:

*10: .....and you know – I need to cut, I need to cut but it's like you're putting it off. I suppose it's like going to the dentist or whatever – you know you're putting off making that appointment until you've really got toothache and you put it off and put it off. You could put it off three for or four days and then you have to – you just get to that stage and then – I've got to cut you know.....*

It is interesting that this participant uses the example of going to the dentist to illustrate the intensity of the urge to cut. In both of these situations there is the possibility of having to experience pain or distress in order to feel better and this is

avoided until the person can bear the toothache or urge no longer. Participant 14 reported that for her the strength of the urge did not always equate to the severity of the cutting. She aimed to limit the damage she inflicted upon herself so even if she experienced a really strong urge to cut this did not necessarily mean that she would cut herself more severely. She appeared proud that she could control the level of her cutting regardless of the strength of the urge:

*14: No it varies (strength of urge equating to cutting severity) because I really take pride in being able to control myself...erm and to make choices – they may not be...the best erm..sort of decision, they may not be the best decisions to make out of the choices you have but I try and limit the damage I do to myself*

At times the participants experienced urges which were fairly weak in intensity. For example participant 05 reported that he often experienced the urge during the night:

*05: ... during certain periods it can be...every night um.....the thought comes in to my head when empty quite easily but it's, it's often quite an em.....weak form...you know, the idea often comes through with little power or conviction..*

A few of the participants who had not cut for some time commented that they still experienced the urge to cut themselves, but that this urge was weaker than it had

previously been. For example participant 07 described the strength of the urge as being:

*07: ...maybe not to quite the intensity than I did at the time...*

Participant 14 had days where the urge did not feature and although she still experienced the urge to cut herself, overall the intensity of the urge was weaker.

*14: Erm....each day is different really. Sometimes, sometimes, I mean it's definitely sometimes it's definitely the urge is not at bad you know – sometimes the urge isn't there at all....*

Similarly, 'Jill' a participant in Sutton (1999) found that the urge became weaker over time: "As time goes by the urge has become much less intense and no longer dominates my mind" (p. 67). Overall, for some participants the intensity of the urge determined whether or not it was satisfied or resisted whereas others seemed to be able to weigh up the situation, and it depended on the context whether they cut or not.

### *Intermittency of the Urge*

The property, 'intermittency of the urge' describes the participants' experiences of the urge in terms of the way it disappeared and reappeared over time. The participants did not talk about being continuously preoccupied with the urge to cut however they reported still feeling affected by the urge because they faced the



uncertainty of not knowing if and when it would reappear. Over the next four chapters the dormant and active nature of the urge will be discussed in more detail.

Figure 4.4 (see p. 142), resembling a sequence of 'volcanoes' with the urge lying dormant and then becoming active, provides a representation of the development or path that the urge to cut can take. Each participant's experience of '*living with the urge*' appears to be different, with variability in the frequency and length of the dormant periods.

Interestingly, a participant in Arnold (1995a) used the concept of a volcano to describe her feelings: "I'd go for a while then it would build up again and eventually I would explode like a volcano, smashing everything in sight. Only when the blood came out of me was I able to let go and cry" (p. 15). When the urge was triggered and the participants were aware of the active nature of the urge this did not always mean that they responded by satisfying the urge. The participants sometimes used personal strategies to resist the urge however if these failed then an episode of cutting took place and the urge was satisfied. The height of the 'volcanoes' represent the intensity of the urge at that point in time; however as illustrated the likelihood of the participants satisfying the urge did not necessarily increase with the intensity of the urge. The core category '*Living with the Urge*' links the three phases of life before self-cutting, life with self-cutting and life without self-cutting, and their corresponding main categories.



LBC = Life before Cutting  
 LWC = Life with Cutting  
 LWOC = Life without Cutting

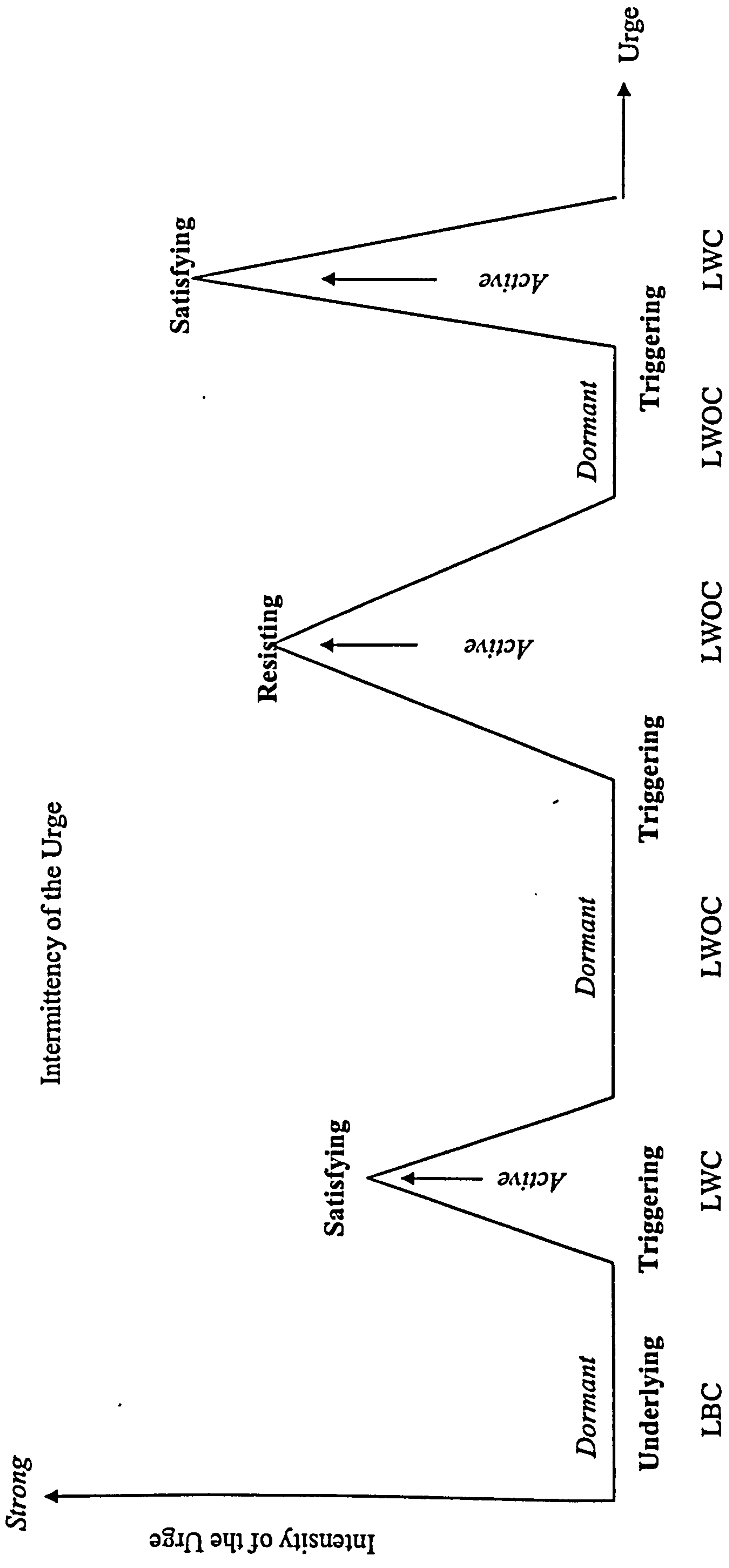


Figure 4.4: A Snapshot of the Urge

Phases of Cutting (over time)

The following brief summaries provide an introduction to the main categories which will be explored in subsequent chapters:

### **Life before Self-Cutting (LBC): Underlying Urge**

In the first phase (life before self-cutting), the urge to engage in self-cutting appeared to be lying dormant and had not yet been triggered. The participants were living with an ‘underlying urge’ and were not consciously waiting for the urge to emerge (see Chapter 5 – ‘Underlying Urge’).

### **Life with Self-Cutting (LWC): Triggering and Satisfying the Urge**

Once the urge was triggered for the first time from a dormant to active state the participants entered the second phase (life with cutting) and were actively ‘living *with the urge*’. The urge seemed to thereafter lie dormant for periods of time becoming active under certain stressful circumstances. The details of these circumstances will be explored in more depth in a subsequent chapter (Chapter 6 – ‘Triggering the Urge’). Through ‘satisfying the urge’ the participants were effectively living with cutting and the consequences of the behaviour (see Chapter 7 – ‘Satisfying the Urge’). Participants were able to look back, once they entered this second phase and started cutting, on the urges they had to damage themselves during the early phase, life before cutting.

### **Life without Self-Cutting (LWOC): Resisting the Urge**

The third phase (life without cutting) describes how the participants ‘resisted the urge’ to cut and were living without cutting. In this phase the urge could be intermittently dormant or active depending on how the participants were coping with life (see Chapter 8 – ‘Resisting the Urge’). All of the participants in this study still experienced the urge to cut during this phase.

### **Chapter Summary**

The core experience for the participants in this study appeared to be that they were ‘*living with the urge*’ to cut. This affected the participants’ lives not only when they were actively cutting but also when they were not engaging in the act. The properties of the core category ‘*Living with the Urge*’ provide some insight into the meaning of the urge through describing what the urge to cut felt like for the participants, the intensity of the urge and how it disappeared and reappeared over time. The urge was described in a variety of ways, from an emotion or thought process to more intrusive types of urge such as voices or distorted thoughts. Some of the participants also commented on the nature of the urge in terms of it being quite specific in relation to how they should cut, where and with what tool. The urge could also be experienced in more general terms, for example not having to use a specific type of cutting tool. Through ‘*living with the urge*’ over time the participants experienced periods where the urge appeared to be dormant and then episodes where the urge became active, and consequently the participants never seemed to be free from the urge.

A substantive theory is proposed which describes how people who self-injure face a paradox of finding it very difficult to live with self-cutting, and simultaneously facing the challenge of life without self-cutting. This paradox can be understood within the context of *living with the urge*, a process which begins before the onset of cutting in the form of an *underlying urge*, and continues not only while people are cutting but also when they are trying to live without cutting. From the first time the urge to cut is *triggered* and the world of cutting is entered, the urge seems to reappear intermittently, and people who self-injure face the struggle over either *satisfying* or *resisting* the urge. The experience of '*living with the urge*' varies depending on the type, nature, intensity and intermittency of the urge both across and within the main categories: '*Underlying Urge*', '*Triggering the Urge*', '*Satisfying the Urge*' and '*Resisting the Urge*'. The next four chapters will illustrate how the participants responded to the urge to cut themselves through exploring these main categories of the core category





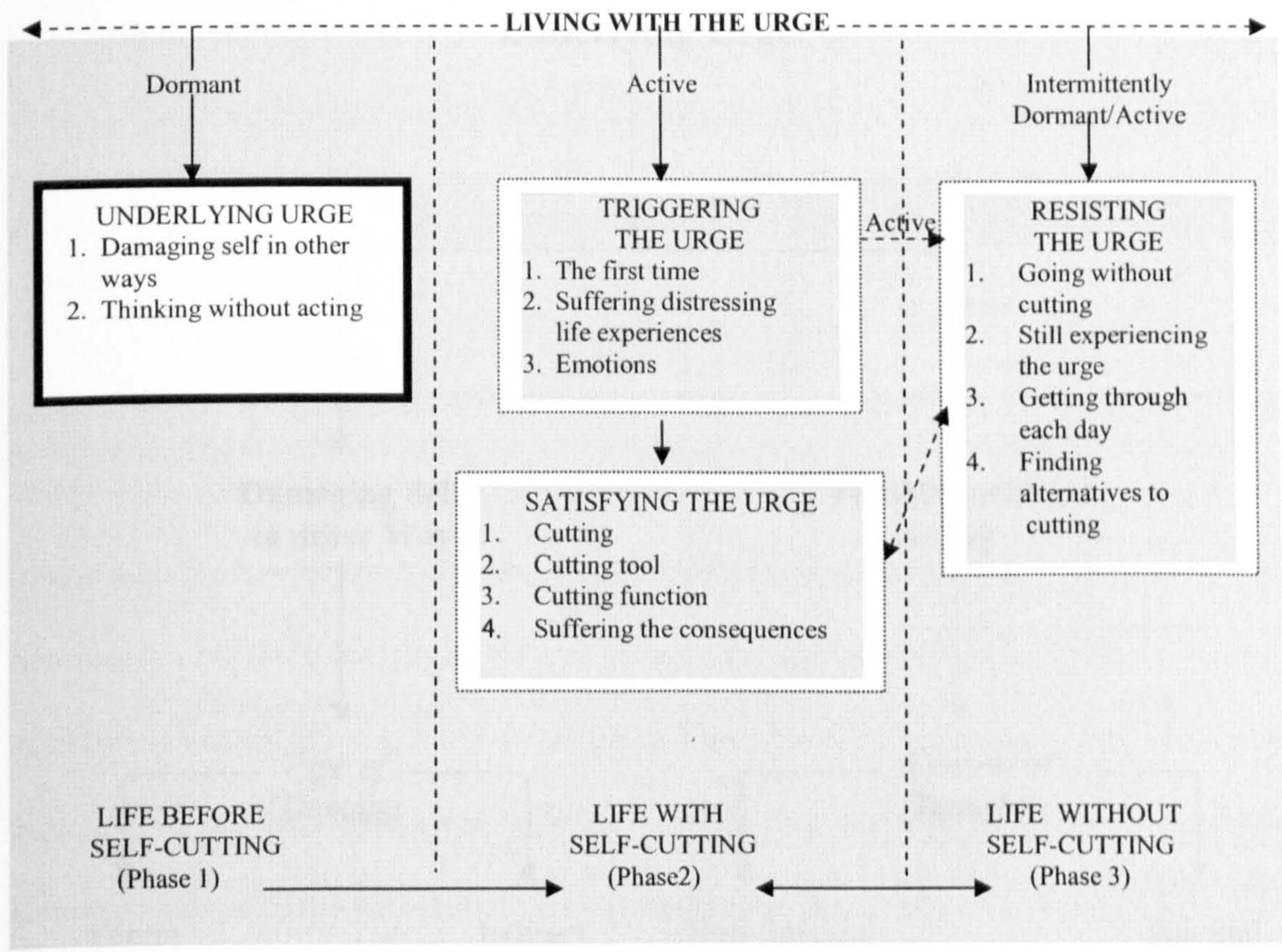
## Chapter 5

### Life before Self-Cutting: Underlying Urge

#### Introduction

The previous chapter described the core category, '*Living with the Urge*' and gave a brief summary of the three phases in the process – life before self-cutting, life with self-cutting and life without self-cutting and their relationship to the urge to self-cut. This chapter will look at the first phase, life before self-cutting. This was the stage in the participants' lives before the urge to engage in self-cutting was triggered for the first time. In this phase self-cutting had not yet entered their lives; however analysis of the transcripts suggested the presence of an '*underlying urge*' which the participants were perhaps not aware of at the time. This chapter will explore the main category, '*Underlying Urge*' which suggests that the participants were living with a dormant urge before they had even started cutting. The position of the main category '*Underlying Urge*' in relation to the core category and the other main categories is presented below in figure 5.1. The subcategories of '*Underlying Urge*' are '*Damaging the Self in Other Ways*' and '*Thinking without Acting*' and they are presented with their corresponding properties and dimensions below in figure 5.2.



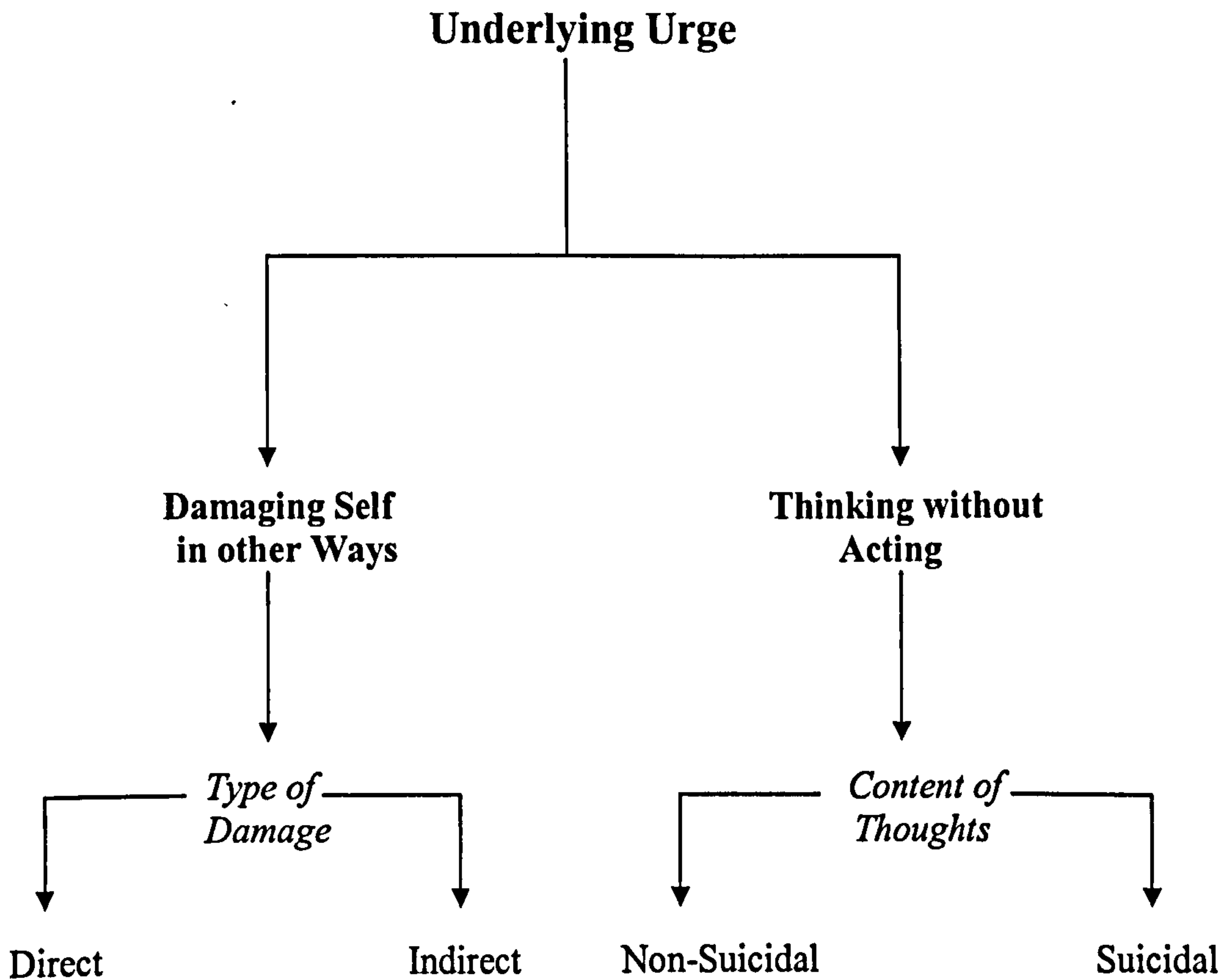


**Figure 5.1: The main category ‘Underlying Urge’**

**Damaging Self in Other Ways**

Cutting is just one of a variety of methods of damaging oneself and some of the participants identified that they had behaved in other self-destructive ways before they started cutting. The urge appeared to lie dormant at this stage but eventually becomes active and turns into a conscious urge to cut (discussed Chapter 6). The property ‘type of damage’ illustrates the various kinds of damage which the participants inflicted upon themselves suggesting the presence of an ‘underlying urge’ to cause harm to the self:





**Figure 5.2: Underlying Urge (Subcategories, *Properties* and Dimensions)**

*Type of Damage*

This section will describe the property ‘type of damage’ through exploring the general urge to harm oneself that manifested in a number of directly and indirectly damaging ways. It seems as though the participants were not always aware of this urge at the time. The following participant remembered engaging in directly damaging acts such as frequently throwing himself down the stairs and intentionally falling over:

*04: ....I don't, I don't know if it's classed as self-harm....but when I was younger I used to, I used to throw myself down the stairs....I don't know whether that's..... I remember that quite vaguely like, that I used to, used to*



*throw, throw myself down the stairs quite a lot like. Or erm, I did try it once, I was out walking on some hills and I tried to fall over, sort of thing, so that I would probably fall down a hill and find out that I've really hurt myself like you know. That's what I tried but it didn't work like, you know, didn't work like.*

Participant 14 also started harming herself through acts which mimicked accidents however she was aged only 5 years old at the time:

*14: Whey I was very, when I was a lot younger you know and you sort of fall down accidentally on purpose and you graze your knees...*

A participant in Harris' (2000) study remembers engaging in similar acts at 6 years old, for example falling over in the playground, falling off equipment in the school gym and hitting her bedroom wall. She learned that such acts provided relief from the emotional pain she was suffering. Participant 14 suggested that when you are a young child it is more difficult to access implements like knives, however it is not clear if she actually thought about doing so at that stage.

*14: Erm, right, well erm....started self-harming at, uh, about 5. I would say it was probably just after I started school. It was quite a traumatic experience for me going to school erm....but obviously at that age you know you, I mean you don't have access to like knives or anything so it's things like erm...hitting your head off a wall, falling about accidentally on purpose (laughs)....*

Unlike the above participants, the following participant did not cause damage to herself through intentional accidents but instead she picked at her skin and spots from an early age. Participant 06 said that she was not aware that this was an act of self-injury until someone told her:

*06: I pick, I pick a lot, I've always picked, all my life, you know, and I remember X says to me - it's like a self-harm as well when you're picking as well. And I said – what, I've done that all my life...but I mean I can't help – it's like, spots...I don't know....*

Skin-picking is a form of self-injury which is less common than self-cutting. Neziroglu and Mancebo (2001) report that skin-picking was once a condition which was more likely to be seen in dermatology literature, however it is now often recognised as a symptom of psychiatric illness. They cite a number of reasons for why people might engage in compulsive skin-picking, for example obsessions with minor or imagined skin defects, and emotion management.

Although participant 07 did not start cutting regularly until she was in her thirties, there was a period during her teenage years where she tried to harm herself through overdosing and cutting. She reported that she was not aware that it was self-harm at the time but on reflection she realised that it was. Similarly, some of the young people in Spandler's (1996) study reported that it was only when they read literature on self-injury or thought about their behaviour in relation to others, that it occurred to them that

their self-injury had begun earlier than they had previously imagined. For example, some participants remembered banging their heads as children or eating glass and they asked if those behaviours counted as self-injury. Bywaters and Rolfe (2002) found that some of the participants in their study reflected upon the gradual escalation of acts in their past, and now regarded those behaviours as self-harm. It appears then that sometimes it is only once people start cutting and then remember back to their life before cutting, that they understand what they were trying to do at the time:

*07: Well there's, there's two distinct um, I can talk about when I was a teenager although at the time I didn't know it was self-harm but looking back on it I now know...*

Participant 07's first incident involved taking tablets whilst at school although she said she did not take enough to do any damage to herself. She said she wanted help but was unsure what for and the attempted overdose was her way of getting people to notice that she had problems:

*07: ....and I think as a teenager um.....(clears throat) I did self-harm about three, well three times that I can consciously remember, um and can't remember in what order but one of them I remember I kept bunking out of class, not because I wanted to be naughty but I sort of wanted....help. I mean I don't even know what I wanted help...for but I was very unhappy and very unhappy at school and home and I sort of just wanted a teacher or someone to come and*



*say “what’s the matter, what’s wrong, can we, can we do anything?”, and I remember it sort of became – one of the times I’d bunked out um.....and I took I think it was only about 5 paracetamols, something like that with the intention um, I knew that wouldn’t do anymore than hurt me – I knew it wouldn’t be sort of too dangerous to kill myself. But it didn’t actually do anything...it didn’t even make me sleepy or anything but I’d fantasised that I’d collapse in class and everyone would be round me and the like....*

Although she also superficially cut her wrist on one occasion, she felt it was a different type of cutting to that which she engaged in years later when she was in her thirties. The teenage cutting incident was for the same reason as she took the overdose and she felt it was to communicate to her teachers that she had problems and needed help. As will be seen in the next chapter her adulthood cutting was for different reasons and unlike the incident below she liked to keep her later cutting hidden from others.

*07: So I can remember that and I can also remember taking a razor blade into school and um...a very silly little cut on my wrist and um someone else was there and found out and that and sort of went to the headteacher and my mum was called and that was the last thing that was ever said.*

There was a gap of approximately twenty years between the teenage self-destructive incidents and the first time the urge to cut was triggered. This participant felt that her desire for cutting came from nowhere at this later stage and she did not associate it with



the earlier incident. In terms of the proposed theory of self-cutting, this suggests that the urge had not been properly triggered during her teenage years and continued to lie dormant for a long period of time. As with participant 07, the following participants took overdoses before the urge to cut was triggered for the first time however in both cases the women said they wanted to die at the time:

*11: Well I was only 18 at the time, no I was 17 so she (friend) didn't really, she knew there was something wrong but she didn't know what it was and then I took the overdose – the very first overdose that I took, I meant to kill myself.... and boy was I pissed off when I woke up in the morning (laughs)...*

In the above example participant 11 referred to her friend being worried about her behaviour prior to her taking the overdose. She was upset when she woke up and realised that her suicide attempt had failed. Similarly, the following participant expressed a serious wish to die:

*13: Uh....yeah I think the very first thing I did was the overdosing and that's when nobody even noticed I'd taken anything....no one noticed, not at all (sighs)....I was falling asleep in school and no one noticed. The teachers were shouting at me because I was falling asleep rather than finding out why...and I didn't care because I wanted to die because I actually did want to die with that one back then.*

Both of the participants appeared to be looking for a way to deal with whatever problems they were experiencing at that time, and they must have been quite desperate given they wanted to end their lives. Guertin et al. (2001) propose that adolescents who attempt suicide should be screened for self-cutting given the high rates of cutting they found amongst young suicide attempters. Their study also demonstrated that the group of adolescent suicide attempters who also reported histories of self-cutting, had higher rates of depression, loneliness and risk-taking behaviours, than the group of suicide attempters who had never engaged in self-injury. These factors could alert clinicians to the risk of self-cutting if present in patients who have overdosed.

As well as carrying out direct acts of self-injury such as purposively falling over, skin-picking and overdosing the participants also engaged in self-destructive behaviours which were indirectly harmful. In contrast to the direct forms of self-injury, it appears that the indirect behaviours which were carried out were not immediately destructive but had negative consequences. The following participant abused heroin and other hard drugs a long time before he started self-cutting:

*04....many, many years ago when I was living in X, I was in a rehab centre for em drink and drugs. I was taking heroin and everything, like you know...Aye real big stuff like, big style, like you know. I was spending lots of money as well...*

His drug-taking behaviour became sufficiently severe that he suffered both financially and physically. He became so thin that his parents intervened and sought help for him:

*04: When I first went into rehab I was 8 stone...I was as thin as a rake, like you know, thin as a rake and it was my parents that got me in there, like you know. I went home and eh I was drinking a lot as well and eh I went home this day and my mother said to me – she said I'm getting you help and I said –I don't need help and she said – you do, she says and I'm getting it for you and she rung the doctor and the doctor took one look at me and he said – right come on, off we go like, you're coming with me, like. Oh I was in a right state, like you know...*

As well as taking drugs the above participant was also drinking heavily in the years before he started cutting himself. People who use alcohol to cope with their problems can get caught in a cycle of drinking and can become dependent on alcohol. Sutton (1999) notes that alcohol abuse and more direct forms of self-destructive behaviour such as cutting have a number of features in common. For example, as is often the case for people who self-injure, the women in Sutton's study reported that alcohol helped them escape from emotional pain and that it also functioned as a coping mechanism. One participant had a similar experience:

*07: Yeah, I mean drinking I suppose is a form of self-harm, I feel there are so many forms of self-harm and I mean at the time just before I started self-harming I mean I reckon I was about that far (demonstrates using hands –*



*basically small amount of time) from becoming an alcoholic as well...um as things were getting worse I was drinking more and more and I was getting back from work and it was just the couple of weeks leading, leading up to me going off work and I was literally getting home and it was like I've got to have a drink.....so I was really, really close and I sort of, I think I recognised it and nipped that in the bud...*

Participant 07 was aware that her drinking was getting out of control and somehow managed to break the cycle and stop drinking. Heavy drinking could be perceived as a type of self-harm especially within the above context, and participant 07 acknowledged this. Connelly (1980) describes alcohol abuse as a form of indirect self-destructive behaviour where the self-destructive intent is not as explicit as in self-cutting, and furthermore unlike participant 07 it is often denied by the person. However Connelly (1980) also finds similarities between alcohol abuse and directly harmful behaviours in that both are often linked with depression, feelings of hopelessness and high risk-taking behaviour. Several studies have reported histories of alcohol and drug addiction in people who self-injure (Graff & Mallin, 1967; Rosenthal et al. 1972; Walsh & Rosen, 1988; Favazza & Conterio, 1989; Schwarts, et al. 1989; Lacey, 1993; Bolognini et al. 2003; Warm et al. 2003), yet few asked the participants what the meaning of alcohol and drugs were for them.



## **Thinking without Acting**

Life before the participants started self-cutting was also characterised by thoughts relating to harming the self. Unlike the direct and indirect self-destructive actions described above, the subcategory, 'Thinking without Acting' illustrates through the property 'content of thoughts' that in some instances the harmful thoughts did not turn into such actions.

### *Content of Thoughts*

The property, 'content of thoughts' describes the self-destructive thoughts experienced by the participants in their lives before cutting. Spandler (1996) states that the young people in her study reported experiencing self-destructive and/or suicidal thoughts in their lives before cutting however like some of the participants in the present study they never acted upon the thoughts. The following participant at the time of interview had been cutting for three years so therefore had experience and knowledge of the urge to cut. He was able to reflect on his pre-cutting days and he recognised that he had experienced thoughts of injuring himself but was not perhaps fully aware of them at the time. He believed that the urge had always been there: a dormant urge which was never acted upon.

*04: ...probably the urge was always there to do something like that like you know, I mean – I think probably I did have some tendencies at the time but I never acted upon them. I mean I worked in a X and eh I'm sure I had thought some time about putting my arm in the melting pot, like sort of thing, and eh*

*really burn myself, like, you know, eh not cover myself up sort of thing and really burn myself, like, you know. I'm, I'm sure I had thoughts then but I never acted upon them, like, you know, so eh I'm, I'm quite sure that probably the urge was there sort of thing but it was never acted upon...*

Participant 07 also had similar self-destructive thoughts in terms of burning herself and again she did not think that she had been aware of the urge to harm herself at the time:

*07: ...when I was at my most ill and before I knew there was such a thing and that's um this real urge, and I actually sort of said to my CPN – I really had an urge to go out and buy a packet of cigarettes and burn myself. And, it, I mean I now know that that's another quite usual form...but the funny thing was I don't smoke and I don't really know anyone who does smoke. I disapprove of smoking and never heard of anyone else...doing it but yet I had this real urge just to go and buy a packet of cigarettes specifically to burn myself with. And nothing else, I mean there was other things I could burn myself on the cooker, or you could do other things, but that was the specific thing...*

Participant 07 also fantasised about being knocked over and her aim appeared to be for people to notice and help her rather than to seriously hurt or kill herself. She wanted to be cared for and being knocked over by a car seemed to be the only way she could think of achieving this fantasy.

*07: I used to, used to have a big fantasy of um being knocked over by a car or a bus even....and I used to fantasise about it and I used to want to be taken into hospital and people would be like “oh you poor thing, what’s the matter type of thing?” Um and I think it was just too dangerous to do...um not...um... I couldn’t be... sure of not hurting myself I suppose. I didn’t even know that I was wanting to hurt myself at the time – I just fantasised about it....*

Although she was too frightened to go through with the fantasy because of her fear of getting injured, looking back participant 07 believed that she actually wanted to hurt herself. It was not until years later when she had started cutting and was familiar with the urge to hurt herself that she realised what she had been trying to do when she was a teenager:

*07: And looking back on it I can see what it was now but at that time I remember I used to walk along and just want to step out...*

The following participant had agreed to talk with me in terms of validating the emerging theory. When shown a diagram (see fig 5.1) of the categories and their relationships to each other, he made the following comment:

*08: Mmm yeah, it makes sense because if you think of that as – you would realise that (pointing to the underlying urge –life before cutting) when you got*



*that (pointing to satisfying urge – life with cutting) – you would suddenly think oh yes that explains why I felt like that beforehand, and yes I quite like that...*

Participant 08 explained that once he started cutting he realised that he had experienced similar self-destructive thoughts and feelings in the years before the urge was triggered for the first time. Unlike the previous examples, the subject of participant 08's harmful thoughts was cutting. His thinking was in the context of suicide though as the concept of self-injury was not familiar to him at that stage:

*08: ... and one day well, the first time I ever thought of doing any damage to myself...and at that time I thought in terms of suicide rather than self-harm was on a field trip where I thought – I remember wandering into the woods whilst people were studying some patch of grass and I walked past more or less and I had a sailing knife on me and I remember sort of thinking I could just cut myself and do something horrible to myself and I didn't do anything but that was the beginning of thinking about it...*

Participant 08 further explained how before the above incident, cutting and suicide were not choices that he was conscious of despite feeling very down at that time:

*08: I think when I go back there's the time when cutting or suicide became an option, which was on that field trip. Before that there was a time when I was really unhappy – at that time the idea of cutting or suicide wasn't, there was*



*no... that didn't come into my mind. It wasn't an option or a possibility, it just didn't feature at all. It is strange isn't it because you just live through the days and the days were pretty horrible but you got through them even though you hated where you were. And then there came the time when the idea of self-harm or suicide became a possibility and I suppose – it is very hard to think in retrospect...in a way...in a way that sort of thing seems so outlandish that you need the time to make it a reality....*

Participant 08 suggested that perhaps the reason why he did not immediately act upon the thoughts he had on the field trip was because the idea of suicide or cutting was so alien and bizarre to him. Over time, suicide and cutting became more appealing as he began to understand what the acts meant in terms of what he called his own 'reality'. This new understanding gave him the courage to finally act on the urges and move from life before cutting to life with cutting.

*08: ...and gradually it builds up a power within you where you actually act on it but it is very frightening, the very possibility of doing it but, erm, it gains a currency, sort of gains a logic that it didn't have in the past and I suppose that's where the gap was between first thinking of it and actually acting on it. Erm, it built its own logic I think...*

Participant 05 experienced suicidal thoughts and gave a similar explanation to participant 08 as to why these thoughts were not acted upon at first:

*05: ....I hadn't had the erm...I don't remember having the idea before and deciding not to do it although I may have done because it erm...yeah before you do it, it seems a lot if you've never done it, it seems a lot tougher than it is so I think what I might have done is just dismissed it because erm....probably feeling I wasn't capable of it or something...*

Participant 05 found it difficult to remember the phase before he started cutting, but speculated that he might have had self-destructive thoughts but subconsciously rejected them. He explained that before cutting for the first time he found the concept of cutting hard to grasp and this was possibly why he never acted upon any urges to do so. He then remembered that before the urge to cut was triggered for the first time, he often wished he would die; yet strategies for acting on these thoughts never entered his head:

*05: Yeah...it, it is an odd thing now I come to think of it that for so long I would sometimes wish I was dead but never think about doing anything about it or harming myself...even though I would feel it quite strongly...it didn't occur to me to actually do anything about it...*

Participant 07 also experienced quite strong suicidal thoughts in the months before she started cutting, but for her the possibility of acting on them appeared to be greater than that of the above participants. Garrison et al. (1993) found a strong link between suicidal ideation and self-damaging acts and advised clinicians to be aware of the

possibility of suicidal risk in people who have carried out non-suicidal self-injurious acts. This link is currently reflected in suicide risk management. Participant 07 managed to resist her suicidal urges and started feeling better:

*07: but I was just going more and more and more downhill rapidly and not being able to cope with things um...and then I went through a very suicidal – this all sort of happened very rapidly now – within a space of weeks. I became really, really suicidal and....especially at night time I really used to have to fight my thoughts of going off and committing suicide. I know, I went through a stage that I know what suicide....is um....and I sort of worked through that and I'd come out the other end...*

Many of the young people in Spandler's (1996) study perceived self-injury as 'the next best thing' to suicide. They stated that they did not want to die but they needed a way to cope with their unbearable feelings. One person described a feeling of "wanting to be dead but not wanting to kill yourself" (p. 35). A number of the interviewees made a clear distinction between self-injury and suicide and said that self-injury prevents suicide. It could be the case that once the 'underlying urge' becomes active and people start cutting, they realise that this behaviour helps them cope with life and they no longer feel the need to kill themselves.



## **Chapter Summary**

For the participants in this study, life before cutting was characterised by self-destructive acts (other than self-cutting) which were either directly or indirectly harmful, and self-destructive thoughts which ranged from non-suicidal to suicidal but in some instances were never acted upon. In relation to these acts and thoughts the participants did not appear to be aware of their self-harming nature at the time, and it was only when they remembered back to that time in their lives that they could rationalise their behaviour. The thoughts and acts all suggested the presence of a seemingly 'underlying urge' to injure the self during the period of time before the participants started cutting. The next chapter will discuss how this 'underlying urge' changed from a dormant to active state when triggered for the first time, and thereafter the incidents, feelings or experiences which the participants felt continued to trigger the urge to cut will be explored.



## Chapter 6

### Living with Self-Cutting: Triggering the Urge

#### Introduction

As described in the previous chapter, before cutting for the first time most of the participants had thoughts about damaging themselves, or engaged in acts which either directly or indirectly caused harm to their bodies. Emerging data suggests that the participants were not fully conscious of their intentions at this time, pointing to the presence of an 'underlying urge' (see Chapter 5). The main category, '*Triggering the Urge*', illustrates a change in the urge from dormant to active. This chapter will describe the various circumstances in which the urge to cut was triggered for the participants, including the very first time they became aware of the urge to cut themselves. The participants were able to identify significant events, life experiences or emotions which they believed triggered episodes of cutting. The main category, '*Triggering the Urge*' is situated within the second phase of the process of 'Living with the Urge' where the urge to cut is active and the participants are living with cutting (see figure 6.1). The subcategories within '*Triggering the Urge*' are 'The First Time', 'Suffering Distressing Life Experiences' and 'Emotions' and these are visually presented in figure 6.2 along with their properties and dimensions.







# Triggering the Urge

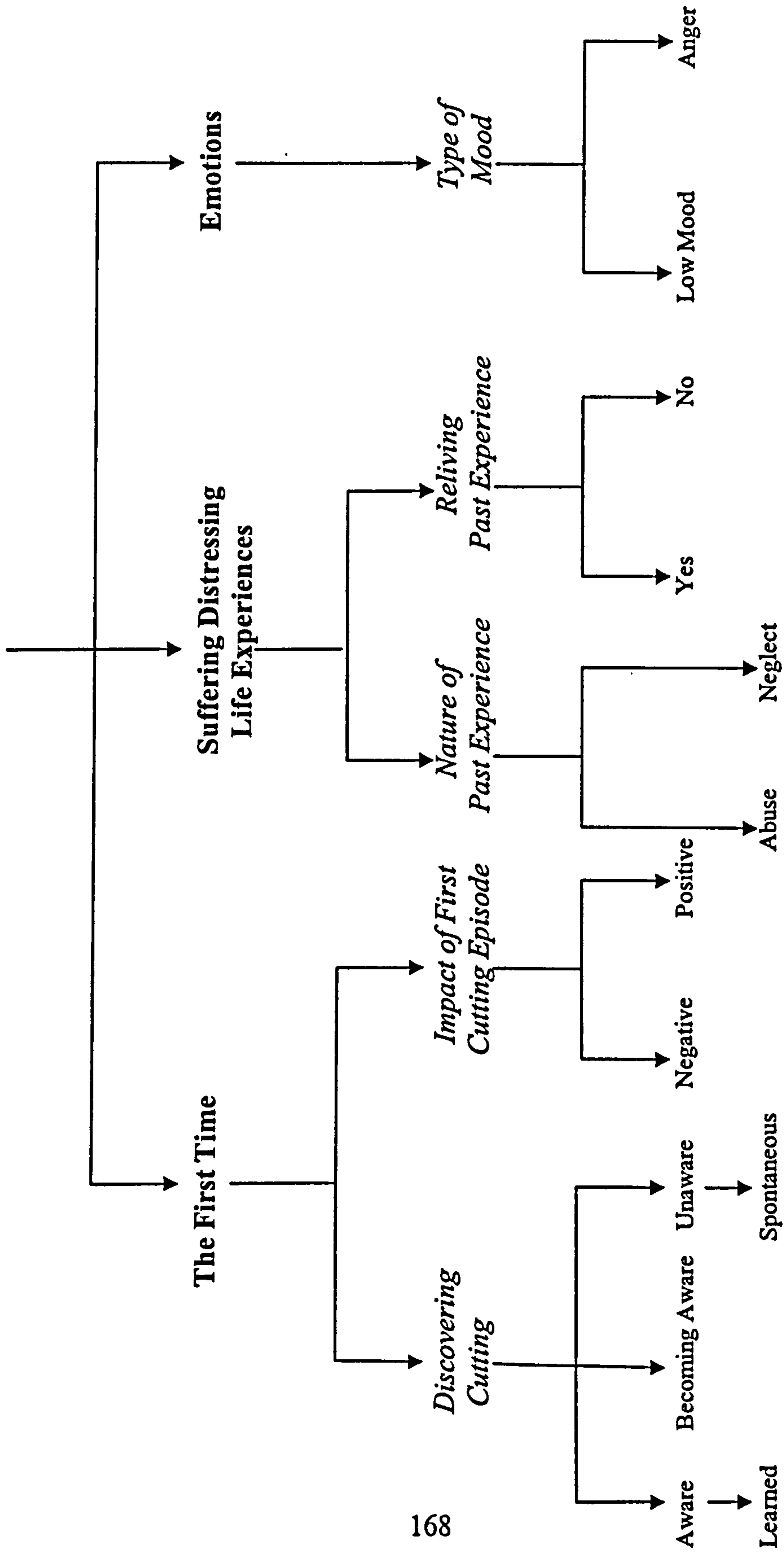


Figure 6.2: Triggering the Urge (subcategories, properties and dimensions)

### *Discovering Cutting*

'Discovering cutting' is an interesting property because it illustrates how the participants first considered and undertook cutting. Very few studies have asked people who self-injure about their first experience of cutting. Himber (1994) obtained data from 8 female psychiatric inpatients about the first time they cut themselves in terms of age of onset, where the cutting incident took place, whether the women were suicidal or had been drinking alcohol at the time. Although this information is useful for describing the women's first encounter with cutting, it does not reveal how the women discovered cutting for the first time or whether they had prior awareness of the act. In the present study, some of the participants initially learned about self-cutting when they became aware that other people were engaging in this behaviour. A few of the participants had been inpatients in psychiatric hospitals, and it was through interacting with other patients in this context that the act was discovered:

*11: I never actually thought about cutting at first. It was, I seen someone else doing it and I seen the relief that, on their face after they had done it. I wanted the same relief I had seen on them and it triggered it off really I suppose....*

Like this participant, people who are inpatients in psychiatric hospitals are in a vulnerable state, and are usually admitted because they are perceived to be at risk and are finding it difficult to cope with everyday life. Arguably, being in the same setting



as other people who are experiencing similar problems can lead to a situation where patients look to each other for comfort, and it is understandable that the participant wanted to try something that seemingly helped to make another patient feel better. In the present study most of the participants did not learn the behaviour in hospital, and furthermore only half the participants (n = 12) in Ghaziuddin et al. (1992) started cutting whilst in hospital.

Self-cutting behaviour is reported as being contagious in settings such as hospitals and adolescent units (Simpson, 1975; Favazza, 1989; Ghaziuddin et al. 1992). Rosen and Walsh (1989) define self-cutting contagion as “the infliction of self-injury by one individual and the imitation of others in the immediate environment” (p. 656). For the purposes of Rosen and Walsh’s study, acts of self-cutting involving two or more people which happened on the same day or consecutive days constituted an episode of contagion. They studied contagion of self-cutting in a treatment program for vulnerable adolescents and found that over a ten month period, 80 acts of cutting were carried out by the 12 participants, with 46 of the acts being episodes of contagion. Rosen and Walsh (1989) suggest that contagious self-injury may be regarded as a demonstration of affinity between two people where the act is used to create a close but temporary bond in the relationship. Similarly, Hartman (1996) observed that in an inpatient setting, cutting occurred within the context of a close friendship with another patient however this was not apparent in the present study. Rosen and Walsh (1989) point out that it would be wrong to state that one patient can cause another to engage in self-cutting as more research is needed to understand the

act both within and beyond this social context. The phenomenon of contagion is explored further in Chapter 9.

If an inpatient sees another person self-cutting in hospital it does not necessarily mean that he or she will start cutting immediately. A participant in the present study became aware of cutting in hospital, but the urge to cut was not triggered for the first time until a number of years later. Because of his prior experiences, participant 04 explained that he knew when he started cutting that other people engaged in the behaviour and that he was not alone:

*04: When I was in hospital down south there was people there doing it, young lads were doing it eh...because...eh the hospital that I was in they had an adolescent unit as well, like you know and you used to see people in there with their arms bandaged up sort of thing so I, I knew, I knew, no I knew I wasn't the only one that was doing it...*

Awareness of cutting does not only arise from seeing other people in hospital engaging in the act. Participant 05, who had never been hospitalised prior to cutting for the first time, was aware of cutting when he initially injured himself although he did not say where he had learned about the act.

*05: I was aware of the practice; it didn't come to me spontaneously...*

Solomon and Farrand (1996) describe the case of Liz who from an early age observed her mother injuring herself. Liz began self-cutting at fifteen years old when she was upset after her boyfriend finished their relationship. She explained that she did not go home and cry but instead cut her arm because that is how she learnt to cope in a crisis. In the current study a participant reported feeling guilty that her daughter also self-injured. For the above participants, self-cutting was a learned behaviour and they had some awareness of the act before the urge was triggered and they started cutting. In Hodgson's (2004) study one third of the participants discovered cutting through other people or reading about it in books or the internet and she referred to this as 'other-learned'. That is, cutting was learned from a source other than the self. In contrast to this, some participants in the present study felt that the urge to cut was triggered for the first time spontaneously or accidentally and most of them appeared to have no prior awareness of the act. For example, an ordinary activity such as gardening gave participant 07 the idea to cut herself:

*07: I had got up in the morning and I'd been doing some gardening and it was very soon, just days after this that I'd got a couple of scratches on my wrists from doing the garden and it just, it was weird. It went through my mind, hey that's a brilliant idea and...um...later on in the day I went out, it was almost as if I couldn't wait to get out and scratch my wrists on and I just used the plants out in the garden...*



Although participant 07 did not understand what she was doing to herself she appeared sure that she did not want to kill herself:

*07: I didn't know there was anything like self-harm and I knew that I hadn't wanted to commit suicide...*

Participant 13 also discovered self-cutting by accident. Interestingly, as with participant 07 it was also during an incident which could be viewed as being self-injurious:

*13: Then, then for some reason and I don't know, I know how I discovered it – punching walls and bleeding from there (points to knuckles) from my knuckles I discovered, I think that was how I discovered the self-harm and then I, then I started with the glass, bits of glass...*

The bleeding caused by punching the walls appears to have triggered the urge to draw blood which participant 13 subsequently achieved through cutting with glass.

Notably, a number of participants in Hodgson's (2004) study also discovered cutting by accident, for example receiving a paper cut and then realising it made them feel better. A few other participants in the present study were also unaware of cutting when they first engaged in the act. For example, initially participant 10 did not even perceive cutting as being something that damaged herself:

*10: I suppose I didn't actually realise that I was cutting but I didn't sort of associate it with sort of harming myself – I don't know if that even makes sense...*

Self-cutting must be very difficult to understand for a person who engages in the act for the first time without having heard about it previously. Participant 08 was aware of suicide but he was not familiar with self-cutting and within this context he rationalised his behaviour as being a suicide attempt:

*08: I'd never heard of it but I had heard of the concept of suicide and I think, that's interesting because I assumed I was trying to kill myself to start with and maybe that's something about making sense of – you do need this connection to know why you are doing something. Maybe the making sense of it is just your way of coming to terms with what you are doing. It might not be the reason; it might just be a way of understanding it so when the time... you know it must have been nearly twenty years ago that I first started self-harming. At that stage it wasn't talked about at all um but people all knew people who had attempted suicide and that was a more acceptable way of looking at it, and maybe that's what I latched on to as a way of describing to myself what I was doing although I didn't understand it....*

Arguably participant 08 also discovered self-cutting by accident because he believed his intention was to try to commit suicide. Suicide was a more socially acceptable

way for him to understand his behaviour. Having not managed to commit suicide, gradually over time he began to understand the urge to engage in self-cutting and the process became a ritual geared towards hurting himself and not killing himself:

*08: Eventually it became, you know it became very much I would know I was going to self-harm, I would put newspapers on the floor, I would, I transformed from thinking I'm killing myself to thinking I'm damaging myself...*

It was not until after participant 07 began cutting regularly and became aware that other people engaged in self-cutting that she realised that there was a name for what she was doing to herself. In the following quote she described how she found this out:

*07: It wasn't until about a month later um...after I'd got into hospital until I realised there was anything like self-harm so it just came from nowhere. Yes, once I got into hospital I mean it was great to suddenly...I'd even been in hospital a few days before I realised that other people were doing it and um it was late one night when everybody else was in bed and the nurses were in the TV room um and one of the nurses I think was doing some work on self-harm and she was in the self-harm association – she had a newsletter from the self-harm association, it was like....Wow!, sort of what's this? And that was the first time I realised.*



Awareness of cutting appeared to develop after participant 07 had started engaging in the act and this was also the experience of the following participants:

*13: You don't realise it is self-harm until somebody tells you it's self-harm...*

*06: ...but since I've come here you know and since I've found out a lot of people have been doing it and I think to myself – bloody hell, you know....*

It appears that once the participants became aware that there was a name for what they were doing to themselves and that other people engaged in the act, they felt relieved to learn that they were not alone. Although the following participant had never heard of self-cutting when she started injuring herself, she had an idea that other people were possibly behaving in the same way as she was:

*10: Okay I self-harm but I know even with not being in hospital before, I knew that I probably wasn't the only person that did it...*

Gradually, participant 10 grew to understand her behaviour and the reasons why she cut herself:

*10: You know you cut, but erm I suppose really over the past four or five years I started more, sort of aware of it and realising that I'm actually doing it and as to why I am doing it.... compared to what it was sort of like before*

*erm I don't know whether it's with getting older or what and you're sort of realising that you're actually doing it.*

The participants in this study had been cutting for a number of years and their knowledge and experience of cutting was obviously far greater at the time of interview, than when the urge was first triggered. Their initial lack of experience is highlighted by the following property, 'impact of first cutting experience'.

### *Impact of First Cutting Experience*

The property 'impact of first cutting experience' outlines how the participants felt after they engaged in cutting for the first time. The experience of self-injuring for the first time could be positive in that the person feels better after the act, or it could be negative where the person finds self-injury to be distressing and ineffective. The participants in this study mainly found their first cutting experience to be negative. For example a male participant described the first time he cut in the following way:

*08: It was very, very frightening, very emotional and the way I describe it is...the memory I have of it is sort of when a sort of white cold sweat just...really to actually, to actually take a blade against your flesh is quite hard to cope with....I made lots of very, very small scratches with very little damage to myself but was really, really upset..*

This description highlights how emotionally fragile and desperate participant 08 was to finally possess the courage to give in to the urge to cut himself. Fear was also the reaction of a participant in Bywaters and Rolfe's (2002) study when she cut herself for the first time in that she felt "panicky and shaky" (p. 8). The following quote demonstrates how ineffective the first cutting experience was for one of the participants in the present study. She had learned the behaviour from observing a fellow patient engaging in the act and she wanted to benefit from it in the same way he had done:

*11: Erm I remember when I cut for the first time and I thought I don't know what I'm...It didn't work because I had just sort of scratched a bit and I thought God this is sore (laughs) and you know, what was this guy on? (laughs) you know...*

Despite not achieving what she had hoped from her first experience of cutting participant 11 was not deterred from responding to the urge again in the future. Participant 05 talked about his first experience of cutting as being positive because it helped him cope with and channel how he was feeling at that time. He implied that he could have done something more severe or risky had he not responded to the triggered urge:

*05: Um...I see it as a positive, a positive thing because em if, if I hadn't had that channel then god knows what I would have done.*



Although the following participant found her first cutting experience to be positive in terms of the need it met, she did not want to engage in the act again because of its negative nature. However despite a desire on the one hand not to cut, she was unable to resist the urge when it was triggered again:

*14: I made the decision not to, not to carry on with that because it is a very negative thing to do and erm.....eh.....but unfortunately I got into it you know and it is very seductive....*

All of the participants except one continued to engage in cutting at some point in their lives, whether their first experience was positive or negative. This could have been due to the fact that once they started cutting, the urge to cut stayed with them alternating between a dormant and active state. This is also linked to the subcategory 'Cutting Function' which is discussed in Chapter 7 in that participants appeared to continue cutting because of the act's effectiveness in meeting their needs. Participant 12 was the only person to cut on one occasion and that was when he was a child. Although he never repeated the behaviour he did however burn himself, hit his head off walls, took overdoses and became addicted to alcohol. He found other means of dealing with his problems but they shared a common theme with self-cutting in that they were all harmful to the body.

*12: All this pain I was getting around me, my family, my ex-wife and all this....coming all together and for me then to get a release from that you know erm....alcohol, tablets...*

He still had to live with the urge, mainly in relation to alcohol abuse and at the time of interview he was successfully resisting the urge to drink:

*12: Today I'm fine you know and I've been fine for a long, long time you know and it's not a problem today thankfully the alcohol you know but I know myself it can easily be....*

Regardless of how the urge to cut was triggered for the first time, all participants recounted events in their past or present lives which influenced their emotions and the way they felt about themselves. The urge to cut appeared to be triggered by negative past events or the feelings associated with such events. The subcategories 'Suffering Distressing Life Experiences' and 'Emotions' represent the triggers which the participants associated with the urge to cut themselves.

### **Suffering Distressing Life Experiences**

This subcategory through its properties, 'nature of past experience' and 'reliving past experiences', describes the life experiences which some participants reported as being at the root of their self-cutting behaviour. In addition the impact which these events had on the participants is also illustrated. The experiences were often very distressing

and appeared to deeply affect how the participants viewed themselves. Arnold (1995a) explored the experiences of women who self-injure and found that out of the 63 women who responded, the majority (62%) cited childhood experiences alone for what they thought had led to them engaging in self-injury. Rather than seeing their cutting as a symptom of 'psychiatric disorders' most of the participants in the present study described their behaviour as a triggered consequence of a negative experience or mood, in other words in quite specific rather than diagnostic terms. The following participant spoke out against her cutting behaviour being seen as a symptom of an illness, instead of being understood within the context of her life experiences:

*14: It's really erm – this whole concept of....(sighs), some people...we are all individuals and no two people think alike, no two people react to a situation in the same way and.....people..society has a lot to answer for you know erm, this pigeon-holing and labelling business is not helpful at all – all it does is it victimises the people who are going through it because you know I just, I've had it up to here with mental health people (laughs) because erm I've tried you know erm explaining erm like for instance I mean about the self-harm and the cutting and I tried with a CPN, actually she is my current CPN and I had a conversation with her one day and I was trying to explain the reasons why I personally self-harm and she would not take it on board at all. She used to go – I think you'll find you self-harm because you get a sense of release you know – and I think really whether I get a sense of release or not is not, not the actual issue. The actual issue is why are you doing this in the first place? A*



*lot of it is because it's trauma in life, in childhood and in adulthood as well and erm if these problems within society are not addressed then the same things are going to carry on and it is a lot easier for people – you know I've noticed it all through my life with different things that have happened to me erm....it's a lot easier to blame the individual person than to say now hold on a minute there's, there's a problem in society here you know, whether it's school or whatever you know?*

Participant 14 found that health professionals did not look beyond her as an individual in understanding the cause of her cutting. She felt that factors in society which had affected her negatively and triggered the urge to cut were disregarded as an explanation for her self-destructive behaviour. Johnstone (1997) also argues that the medical model individualises the problem with diagnoses being assigned to individuals and not couples, families or social groups. Furthermore Johnstone points out that if the problem is perceived to be contained within one person, there is the likelihood that the relevance of interpersonal relationships past and present, culture and social circumstances will be ignored. Participant 11 had a similar experience of feeling misunderstood by health professionals:

*11: Erm.....I suppose it must be quite hard for somebody who has never gone through such emotional pain to try and understand you know it....you have people who want to understand but I think a lot of medical people just aren't interested in trying....to understand you know... I mean I've had a few*

*(diagnoses), some of them looking back have been completely off the wall, you know and I think no that's not what was wrong...*

This is in contrast to participant 13 who did not mind having a diagnosis of personality disorder. Although she was diagnosed with borderline personality disorder only a few years ago she believed that she had personality problems from an early age and in addition to other experiences this also caused her to self-injure:

*13: I don't know but I think from that, from a very young age I already had borderline personality disorder anyway and the mood disorder. They think that's what....what caused it (cutting) and then obviously events...*

Fallon (2003) found that despite the stigma they experienced, the participants in his small-scale study found it helpful having the label of borderline personality disorder as it enabled them to better understand their feelings and behaviours. Similarly, participant 13 saw the diagnosis of personality disorder as an explanation for the way she had been behaving throughout her life:

*13: I was relieved, a lot of people don't like it but I was relieved because it explains a lot of things...and I know it's long-term, I don't know whether I am going to have it for life or what?*

However, most of the participants in the present study with a diagnosis were angry that the urge to engage in cutting was not understood within the context of their traumatic life experiences, and did not like cutting to be seen as a symptom of a disorder. This is in agreement with Alexander and Clare (2004) who argued that self-injury should be understood as a coping mechanism that arises within a social context instead of seeing the behaviour as a symptom of individual intrapsychic disorder.

### *Nature of Past Experience*

The property, 'nature of past experience' describes the various experiences to which the participants subsequently attributed the onset of self-cutting. Being a victim of sexual abuse is one of the most devastating and traumatic experiences that a person can suffer and it can be very damaging to the victim. There is a strong association in the research literature between childhood sexual abuse and the onset of self-cutting (Favazza & Conterio, 1989, Ghaziuddin, et al. 1992; Shearer, 1994; Arnold, 1995a; Spandler, 1996; Briere & Gil, 1998; Santa Mina & Gallop, 1998; Bywaters & Rolfe, 2002) and the findings in this study supported this link. Four of the participants, one of whom was male, openly disclosed that they had been sexually abused during childhood:

*04: The first time I started cutting was when I was doing the work with my psychologist about um the sexual abuse I suffered when I was 13 and 14 like you know. And it wasn't just, it happened while I was at school...erm..I was doing a X (scheme for young people) and it started then but...my, it was*



*happening to me at home as well, my own father was doing it to me as well like. Then I (coughs) ran away from home when I was 14 and stayed in X, stayed at an X and it happened to me there but that was quite horrific, er, because I was...and I was sexually abused then like...*

Although the abuse happened many years ago, participant 04 still lived with the devastating effects of the abuse:

*04: I'm still.....well to put it bluntly, I'm still suffering everyday from my abuse like you know. So there's not, there isn't a day goes by that the abuse doesn't affect me sort of thing like you know...*

Van der Kolk et al (1991) found that histories of childhood sexual and physical abuse were highly significant predictors of self-cutting. From the 28 participants who reported self-cutting at the beginning of their study, 79% of them had histories of significant childhood trauma, including sexual abuse. Like participant 04, participant 06 was also sexually abused and she did not understand what was happening to her at the time:

*06: Well eh, I was abused... erm I thought you know all kids had, you know I thought it was the in thing or something, I didn't understand it....*

Participant 11 was a victim of sexual abuse and she eventually received counselling to help her confront her traumatic past:

*11: ...well the counselling I got it was a place in X - it is for sexual abuse...*

As with participant 06, participant 13 did not understand what was happening to her when she was abused:

*13: I remember it, I remember what he done to me but I didn't, I had no idea until...it was my friend that told me that it wasn't right and that he shouldn't have done that and that's sexual abuse....and I said – oh is it? And that's when it hit me and then it, then it made sense about the questions that he was asking – some really weird questions....*

A friend made her understand and realise that what had happened to her constituted sexual abuse and looking back she could see that his behaviour had been inappropriate. In addition to the sexual abuse, participant 13 was also a victim of physical abuse. Her father often hit her and she also had to witness him being violent towards her mother:

*13: My parents were, well my dad was constantly drunk and I think he was, he was a bit violent with my mum and he was a bit violent with us – he used to hit us quite a bit....*

Other studies have suggested a link between physical abuse in childhood and the onset of self-injury (Green, 1978; Carroll, et al. 1980). Participant 13 not only had a difficult home life in that she was also bullied at school. She reported that she thought the bullying triggered the urge to cut as well as the family problems she experienced at home.

*13: I do think it (cutting) was down to the bullying at school and other things that were going on, and down to my parents, you know.*

The following quotes demonstrate the damaging effect which bullying had upon participant 13. It appears that the mental abuse she suffered caused her to shape her self-view based on what the bullies had said to her:

*13: But I tell you one thing that really gets me is that people don't understand bullying – oh everybody gets bullied at school and they don't. They don't know the extent of it – they weren't there, they don't know what it is like....and another thing about people who self-harm is that they really hate their bodies, they can't stand them. I hate my body and some of that is because of they way, what people said about my body then and it was REALLY nasty things, very, very nasty things, some sexual stuff as well you know which was terrible.....and when your parents don't reassure....they all add up in your head and you think – oh they hate me....*



Arnold (1995a) found that out of the 76 women she interviewed about self-injury, there were more reports of emotional abuse (43%) than physical abuse (25%) during childhood. Participant 07 suffered a different type of distressing life experience relating to problems with her family. After her parents split up she felt very unhappy and had a difficult time with her mother who neglected the household. Participant 07 was affected personally and socially by her mother's neglect:

*07: Yeah so anyway that was sort of my early days, very unhappy childhood, a lot of it because of the split up of my parents and um...we were brought up by my mum and it was a very dirty, untidy house which I couldn't invite friends back to so I had problems with relationships with friends....*

In Arnold's (1995a) study, 49% of the women felt that childhood neglect had been important in leading to their self-injury. Gratz (2003) states that the relationship of neglect to self-injury has received less research attention than the impact of childhood abuse, and he reports that the studies that do exist are inconsistent. He explains that this inconsistency could be caused by the manner in which the concept of neglect has been defined, with some researchers not distinguishing between emotional and physical neglect. Gratz suggests that emotional neglect may be more closely related to the onset of self-injury than physical neglect.

### *Reliving Past Experiences*

The property, 'reliving past experiences' describes how some participants talked about reliving distressing incidents from their past and the profound affect this had upon them. 'Reliving past experiences' seemed very traumatic for the participants and this appeared to trigger the feelings and emotions that were felt at the time of the above past experiences. Collins (1996) proposes that the onset of self-cutting may be triggered as repressed or forgotten memories begin to emerge, and highlights that this is particularly relevant to people who have been victims of childhood sexual abuse. For example, participant 04 kept the secret of being abused to himself for a very long time and it was when he finally had the courage to disclose his traumatic past that the urge to cut was first triggered:

*04: I carried it around with me for about 20 years and never told anybody and then when I first came to X, I was seeing a woman called X and I started doing this work with her and talking about it and everything and then she referred me to see a psychologist and we started doing some work which was quite deep and it was then that it brought it all back to me .....and I started cutting.*

Participant 04 could not even escape the abuse at night when he went to bed and this was in fact the worst time for him in terms of suffering flashbacks:

*04: ...it's worse at night, night time when I try to sleep because I can feel them touching me like you know and especially, especially my back, my backside like you know...I can feel them touching me there like you know and they touch my front as well like you know.*

Participant 11 also found nighttime to be a difficult period in terms of experiencing flashbacks which triggered the urge to cut:

*11: Eh...I always find night time a bad time....a lot of the time, normally a lot of the time I would tend to get flashbacks and things like that so after having a flashback that was the most dangerous time for me erm I would just be wanting to reach for a razor blade...*

Participant 11 also cut when she faced her past whilst going through counselling, but unlike the above participant she was already cutting regularly by that stage. She received the counselling at a voluntary organization for victims of sexual abuse but they did not suggest strategies for her to cope with the intense feelings that emerged:

*11: Even when I was in hospital, once a week the nurse would take me there (centre for victims of sexual abuse) and I felt that, it got me to speak about what had happened and that but it didn't, nothing to show me how to cope with the feelings so the feelings would come out and then I was sort of left,*



*like I would tell them what had happened and that and there would be a whole mixture of feelings and I didn't know what to do...*

Talking about distressing past experiences can be very painful and difficult and usually a lot of courage and support is needed to face the past. Participant 11 suffered greatly whilst going through counselling, however she admitted that if she had not confronted the past then she probably would have ended up killing herself:

*11: Yeah and then eh, I got eh.....counselling and when I was going through counselling I cut up pretty badly, tried to set myself on fire, (sighs), tried to cut out parts of my body that I didn't like...I had to go through a...I realise now I had to go through the counselling to get where I am today but it was very, very difficult you know. I think if I had just given up and kept cutting I don't think I would actually be alive today...*

When memories and feelings about past abuse emerge, an increase in self-cutting may occur or there could be an increased urgency to engage in cutting (Wise, 1989). Like participant 04, participant 07 kept her feelings inside for many years until she could no longer bear to carry the emotional burden relating to the unhappiness and neglect she suffered as a child. It got to the stage where she felt like she was going through the experience again and this prompted her to disclose her distressing past to a healthcare professional:

*07: I'd almost gone back into a different time of my life when things had effected me and...other people (participants) have probably spoken to you about the Pandora's box – so much was coming up and being relived and one day I just had the confidence and it all came out to the CPN and having sat down with the CPN and in just that one telling um and then having told my CPN I was able to tell my husband more easily about a lot of the things....*

She felt better after offloading her traumatic past and within a very short space of time when she was in a more positive frame of mind the urge to cut was first triggered.

*07: Yeah, yeah....I wouldn't want anyone to go through that. But also I think now um.... that time I think in some ways has done me a favour now and I look at it that it's got rid of a lot of the junk that I've been carrying for 25 years and there's been things there that have been affecting me over that time and as I had to go through that four months or whatever and the recovery, there's a lot of things that I carried then that I've totally got rid off and in many ways I am better than I've ever been now....*

Participant 06 however preferred not to talk about her past abuse and had warned her family not to discuss it with her. Perhaps her way of coping with the past was to shut out what happened:

*06: But we don't really talk about it, I mean, I mean I did say to them and everybody – I says you know don't ever mention what happened at school because I'm not going to say anything, don't say anything,...*

Perceived danger, guilt, shame, and instability are among the factors which sometimes prevent people who have been abused from disclosing their secret (Calof, 1995b). Although the abuse, neglect and bullying suffered by the above participants happened a number of years ago it was still very distressing for them when they relived or thought about these traumatic past experiences. At times they had no control over reliving the past in terms of the flashbacks, and this was perhaps a more dangerous time than when they disclosed their past to a healthcare professional, where there was support and help available for them.

## **Emotions**

The subcategory 'Emotions' describes the range of emotional states which the participants associated with 'triggering the urge' to cut. Cutting brought about a temporary change in their emotional state which usually made them feel better (this will be explored further under the subcategory 'cutting function' in the chapter 7).

The following property, 'type of mood', illustrates the different moods which the participants reported as 'triggering the urge' to cut.



### *Type of Mood*

Bywaters and Rolfe (2002) discovered that some of the participants in their study felt that their emotional state was the main reason for cutting. The following quotes demonstrate how low mood and depression were reported as affecting the participants in the present study and triggered the urge to cut:

*04: ...erm the most time that....when.....I cut my arms or think about cutting is when I feel really down and I don't go down gradually, you know I don't go down so erm its not like a period of 3 weeks where I go down gradually, I just go straight down like you know.*

The above quote suggested that the urge could be triggered quite quickly for this participant because his mood deteriorated so suddenly, and this was when he felt like cutting. His low mood was characterised by feelings of low self-worth and self-esteem and it appeared as though he felt very alone:

*04: ...but when I'm, when I'm feeling down and depressed and low and feel that the world is against me and everybody hates me and nobody wants to help me, when I feel like that then....you know that's when I start to feel that I want to cut...that's the hardest time like you know...*

Low self-esteem and feelings of worthlessness also triggered the urge to cut in many of the participants. It appears as though they cut because they had such a low opinion of themselves and felt they deserved it. For example:

*07: If something goes wrong, if I've done something and I feel stupid my first feeling is to....to cut myself, not badly*

*14: Sometimes it's self-hatred and just wanting to damage yourself as much as possible really because you deserve it,*

When participant 06 felt down she sometimes drank alcohol alone in her house and often this made her feel even worse and the urge to cut was then triggered:

*06: I mean sometimes when I'm bad, I'll drink at home and then you know it's like – oh itching and cutting myself...*

Participant 08's depression developed over a few years and his description of what it feels like to experience a very low mood conveys the image of being trapped in a constant darkness:

*08: So gradually I became sort of unhappy – the way I describe it, which lots of people describe it as, – I felt that I was stuck in some sort of dark hole, some dark prison...*

In addition to depression or low mood 'triggering the urge' to cut in some participants, feelings of anger were also reported. It appeared as though the participants could not keep the anger inside for very long. The source of the anger was either internal or external but in both cases it appeared to be controlled through cutting. The urge to cut was triggered in the following participant when she became angry and wanted to get rid of that feeling:

*06: I think it's when you're really, ....really upset you know and you want to get anger...*

Participant 11 appeared to feel dominated by the anger that was inside her and it affected the way she interacted with her family. It seemed as though the anger would get to a certain level and then the urge would be triggered for her to release it:

*11: When you've got so many emotions going through your head you know, and when you're so ....so angry...that nothing else matters, you've just got this constant anger and you're destroying your family, you're destroying everything about you but you can't help it, you know..*

*11: Yeah and just I suppose as well he (husband) was preventing me a lot of the time from cutting so I still had all this anger inside and then I had the anger as well towards him.*



The anger experienced by the participants did not just come from within it also emerged as a result of interactions with other people. For example in the above incident the participant already had anger inside her and then she started to feel angry towards her husband because he was preventing her from cutting. Participant 05 reported that his anger was mostly targeted at other people and he expressed this through cutting:

*05: ...and em I now think most times as being anger towards em another person that's um been involved although I would...more often even prevent them finding out....the anger in some way being directed towards them. I would be feeling at the time that that's how they made me feel...*

The following participant explained the difficulty she had communicating with people and she partly attributed this to her diagnosis of borderline personality disorder. She found it frustrating that she could not express how she felt and this led to her getting angry and then the urge to cut was triggered:

*13: Mmm could be an argument with my husband, could be, because I can't, I'm not very good at getting things across at him – communication is quite hard because they say, I don't know whether it is a lot of people but...because I've got borderline personality disorder and they are not very good at understanding what emotions are what or and they find it hard to use the right words to get across and so there is mis-communication and I still find it very*

*difficult to communicate so in the end I get so frustrated and so angry and so upset that I end up self-harming....Blooming anger, the anger is terrible....*

She explained that instead of physically or emotionally taking her anger out on other people she directed it towards herself:

*13: .... and the cutting I associate with me as being anger....Yeah, rather than wanting to hurt anybody else you hurt yourself.*

Participant 14 sometimes felt angry because of the actions or words of other people and like the above participant did not direct her anger outwardly but internalised it and cut herself. She believed it was more socially acceptable to cut herself than to react angrily to comments made by another person, so whenever she found herself in that situation the urge to cut was triggered:

*14: Sometimes it's because you are so angry because someone has come up to you in the street and said to you in the street, and you don't even know who they are and they've given you a whole load of abuse you know. Sometimes it's just erm you know I feel like just mashing their brains into the pavement (laughs) you know and erm but in a person that's not acceptable you know so I internalise it and take it out on myself*

This is similar to the experiences of Sue (Solomon & Farrand, 1996) who also talked about taking her anger out on herself through cutting instead of hurting someone else.

### **Chapter Summary**

The first time the urge was triggered in the participants appeared significant in that their lives were never the same again. It did not matter if the urge to cut was triggered by accident or learned, all of the participants except one continued to cut and were then consciously '*living with the urge*'. The urge became a part of the participants' lives and they described the experiences and emotions which they believe continued to trigger the urge to cut. The participants took on the new identity of being people who engaged in self-cutting compared to how they previously perceived themselves. The next chapter gives an insight into this world of cutting and describes in more detail what happened when the participants satisfied the triggered urge to cut themselves.



## Chapter 7

### Living with Self-Cutting: Satisfying the Urge

#### Introduction

This chapter will explore the third main category, '*Satisfying the Urge*', which focuses on the cutting act itself. It describes what was going on in the participants' lives when they satisfied the urge to cut, and how it impacted on them personally and socially. All this time the participants were living with cutting and the urge was active during this phase. Conditions which made it difficult for the participants to satisfy the urge will also be described. The participants often talked in detail about the cutting act and this indicates how important and meaningful it appeared to be for them to satisfy the urge. While some aspects of the cutting experience have also been touched on in Chapter 6, ('Triggering the Urge') this chapter provides a more in-depth account of the cutting act itself, and serves to 'get closer' to explaining this behaviour which had been or still was central to the participants' lives. There were a lot of similarities between the cutting experiences of the participants, however variation did exist and this will be highlighted.

The main category, '*Satisfying the Urge*' is presented in figure 7.1 in relation to the other main categories and the core category. The subcategories of the main category, '*Satisfying the Urge*' are 'Cutting', 'Cutting Tool', 'Cutting Function', and 'Suffering the Consequences'. Given the volume of subcategories, properties and dimensions, Figure 7.2 has been separated into two parts, with the first part (7.2.1) including the



subcategories 'Cutting', 'Cutting Tool' and 'Cutting Function', and the second part (7.2.2) includes the subcategory 'Suffering the Consequences'.

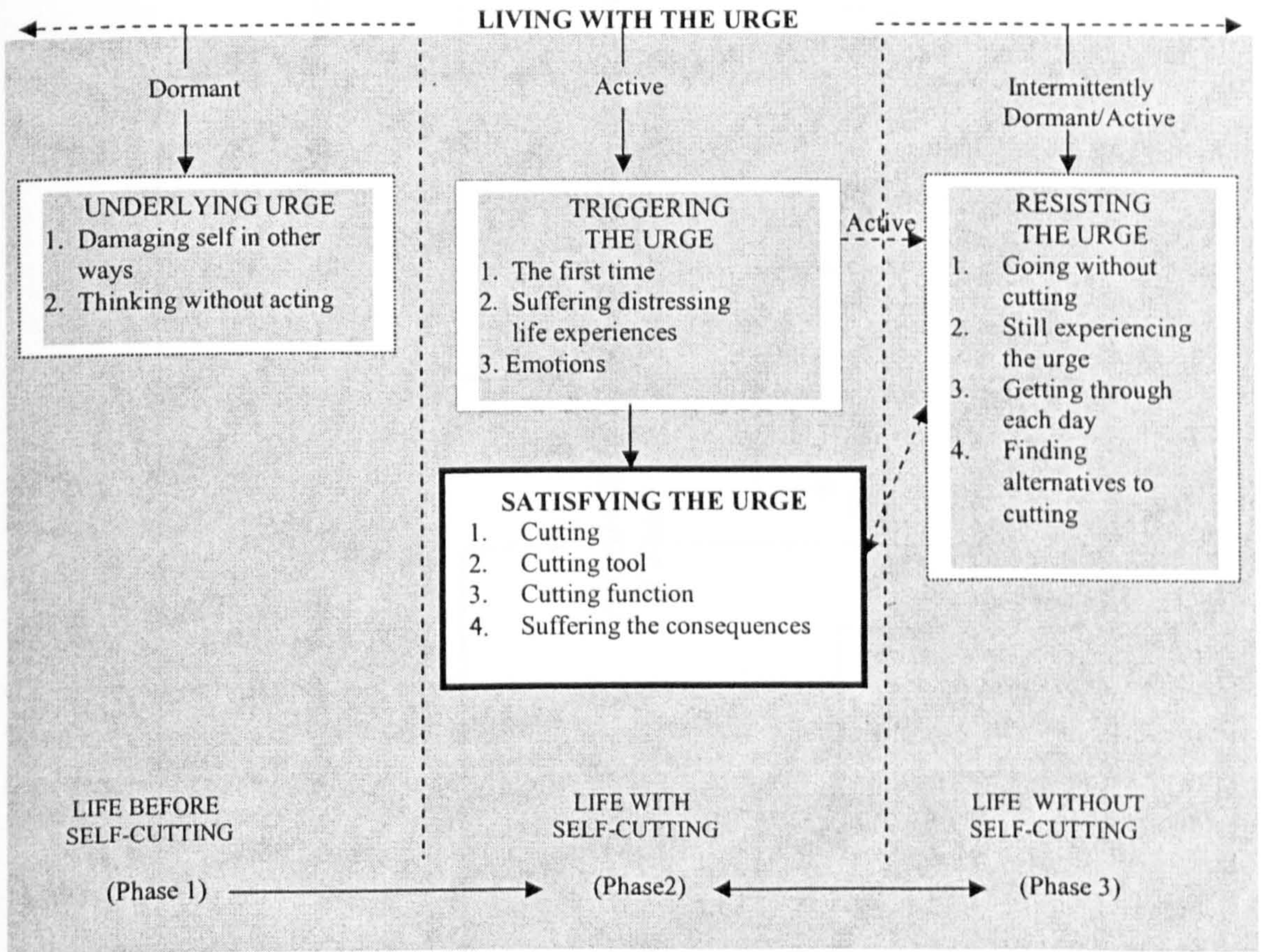


Figure 7.1: The main category 'Satisfying the Urge'



# Satisfying the Urge

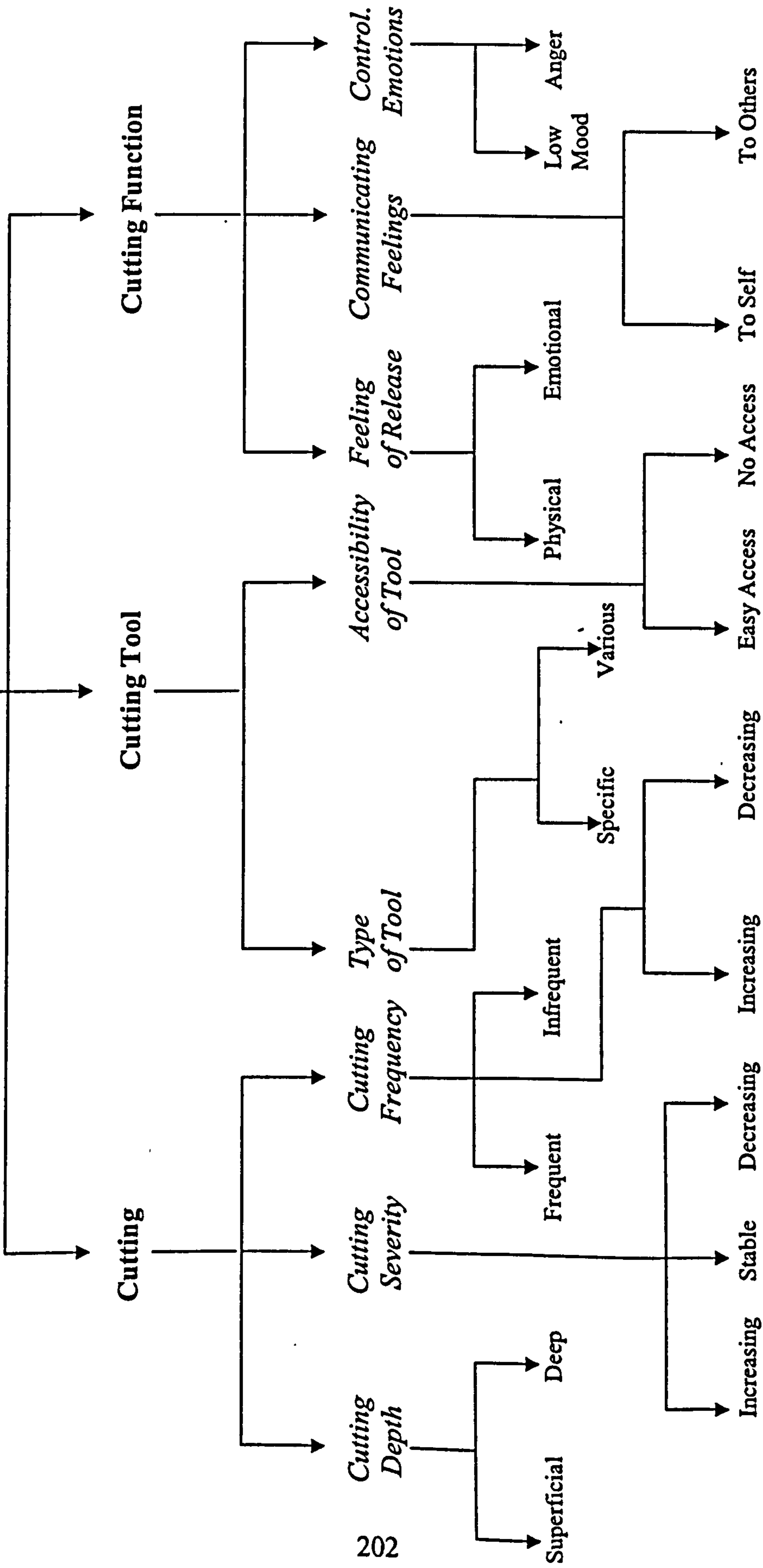
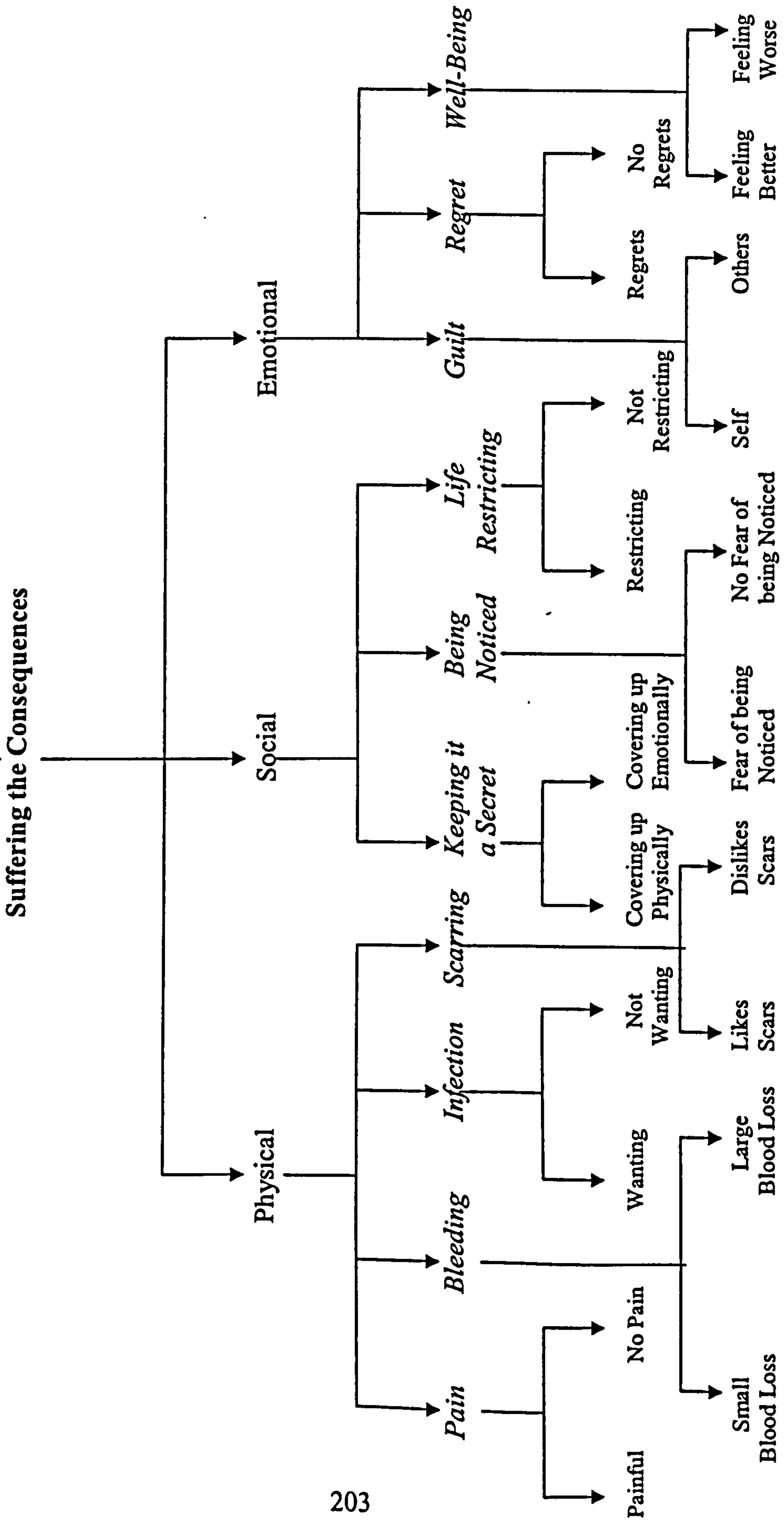


Figure 7.2.1 Satisfying the Urge (Subcategories, properties and dimensions) Part 1



**Satisfying the Urge (Subcategories, properties and dimensions) Part 2 Figure 7.2.2**



## **Cutting**

The subcategory 'Cutting' describes the act which was the focus of the participants' urges and is the most common form of self-injury (Favazza & Conterio, 1988; Hawton & Catalan, 1987; Arnold, 1995a; Herpertz, 1995; Babiker & Arnold, 1998; Briere & Gil, 1998; Hawton, 2000). A number of properties of the subcategory, 'Cutting', were identified in the data: 'cutting depth', 'cutting severity' and 'cutting frequency'. These properties help to illustrate 'Cutting' and highlight the various ways in which the participants satisfied the urge.

### *Cutting Depth*

The property of 'cutting depth' outlines the different depths to which the participants cut themselves. Some participants engaged in minor self-cutting and the resultant damage was usually superficial. For example:

*07: It's just silly scratches um.....*

*08: I understand the self-harm I do where it's sort of moderately safe um and I wanted always to be much worse but certainly I've met people who've really badly damaged themselves, they've put their lives at risk with their self-harm and I don't understand how they can do that.*

*10: Erm I don't cut deep, it's superficial cuts I usually do...I mean I don't, I suppose in one way I don't have the courage to cut deep because I think if I was to start cutting deeper I wouldn't stop... You know I would just keep going....*

Although the above participants claimed they were able to keep their cutting under control in terms of the depth, some of them admitted that they would like to cut deeper but lacked the courage to do so. The participants were not putting their lives in danger by cutting superficially and this was perhaps the reason why they kept their cutting behaviour stable and quite controlled. Notably only one participant cut deeply from the outset. There appeared to be different paths of cutting; with some participants cutting either deeply or superficially all the time, and others who started cutting superficially and then increased the severity of their cutting.

### *Cutting Severity*

Unlike the participants who appeared to keep their cutting depth at a fairly stable level, the property 'cutting severity' describes the situation whereby superficial cutting did not continue to meet the needs of the participants. In order to satisfy the urge to cut some of the participants progressed to deeper wounds:

*05: When I first started doing it um.....there were minor ones which didn't require medical attention and it was gradually a process of escalation...some people manage...to go on...through their self-injury career just keeping to that*



*level and that's probably more sustainable as a coping mechanism but I, I couldn't do that...*

This participant was aware that some people manage to maintain their cutting behaviour at the same superficial level over time; however this was not possible for him. Like participant 05, the following participants also experienced an increase in severity of their cutting:

*11: The first time it was just a couple of scratches and what not, just to see what it was like and then it got worse...*

*13: I thought to myself I don't want to do things superficial anymore,*

*14: I started doing it a lot deeper when I moved out of the hostel and I was staying in a room in a family house, that's when I really started going for it you know....*

As well as progressing to deep cutting two of the participants actually went one step further and cut out parts of their skin:

*11: Yeah I used to um.....eh.....I would try and cut away – I had like bad points on my body or what I classify as bad points on my body – I would try to cut those away*

Participant 11 experienced the urge to cut out what she called 'bad points' on her body, areas which she perceived to be bad. This participant had been abused as a child and the 'bad points' could have been related to this distressing experience. Similarly the following participant also cut out parts of her skin however she did not refer to these parts as being 'bad'. Once she had cut off a piece of skin she would then dispose of it:

*13: Then I started uh, mutilating parts of my body, just taking off, taking lumps of skin out and just...cutting them off and getting rid of them.....*

In addition to this severe type of cutting, she also engaged in blood-letting. She explained what she meant by this term:

*13: ...blood-letting, have you heard of that? You cut your veins and then you just bleed....*

Blood-letting appears to be a rare form of self-injury and has been linked to bulimia nervosa and borderline personality disorder (Warren et al. 1998; Margo & Newman, 1989; Parkin & Eagles, 1993). Warren et al. (1998) proposed that both the expressed intention and the meaning of blood-letting for people who carry out the procedure is important for ascertaining its diagnostic significance. Furthermore, they argue that a complex behaviour like blood-letting is unlikely to have one cause or one which is diagnostically significant. A participant in Bywaters and Rolfe (2002) also progressed from cutting to blood-letting. She explained that because she liked the feelings

associated with blood loss she "needed to get into veins, to let the blood come out, because it was that that I was trying to release" (p. 8). Interestingly, blood-letting relieved feelings of tension, anxiety and anger in three women who engaged in the practice (Parkin & Eagles, 1993). There are reports in the literature of people discovering the practice of blood-letting through their work places, for example veterinary school and medical school (Margo & Newman, 1989; Parkin & Eagles, 1993). Participant 13 however did not know where the idea of blood-letting came from:

*13: I don't really know how I discovered it, one of the veins broke probably and then cos it weren't bleeding and bleeding I thought well I want.....and then you put a tourniquet round it so you would, so it would bleed even more and it was all over the place...*

It might be assumed that the deep cutting described above indicates that the person is in a more distressed state at the time than someone who cuts superficially but this does not seem to be the case. Pembroke (1994) has personal experience of self-cutting and she states that the underlying feelings may be the same whether the injury is a superficial scratch or a deep cut. When asked if the severity of his cutting related to his level of distress, participant 05 responded by saying:

*05: No, particularly some of mine were quite neat and so that...you know...it's probably deeper and more severe than you know a really agitated, frenzied show of hacking which would probably have indicated more distress...*



Participant 05 suggested that superficial cutting is just as likely to be indicative of a distressed state as deep cutting. It would appear then that once the urge to cut was triggered the type of cutting needed to satisfy this urge varied not only across the participants but also over time. Some of the participants increased the severity of their cutting in order to meet their needs. Cutting ranged from being fairly minor with little damage to the skin, to deep cutting which in some cases involved the severe practice of cutting out lumps of skin and the letting of blood.

### *Frequency of Cutting*

It was not only the level of cutting that varied across the participants. The property 'frequency of cutting' describes how often the participants engaged in cutting which varied over time for most of the participants. There were periods where they cut very regularly and then at other times did not cut for weeks or months. The following participants cut at least once a day when their cutting behaviour was at its peak:

*06: When I was first not well I was doing it a hell of a lot... all the time...*

*11: ... sometimes two or three times a day...*

Cutting once a day does not necessarily mean that a single cut occurred:

*10: ... I'll only sort of do it once a day, cut once a day but by saying that it's an area I will cut, you know it could be the whole forearm I'll cut even though it's superficial it's not just like the one cut.....*

In contrast to the above, only one of the participants reported his cutting rate as being infrequent:

*05: Not too regularly... the smaller ones were more regular. I'm amazed at the number of tiny ones now...I, I can't remember doing anywhere near that many....*

He did however cut a number of times over one weekend but he had a reason for increasing the frequency and this was to get into hospital:

*05: There was one.....I had, I had one strange episode where I did it a few times in a weekend when I was trying to get into hospital*

Participant 07 also increased the frequency of cutting but unlike participant 05 it was because the urge to cut became more frequent. Participant 07 appeared to find that she had to cut more often in order to fully satisfy the urge:

*07: But it got to the stage where I just knew I was wanting to do it more and more and it was getting sort of worse and worse and I knew that...*

As well as increasing the frequency of cutting there were also occasions when the participants decreased the rate at which they had been cutting. Most of the participants at the time of interview had not cut for periods of time varying from a few weeks to more than three years (Chapter 8 will look in more detail at how the participants decreased the frequency of their cutting and '*resisted the urge*' to cut).

### **Cutting Tool**

The tool which was used to cut the skin appeared very important to the participants because it was the means by which the urge to cut could be satisfied. The subcategory 'Cutting Tool' outlines the various tools which the participants used to cut themselves and through describing the properties 'type of tool' and 'accessibility of tool' the importance of tools is highlighted. These properties relate to the subcategory 'Cutting' and its properties in that the 'type of tool' used and the 'accessibility of cutting tools' appeared to have some effect on both the 'severity' and 'frequency' of cutting.

#### *Type of Tool*

The property 'type of tool' describes the instrument which the participants used to satisfy the urge to cut. Some of the participants had a specific tool which they favoured when cutting:

*07: I can only remember cutting with the nail scissors and they sort of became my special, that was...the....that's, that's what I wanted to use and I could like press hard enough to make a mark...*



Harrison (1995) explains that possessing a favourite tool may reflect a small amount of self-worth and concern regarding what one does and how it is done, and furthermore it gives people a feeling of control over what they do to their bodies. This is exemplified in participant 07's use of scissors in that they may have given her control because she knew how to use them in order to get the desired interaction with her skin. She highlighted the danger of using an implement which she was not familiar with. The unexpected sharpness of a knife made participant 07 realise that she could not engage in deep cutting.

*07: I remember once I got the bread knife and it was just horrendous – I sort of started with the bread knife and it was too sharp and too – oh I can't do it with this so that was very significant what you could and couldn't....do.*

Although participant 10 had tried other cutting tools, like most of the participants she preferred using razors:

*10: I mean I don't use the likes of glass, I don't, I'm not, I don't break glasses or anything like that – it's normally razors I use but I have erm broke cups on the odd occasion and tried using the cup you know to cut myself but never worked for me (laughs), never worked for me...yes it depends whether it smashes or not as well...*

Similarly participant 14 used razor blades and even bought a specific brand:

*14: ...personally I use Bic razor blades you know*

Other studies have also reported razor blades as the most common choice of cutting tool (Rosenthal et al. 1972; Sutton, 1999). Participant 14 was very careful with her cutting in terms of limiting the damage she caused to herself and for her cutting was like a ritual. She did not want to use implements which might increase her risk of infection and cause her to have to seek medical help:

*14: I also always used to use a erm, a razor blade because I really believe that you've got to be very careful about...I mean I wouldn't use things just like a jagged piece of glass because you are going to get a very....bits of glass are going to come off in the cut – that can cause complications erm you would have to go to hospital and get all this attention that you don't want you know. I used to take very great care about disinfecting everything and of course it's also a ritual as well you know – it's very ritualised...*

Participant 13 explained that she had a ritual of keeping a supply of razor blades hidden in her house:

*13: I've got to have my blades...I've got to have them, I have a ritual, I get all the ordinary throw away razors and I pull them to bits and I put them all nice*

*and tidy in a little box, hidden in my blooming drawer and I've got to have them around...*

This careful storing of razor blades was important to 'Christine' (Smith et al. 1998) who numbered her blades and used them in sequence until they were blunt. Tsai (2002) describes how cutting appears to be mainly performed as a ritual and he compares this to self-mutilating practices common to ancient and primitive cultures. Tsai (2002) explains that a cutting ritual may involve setting out the instruments or tools in a certain order, choosing a special area on the skin, cutting a specific amount of times in parallel patterns and to a controlled depth. Although this may be true for some people who self-injure, the cutting process can be highly variable in terms of how it is carried out. The following participants did not have a specific tool for cutting and were prepared to use any instrument to satisfy the urge to cut:

*04: It could be anything sharp like sort of thing, if it's got a sharp edge on it sort of thing, would do like, you know*

The only requirement that participant 04 had for the tool he used was that it had to be sharp and he even tested out tools to check their suitability:

*04: I practised the other day on a bar of soap to see how sharp the knife was still and it was still quite sharp like because I put the knife to the soap and then I just pressed and it cut quite deep sort of thing into the soap like so I thought to*



*myself – well at least I've got a nice sharp knife now like, I don't, I don't have to smash a picture to get a piece of glass to get something sharp like you know. But it doesn't, it doesn't have to be a knife....*

Although the following participant preferred using blades to cut she was not quite as dependent on them, and she felt okay providing she had access to glass. This obviously gave her more options if the urge did arise:

*11: I prefer blades but I sort of figured it out that as long as there was plenty glass, then you know I was sorted, it was okay...*

Using a specific tool enabled the participants to build up knowledge about the instrument in terms of what it was capable of, thus reducing the risk of cutting more severely than they had wanted. Cutting with pieces of glass or basically anything with a sharp edge increases the chances of the cuts becoming infected and presents increased risks.

### *Accessibility of Cutting Tool*

The property 'accessibility of cutting tool' describes circumstances in which the participants had no access to their favoured cutting tool or in fact any means of cutting. One such example was when the participants were admitted to a psychiatric hospital and under this condition '*living with the urge*' appeared to be even more difficult in that the participants had very few opportunities to satisfy the urge to cut:

*04: I had a period of...3 months in hospital and then when I couldn't eh....when I couldn't get a knife or anything I was, I used to throw myself against a wall like you know to try and hurt myself like you know.*

Participant 04 resorted to other methods in order to meet the need of hurting himself. Instead of using implements to injure himself he had to find strategies which did not require a tool. This was also the case for 'Joanne' (Bywaters & Rolfe, 2002) who banged her arm against a wall, occasionally burned herself or took overdoses when she had no tools to cut herself with. Participant 08 was sometimes unable to cut himself when in hospital and it was even more difficult for him when he was under observation by the staff:

*08: I was then put on special observation for two or three weeks so there was someone with me all the time but I carried on trying to burn myself which I succeeded in sometimes. All the things with which I could damage myself were taken off of me and, including cigarettes*

Some of the participants however managed to find other implements suitable for cutting when they were in hospital:

*07: I did it a few times in hospital um..... when I was in hospital I couldn't get hold of my scissors so I did it with like a nail file which isn't too sharp on the end...*

Despite not having access to her favoured tool she was still able to cut herself using a similar implement to her preferred choice. Participant 11 did not let the hospital environment prevent her from cutting, and she explained that if the urge was strong enough she would find a way to cut herself:

*11: ...they put me onto constant obs (observation) and things like that but I would go down to the coke machine and get a tin and pour the juice away – I didn't want the juice I just wanted the tin you know...*

Similarly, Grunebaum and Klerman (1967) described how it was not unusual for inpatients to break windows or smash light bulbs in order to acquire glass. As participant 11 stated:

*11: If you're desperate enough there always a way you can do it and I thought just set my mind on doing it...*

Despite being closely supervised and having access to activities restricted, most of the inpatient adolescents in Simpson and Porter's (1981) study still managed to continue cutting themselves whilst in hospital. Like some of the participants in the present study



the adolescents stockpiled secret supplies of blades or glass until they could use them (Simpson and Porter, 1981). The following participant even managed to go into town and buy a knife and return to the hospital with it. As was the case with participant 11 this highlights how desperate the participants could be in order to satisfy the urge to cut:

*04: I was in hospital, I was in for, what was it, about, I was in for about 3 or 4 weeks to start with and I ventured into the town to (shop) on (X Street) and bought a knife and then went back to the hospital and went up into the old golf course and cut my arms to bits up there sort of thing. Eh so being in hospital it didn't actually stop me from doing it....*

Participant 13 also managed to cut herself in hospital and described herself as being devious when it came to self-cutting:

*13: They took me into hospital again and that's when I, because it is difficult to get hold of stuff in hospital I would get hold of paperclips and put them under, underneath my skin and just leave it there and stuff like that....*

*13: There's always a way to do it – you can get very devious when you self-harm, very devious and for some reason.....I think I had a weekend home or something.....and I took a knife back with me.....*

Participant 10 was also able to cut in hospital and sometimes she did not have to find other implements because she managed to hide her preferred tool from the nursing staff:

*10: I mean I've had razors in my room....but I know they are there and if I need them I can have them*

However sometimes participant 10 found herself in the situation where she did not have a supply of blades in her hospital room and this caused her to panic if she got the urge to cut:

*10: It's like you've no control if you haven't got them there – it's like you've no control and you are panicking and to me I am looking about for – what can I use instead type of thing but I don't want to break anything to use, you know to use that or whatever...*

At times participant 10 had to resort to looking for other implements due to not having access to her preferred cutting tool. Whether the participants used a specific cutting tool or a variety of implements, they appeared to depend on the tool and this is understandable given its role in 'satisfying the urge'. The relationship between the participants and their cutting tools will be further explored in the next chapter, 'Resisting the Urge' focusing on the role of the cutting tool in helping the participants go without cutting.

## **Cutting Function**

This section will explore the subcategory 'Cutting Function', illustrating the benefits reported by the participants of 'satisfying the urge'. Self-cutting is used by a number of people as a coping method and it can serve a variety of functions for a person (Pembroke, 1994; Arnold, 1995a; Harrison, 1995; Spandler, 1996). In this study, participants described a number of beneficial functions which cutting served for them, and these functions generally related to the experiences or emotions which triggered the urges. However empirical research on the functions of self-injury is limited and this area requires further exploration (Gratz, 2003). The properties of 'feeling of release', 'communicating feelings' and 'regulating emotions' represent the cutting functions reported by the participants.

### *Feeling of Release*

The property of 'feeling of release' describes what the release felt like for the participants when they cut. Nearly all of the participants reported experiencing a feeling of release when they engaged in self-cutting, and this was the most common function of cutting in this study. The participants appeared to describe two different types of release experienced when 'satisfying the urge', physical and emotional. Both of these will be described below.

Two of the participants who had suffered sexual abuse in their past described feeling dirty inside as a consequence, and in this context cutting appeared to enable them to physically release the 'dirty blood' from their bodies:



*04: ...because really still to this day like, I, I feel my body is dirty like you know...from the past like you know and uh....it is a release*

*06: I mean I felt I had dirty blood in me and just wanted it out and whatever you know.*

Cutting appeared to be an effective means of ridding these participants of the dirty feeling they associated with being sexually abused. Seeing the blood physically leaving the body appears to symbolise the dirtiness being released and contributes to the feeling of release. Although participant 04 went to A&E when he had cut, he did not want the bleeding to stop because then the feeling of release would also stop:

*04: They just kept putting my arm up in the air and I just kept putting it down again like you know because I wanted to see the blood coming out like you know and eh, eh...that would be like the release sort of thing that I was getting from it...*

Participant 10 did not report why she felt she had 'badness' inside of her however similarly for her cutting was a way of physically releasing this badness. Again, seeing the blood contributed to the feeling of release because she felt that the 'badness' and 'evil' were being drained from her:

*10: ... to me it's just a release, it's a way of getting badness...you know and it just, it's coming out, the bloods coming out and you're seeing it and as I say that's you know, it's like the badness and all the evil...*

Arnold (1995a) reported how for some women, self-injury symbolised washing or cutting out parts of them which they felt were bad. A quote from a young victim of sexual abuse illustrates this point: "If I only cut just the once and see the blood coming out of my veins then it'll cleanse me – make me feel that I've released all the dirt that's sticking to my veins – and I would – I'd cut once and I'd immediately feel the pressure released" (Spandler, 1996, p. 31). Harris (2000) proposes that the women in her study used the term, bad, as a metaphor for the wrong doings of others such as abusers or rapists. Participant 13 reported that for her, the large amount of blood lost in blood-letting provided a big physical release:

*13: ...it is a big release that, big, big release that....*

Participant 14 also emphasised the importance of seeing the blood when cutting:

*14: The release of blood is a, is a big thing you know*

Interestingly, participant 14 commented that at times the feeling of release was essential for survival:

*14: Sometimes it's a way of just continuing to live because if you didn't get it out somehow, you would end up taking an overdose...*

In addition to the physical release which cutting provided, some participants also appeared to experience an emotional release. The following participants talked about the emotional pain which they felt inside:

*04: But the reason I cut is because it releases the pain that's inside of me like you know...*

*11: Erm...eh a release of all the emotions that you are feeling...*

Both of the above participants had been sexually abused in their past and suffered emotionally because of this distressing experience. Through 'satisfying the urge' to cut they were able to release the emotional pain. The length of time that the feeling of release lasted when the participants satisfied the urge to cut varied from a few minutes to a few hours. Participant 07 found that cutting gave her a quick release. Similarly, for participant 10 the release usually did not last very long but it was still effective in making her feel better. She likened the release to "a big sigh" and this gave the image of a build up of negative feelings and then releasing them (or breathing out) through cutting:

*10: It doesn't last long with me – the release...*



*10: Even if it's just a couple of minutes release you're still cutting, that release – it's just like a big sigh...*

The following two participants found that over time the length of the feeling of release became shorter:

*11: ...but then it started that it was only giving me a release for a few minutes towards the end....*

*14: Towards the end of my last cutting, my last few cuttings I did erm I was finding it absolutely frustrating because I actually....initially I was getting immediate release from it for maybe like ten, twenty, thirty seconds or a minute or something...*

There were occasions when participant 10 experienced feelings of release which lasted a lot longer than the above examples of a few minutes:

*10: I mean with me sometimes it can last a couple of hours...*

The following quote gives an example of the circumstances under which participant 10 experienced this longer release and that was when she cut a larger area of her arm:

*10: The fact that I've managed to cut the whole forearm or whatever and there's a lot of blood come out, it does give me more of a release or whatever that will last a bit longer.*

Given that the release did not stop for participant 04 until his wounds were stitched up implies that it lasted longer than for just a few minutes:

*04: Aye, aye – they've done their job, they've covered me up and that's it, it (the release) stops sort of thing.*

Consistent with the experiences of the participants in the present study, Bywaters and Rolfe (2002) reported that the feeling of release appeared to be generally short-lived, but despite this it seemed to be both worthwhile and necessary for the participants.

### *Communicating Feelings*

Some of the participants found it difficult to express to others how they felt and as a consequence stored up their feelings inside. The property 'communicating feelings' describes how the participants not only had problems communicating their feelings to others, but they also struggled to understand and express how they felt within themselves. For these participants cutting functioned as a means of communicating how they were feeling:

*08: It certainly gave expression to things I couldn't express both to myself and to the doctor um...*

The above participant found that cutting met his need to express and communicate the feelings he found so difficult to verbalise. Ritchie and Ashcroft (2004) propose that individuals who are unable to express their pain through words often perceive cutting as a means of expression. For participant 08, cutting was the most effective way of communicating his emotions to his doctor:

*08: ...and in a way that gets to one of the issues of self-harm – I couldn't communicate really at that time and in the doctor's surgery when he asked what was wrong I just rolled up my sleeves and showed him and it was a very graphic way of illustrating how I felt....*

Suymeoto and MacDonald (1995) found support in their study for an 'expression model' of self-injury, with this model receiving the most endorsement from therapists, along with the control model. The expression model perceives self-cutting as "stemming from the need to express or externalise overwhelming anger, anxiety or pain that is seen as unable to be expressed more directly" (p. 164). Participant 10 explained that on occasion her cutting was a way of communicating to the nurses in the hospital how she felt, but at the same time she did not want them to intervene in any way:



*10: I don't want your attention but I am just letting you know – this is how I am feeling erm you know sort of keep an eye on them, it's hard to explain...*

Cutting as a means of communicating feelings to others is often misinterpreted as being an act of attention-seeking. The following participant explained what he thought of this:

*08: My feeling is I think attention-seeking is a very good way of saying it because I used it to get attention. Um, I don't see there was anything wrong with that, um sometimes drawing attention to yourself, to you – you know you need to give attention to how you are feeling um I suppose... that people use attention-seeking as a derogatory label and I think that is wrong...*

It seems to be the case that people do use the term 'attention-seeking' negatively in relation to describing people who engage in self-cutting. For example, people who self-injure have reported being labelled as attention-seeking and manipulative by clinicians in response to their injuries (e.g., Pembroke, 1994; Harrison, 1995). For example, participant 07 tried to communicate her distress through cutting but she still kept her behaviour hidden from her family. She hoped the healthcare professionals would notice her cuts and then help her deal with how she felt:

*07: A lot of people who don't self-harm, sort of associate it with attention-seeking...which it's very much not, and I think I very much wanted the medical*

*people to know, I wanted the nurses to know um, when I was younger I wanted the um...doctor to know and the like but I didn't want my mother to know and I didn't want my husband to know....*

Cutting also helped participant 08 to express and communicate his self-view to himself:

*08: I find that I really get confused with images of....um....self-images. Part of me in the psychotic bit sees me truly as evil and bad, a lot of me sees me as quite a nice person and I think there is a funny mixture there within... and I think self-harm is a way of expressing how bad you feel about your own self-image when sometimes you're not very clear what your own self-image is... yeah.*

Harris (2000) reports that communicating inner distress or making it visible to the self through cutting was a familiar theme both within her study and in the literature on self-injury. Solomon and Farrand (1996) suggest that in their study self-injury may have a communicative effect as a means of expressing intense feelings.

### *Controlling Emotions*

For some of the participants in this study cutting met the need of controlling their emotions. The property, 'controlling emotions' explains how cutting either changed the participants' emotional state from negative to positive or it stopped their emotions from becoming out of control, for example, anger. People who engage in self-cutting often

suffer from low mood and depression and this can trigger the urge to cut (see subcategory 'Emotions' in previous chapter). For example, the most common reason for why the participants in Nixon et al's (2002) study engaged in self-cutting was to cope with feelings of depression. The following quotes describe the positive emotions that emerged for some of the participants in the present study whilst 'satisfying the urge':

*07: ...it felt good...*

Participant 07 found that cutting lifted her mood and made her feel good so she continued to satisfy the urge. She compared the effects of cutting to that of taking drugs and described the feeling as "a real high":

*07: When you do it, it would give you like a real high and, I mean it was like um...yeah it was like taking a drug and it would lift you for a while.*

Favazza (1989) discovered that feelings of euphoria were reported by some of his patients, with one stating that cutting gave him a high feeling. The following participant experienced a similar positive state when 'satisfying the urge' to cut:

*13: And sometimes with me and I think with other people as well, there's different feelings for different parts of self-harm...with blood-letting it's just like*



*you get this feeling of euphoria I suppose, that's one of the words which describes it – euphoria,*

Although participant 05 described cutting as a “buzz” he reported that he did not understand people who cut for that reason:

*05: ...there was in some ways a sort of buzz but em...*

*05: I found the exhilaration quite strange...but I can't imagine that being a factor in anyone doing it unless they're very disturbed, anyone doing it even partly for that reason.*

As well as lifting the mood, cutting also brought relief for some of the participants from an unbearable emotional state. The following participant found that cutting relieved him of the suicidal feelings and dark thoughts he had:

*08: Initially each time I thought I am going to kill myself and I would cut myself and that provided a relief from what I was feeling...*

Participant 14 explained that the pain from the wounds gave her relief from the emotions that were inside of her:

*11: ...but a relief as well because you are physically sore now so it takes away from the emotions....*

Similarly, participant 14 found that cutting brought relief from the emotional pain she experienced:

*14: It takes it away from the emotional pain for a while....*

Anger was another emotion which some of the participants found that cutting helped control and this is consistent with the findings of other studies (Gardner & Gardner, 1975; Himber, 1994; Calof, 1995a; Ross & Heath, 2002; Abrams & Gordon, 2003). The following quotes describe how the participants cut themselves to control their anger:

*13: ... and the cutting I associate with me as being anger.... yeah, rather than wanting to hurt anybody else you hurt yourself.*

‘Satisfying the urge’ to cut helped participant 13 control the anger she felt towards the people who had bullied her:

*13: So um a lot of it was mental torture...yes it was terrible so I think that's why I started hitting out on myself instead because that way I was only hurting, physically hurting me but the thing is it didn't bother me that I was physically hurt, I can handle physical stuff, it's the mental stuff I can't handle. But I thought well if I do that you know it, you don't see it that way at the start, at the*

*beginning. In the beginning you don't see that it's them that you are doing it to, to, but...it helps because you are just so angry....*

Similarly for participant 14 cutting functioned as a way of controlling anger:

*14: it's (cutting) a way of controlling emotions within myself instead of taking it out on other people...*

Participant 14 talked about “internalizing the fight” instead of acting outwards against the people who had upset or angered her:

*14: I actually say okay it's maybe not the best thing to do – to cut yourself or harm yourself in other ways like burn yourself with a cigarette but erm it's actually a lot better than most of society deals with their problems because you know – okay we are inflicting harm upon ourselves but a lot of people just go out, have loads to drink or not even loads to drink, just get into fights and beat people up and....whereas we are just internalising the fight you know....*

Conterio and Lader (1998) acknowledge that for people who self-injure, self-cutting can seem like a safer or more instant option than hitting out at the person or situation that provoked the angry feelings. Babiker and Arnold (1998) explain that the expression of anger appears to be socially unacceptable possibly because anger is often associated with violence and loss of control. As a consequence, instead of expressing



anger directly there is the likelihood that people will search for other ways to deal with their emotions, for example self-cutting (Babiker & Arnold, 1998).

### **Suffering the Consequences**

The final subcategory is 'Suffering the Consequences' which describes how the participants had to suffer the mainly negative consequences of their actions despite initially feeling better after 'satisfying the urge'. The subcategory has been separated into three further subcategories each of which represents the physical, social and emotional consequences of 'satisfying the urge', all of which are presented in figure 7.2.2 (Please refer to p. 203).

#### *Physical Consequences*

When thinking about cutting, the images that most often come to mind relate to the physical aspects of the act, and this could suggest why the average person finds self-cutting difficult to comprehend. It is possible to identify with the physical consequences of cutting because it is something that everyone has experienced when they have cut themselves by accident. The properties of the 'Physical Consequences' include 'pain', 'bleeding', 'infection' and 'scarring'.

#### **Pain**

The property 'pain' describes the varying levels of pain experienced by the participants when 'satisfying the urge' to cut. When people cut themselves accidentally it is usually painful, for example cutting a finger whilst chopping vegetables. People who do not

intentionally cut themselves may find it hard to believe that no pain is experienced when a person engages in self-cutting. There is the presumption that cutting the skin must hurt and therefore it makes the act all the more difficult to comprehend. However, in this study most participants experienced cutting episodes which were not painful. Conterio and Lader (1998) suggest that the question of pain threshold is the most confusing feature of self-cutting for people who do not engage in the act. For example, the following participant suggested that her body went into a different state when she cut herself and because of this cutting did not hurt:

*10: ...but you don't feel the pain when you're cutting yourself there is no pain, there is no pain. But I mean it's like you are away from it all you know you've cut yourself and you don't feel it no matter what you're doing or whatever you don't feel it...*

Similarly participant 11 talked about going into a “trance” and as a consequence she appeared to feel no pain:

*11: The first time (it hurt) yeah – after that no it was almost as if I just cut off erm, I don't know how to explain it – almost sort of in a trance really I suppose...*

Participant 14 also experienced cutting episodes which were painless:

*14: I mean I have really, I have really gone for it sometimes and it's just been no pain at all you know*

Although most of the participants found that 'satisfying the urge' was not painful some of them reported feeling pain after the cutting episode had finished, for example:

*04: I cut real deep and then afterwards I do feel a bit of pain afterwards like you know once I've done it but not, not initially.*

*10: ...a lot of the time with me there is no pain until hours afterwards. It could be sort of twelve hours afterwards and then you sort of think when you go into the shower or into the bath and it stings like that...*

Gardner and Gardner (1975) found that 16 patients (n = 22) appeared to experience no pain whilst cutting but like the above participants they all felt pain within minutes or hours after the episode. The participants in the present study described some situations where cutting was painful from the outset rather than after the cutting episode. An important factor as to whether the participants felt pain or not when cutting appeared to be the presence of the urge:

*07: When you've got the urge it doesn't hurt...*



05: *...because of my strange, curious mind I did, I did erm, I distinctly remember doing it once without really having much of an urge and it was an interesting comparison – it hurt a lot more....*

10: *If the urge wasn't there and it was just a case of oh I'll just do it – just take the razor to myself or whatever, that would hurt because I mean it's like cutting yourself with a knife, you know accidentally like when you're peeling vegetables or whatever and you feel it that sore but when you are in self-cutting mode, you don't get that...*

Participant 10 talked about being in “self-cutting mode” and this implies that whilst cutting she went into a particular kind of emotional or physical state which nullified the pain. This is similar to what the next participant described as a “point” which was significant in determining whether she felt pain or not when cutting:

11: *I've tried a couple of times to cut when – I always say when I reach a point – it is the only way I can explain it but before I've reached that point. I, you know I've tried a couple of times to cut and it is painful which is, I find really weird but I suppose it's just because I cut off you know once I get to that point....*

This participant appeared to switch off when she reached a certain point and she also likened this state in an earlier quote to being in a “trance”. This state could be what the

other participant referred to as “self-cutting mode”. It appeared as though cutting was painful until this point was reached and the participants then entered into the mode of cutting. When people get the urge to cut themselves then perhaps their bodies prepare for it physically and emotionally thus making the act less painful. A medical term for a similar state to that described is known as dissociation. Dissociation is defined as “a process whereby a group of mental processes is split off from the mainstream of consciousness, or behaviour loses its relationship with the rest of the personality” (Davison & Neale, 1998). Conterio and Lader (1998) compare dissociation to a dreamlike state and explain that often the person’s mind is so full of overwhelming feelings that the body and its needs are not of primary concern. A lack of pain during cutting and the simultaneous need to see blood as a sign of when to stop cutting, are typical features of being in a dissociative state (Zila & Kiselica, 2001).

### Bleeding

Generally, people associate ‘bleeding’ with cutting and it is the most obvious physical consequence of the act. The property, ‘bleeding’ describes the blood loss experienced by the participants as a consequence of ‘satisfying the urge’ to cut. Most people try to stop the blood flow if they cut themselves accidentally, however within the context of this study, the participants usually wanted to bleed because of the feeling of release it provided (see ‘Cutting Function’). When the following participant lost a lot of blood as a result of cutting it caused him to panic:

*04: When I cut deep and I see all the blood, then, then I stop like because I think to myself – oh shit what have I done like, you know what I mean?*

The following participant also experienced the situation where she was worried at the rate of blood loss caused by cutting herself and this prompted her to go to hospital:

*14: Erm I went to....when I was down in (town) I went to erm get stitches one day because it was bleeding quite heavily and it wasn't very good and I thought – oh that looks quite bad I think I better go and get it seen to...*

Another participant lost a large volume of blood and this was due to her engaging in the severe practice of bloodletting:

*13: The first time I done it (bloodletting) I lost an awful lot of blood, it was everywhere, it was...*

The consequences of her actions were very severe and she needed to be given blood to replace the large volumes she had lost:

*13: Obviously you are anaemic for a long time but I've had god knows how many blood transfusions because I've gone too far, gone way too far, it was down at 4.7 once...that was extremely low, I turned yellow um*



In contrast to this, the following participant reported that he did not lose much blood when cutting:

*05: There was never a great quantity of blood...*

### Infection

Another physical consequence of ‘satisfying the urge’ to cut is that infection can occur if the wounds are not cared for properly. Infection would seem like an unwanted side-effect of cutting and it was for some of the participants. Lack of understanding from healthcare professionals was enough to deter the following participants from letting their cuts become infected. Participant 14 thought about the physical consequences of cutting before ‘satisfying the urge’ and managed to avoid infection by taking appropriate steps:

*14: – I mean like I’ve wanted infection as well, I mean I have had infections on occasions....but erm eh....no I think I find...it off-putting – people’s reactions erm....I just really thought about things like infection – keep it to a minimum so I wouldn’t have to....again you know such a secretive thing...*

People who engage in self-cutting do not usually want to seek medical attention for their injuries and will do anything to avoid this. The following participant did not mean for her cuts to get infected and resorted to trying to heal the infection herself because of her fear of seeking medical help:

*06: I think it was a dirty blade because there was one cut I did erm there was something wrong with my arm, it was like cold no hot sensations going down it.... I'm like – what have I done and I looked at it I thought, oh shit – it's infected, oh bugger so I didn't want to go to see somebody and you know the wives tale that says put salt on your wound – I put a big mountain of salt on it and it stung like hell – oh my god! (laughs)*

A few participants however said that they wanted their cuts to become infected, and in contrast to the above participants they actively encouraged the onset of infection:

*07: ... they weren't hurting enough so this sounds crazy now, I'd go out into the garden and I'd rub soil. I'd cut them and then I'd rub soil into them um and I couldn't quite get to, up the nerve to actually rub cats' faeces into them but I used to know where the cat went to the loo.....And I just wanted an, an infection in it – I'd put dirt on them and then plaster over so the dirt would stay in there...*

Another female participant also wanted to infect her cuts:

*13: I do stuff like the cloth in the kitchen because I know that's got more germs on it...from cleaning the surfaces, or anything flies have been on you know...but I don't generally do soil because I know that, that most of the time is quite*

*clean...I've done some horrendous things with trying to infect myself....Oh yeah, yeah – I've been at the bloody sides of the bloody toilet and stuff like that and things like that....*

She went to great lengths to make sure her cuts became infected because she knew that the infection would bring relief through making the effects of cutting last longer:

*13: It just makes it (relief) carry on and on... It's longer...my CPN doesn't understand that...*

### Scarring

'Scarring' is the final property of the subcategory 'Physical Consequences of Cutting' and it describes how the participants felt about their cutting scars. Often because of the location, nature and number of scars in people who engage in self-cutting, the scars probably do not appear like they are the result of an accident. People who self-injure mainly cut their forearms (Favazza & Conterio, 1989) and often there are numerous scars all heading in the same direction, for example a series of neat lines going from one side of the arm to the other. For example 'Maggy' (Pembroke, 1994) explained "when I cut I do it in nice straight lines in criss-cross patterns, generally about 50 cuts each go" (p. 13). Most of the participants in this study were permanently scarred as a result of years of 'satisfying the urge' to cut themselves:



*04: Well, some of the support workers have said to me over at X – oh look at, look at the mess you've made of your arms like, you're scarred for life now like you know but that doesn't, that doesn't mean anything like you know. I mean I know my arms are a mess and that if I keep cutting them then there will be nothing left of them sort of thing like you know. I'll just be a mass of scars like...*

The above participant did not seem bothered by the state of his arms and the amount of scars he had did not make him think about wanting to stop cutting himself. Even after not cutting for a long period of time the consequences of cutting were still visible for a number of the participants. Participant 05 liked having some of the smaller scars on his arms, as they were a reminder to him of what his life used to be like, and how far he had come since the times he found it difficult to resist the urge to cut himself:

*05: But the lesser scars I'm glad I've got because I think it helps keep me grounded to remember where I've come from as it were. I don't know if I had it in mind but I remember some of them, I, I deliberately tried to cut to leave a bigger scar you know....*

Participant 05 could remember some of the incidents which led to specific scars on his arms. He talked about one of his bigger scars and how he had deliberately tried to create it. Like participant 05, participant 13 wanted the scars there as a reminder of past experiences:

*13: ... I want to see the scars; I want them there all the time as a reminder.*

Unlike some of the above participants, participant 11 did not like the thought of having the scars as a permanent reminder:

*11: It was actually one of the nurses who said to me – when you get through this you are going to have all these scars, you know, and I thought well that is just going to be a constant reminder...*

Similarly Favazza and Conterio (1989) found that scarring caused alarm in 46% of the 240 women in their study. The women perceived their scars to be ugly and usually tried to hide them. The physical consequences of cutting ranged from mild to severe, however for most of the participants the damage was permanent in terms of the scars which resulted from ‘satisfying the urge’. The skin damage influenced how they went about their daily lives and interacted with friends and family, because often their cutting was a secret but this was made difficult due to the scars.

### *Social Consequences*

The subcategory ‘Social Consequences’ illustrates how the physical consequences of ‘satisfying the urge’ made it difficult for the participants to be a part of the social world, because of the problems concealing their behaviour from others. Favazza and Rosenthal (1993) state that people who self-injure often feel embarrassed by their scars

so isolate themselves and rarely go out in public because of their fear of social rejection. Due to the fear of being stigmatised the participants in the present study did at times end up isolating themselves. The properties of the subcategory 'Social Consequences' are 'keeping it a secret', 'being noticed' and 'life restricting'.

### Keeping it a Secret

Cutting was a private act for most of the participants and they tried to keep their behaviour a secret from friends, family and the general public. The property, 'keeping it a secret' describes how the participants hid their cutting behaviour through both physically and emotionally covering up. In order to physically cover up the scars some of the participants talked about how they avoided wearing short-sleeves. Hodgson (2004) refers to this as 'passing' which she explains is often the first stigma-management technique used when trying to hide a behaviour. The majority of the participants in Hodgson's study chose to 'pass' when they started cutting by concealing their cuts and scars through wearing long-sleeved shirts, cutting in hidden areas, and disguising cuts as accidents. These strategies are consistent with the findings of the present study. Although the following participant preferred to hide her scars, at the same time she would like to wear t-shirts:

*06: Yeah, I mean it would be nice to wear t-shirts but I just don't know but I mean there's a lot of people would stare at you....*



Participant 10 never exposed her arms in public and even when the weather was hot she still would not consider wearing short-sleeves. She had ways of getting around the fact that she was covered up on a warm and sunny day by making excuses about always feeling the cold:

*10: The likes of summertime – you know because you're covered up...well I just tell them I'm cold because I am a cold person anyway...Yes there is ways round it you know you just – oh I'm cold or whatever...*

The only time she did not cover her arms was when she was at home on her own and did not have to worry about other people seeing her scars:

*10: I don't (cover up), if I'm in the house on my own then yes that's different but if I'm outside at all then I just wont...*

Participant 11 cut less obvious parts of her body such as her back, and this made it easier for her to cover up the wounds:

*11: The nursing staff had a problem trying to know when I was cutting because a lot of people do it on their arms or whatever, but I was doing it on my back, my legs, where they couldn't see....*

Participant 14 explained that because cutting was such a personal act, if people found out then she ran the risk of her privacy being compromised:

*14: But there's no way – you don't want anyone to know about it, it's such a secretive thing, it's so private and so secretive and the last thing you want is for people to know you are doing that you know erm....*

The following participant did not hide her scars all of the time except in certain situations, for example in public places or in front of her children's' friends:

*13: I still do hide it sometimes depending on...I will hide it on the bus, I will hide it round the village, I hide it from my children's' friends....*

Unlike the above participants, participant 04 was not so bothered about having his scars on show because for him self-injury was not a secret anymore:

*04: No, it's not a secret – it probably was a secret years ago when I wasn't able to talk to anybody*

As well as physically covering up their cuts, the participants also appeared to keep their behaviour a secret by emotionally covering up. One of the main reasons for the participants doing this was to prevent hurting their family:

*06: But my brother, I don't think, I don't think he can handle it so it's like I have to cover up everything...*

Participant 06 pretended that everything was okay because she did not want to worry her brother. Similarly, participant 07 did not want to hurt her family and initially she did not reveal that she was cutting herself. To protect her family's feelings she made excuses about how she got the cuts on her arms:

*07: I didn't want to hurt anyone um and going back I now had an excuse for the scratches on my wrist and I could turn round and say – oh I just did it in the garden.*

Hodgson (2004) explains that cover stories are often used when a cut or scar is involuntarily exposed and some of the participants in her study were often surprised that people believed them. The following participant likened covering up her emotions to wearing a mask. The self which she presented to other people was not her real self which she appeared to keep hidden. People then found it hard to know how she was feeling and were shocked when she took an overdose when she seemed to be okay earlier in the day:

*11: Yeah I used to tell X that I was putting a mask on when I was going out you know but it was.....and a lot of people I think were disturbed by the fact it could change so quickly for me – it was very impulsive.*



It was difficult for participant 11 to keep the mask on at all times and her real self would then emerge:

*11: ...but I used to think I was just putting a mask on but then the mask would slip you know something would give....*

### Being Noticed

The property 'being noticed' demonstrates how most of the participants were afraid that other people would notice their scars and this is why they concealed them. For this reason being in the company of other people often made the participants feel anxious. The fear related to what people would say, think or do if they noticed the scars on their arms. The following participant kept her arms covered all the time to prevent this situation happening:

*10: ...what if people see it? What are they going to say? And what they're going to think – you know and I'll have to hide it from everybody...*

Participant 10 did not like exposing her arms in hospital because firstly, she did not want to frighten the other patients and secondly, she was worried that they might form the mistaken impression that she was violent because of the cuts:

*10: I don't want people seeing what I've done especially if I'm in hospital because there's so many different people coming in and out of hospital and you*

*know you're getting older ones, or you're getting ones who are sort of very timid or whatever, coming in and if they're seeing your arms all cut and everything the to me and to me I sort of think – what's going on in their head – are they thinking I'm gong to attack them with a razor....you know it's stupid sort of thinking that but that's sort of like the way I see it you know. Do they think I'm a violent person because I cut myself whereas I am anything but....*

The following participant did not want other people to notice her cuts because she was embarrassed by her behaviour. She perceived cutting to be less socially acceptable than overdosing:

*11: I don't know why but for some reason I was embarrassed at the thought of cutting myself and that, and getting embarrassed at people finding out but erm.....the overdoses seem to be quite acceptable for, I don't know why...*

Participant 14 had negative experiences of people noticing her scars by either commenting on them or staring at her:

*14: Yeah, people, I mean, people you get up here are like that anyway...Yeah and erm...just come up and say what's that on your arms, you know, and erm you know....it's just the staring and the sort of screwing the nose up and everything...*

A minority of the participants were not afraid of people finding out about or noticing their scars. Participant 04 reported that he had not received negative responses to his scars, and did not seem worried about the reaction people might have to the appearance of his arms:

*04: They probably think – oh look at the mess of his arms like you know, or what's he done like you know but I just, I don't bother like you know. Nobody's particularly bothered me over them like you know.*

Participant 13 thinks that people probably have noticed her scars and cuts but no one has made her feel uncomfortable because of it, and her friends have been supportive:

*13: I think they do yeah, generally they don't say anything. I've got a lot of good friends, a few good friends who know about it....they understand about it...*

### Life Restricting

The final property of 'Social Consequences' is 'life restricting' and it describes how some of the participants decided not to participate in activities which would increase the chance of their cutting being discovered. This meant they had to live a restricted life as a consequence of 'satisfying the urge' to cut themselves. Swimming was the main leisure activity that the participants avoided, probably because they had to expose so much of their skin. For example:



*14: I mean I like to do things like going swimming – I mean swimming is a very good form of exercise – I would like to lose weight and it's good for toning muscles and things – it's very healthy but I won't go swimming because it's just too....erm it's...eh just....erm.. it would be stressful yeah...there's just no way I would do it really...*

Another participant opted for a different form of exercise if she had cuts that were noticeable, for example going to the gym where she could cover up parts of her body:

*11: I was always sort of physically active you know and did a lot of sports and that but if I had a....bad.....cutting on my legs or...I would choose to maybe go to the gym instead of swimming because I had cuts on my legs erm.....then again that would just be another, another way of me not being able to cope – you know you can't even go swimming because you know I can't cope with my life (laughs)...*

She would emotionally punish herself for not being able to go swimming and she saw it as another sign that she was not coping with life. Even though it was unlikely participant 10 would meet anyone she knew, she would never go on holiday to a warm, sunny climate as she would not be comfortable wearing clothes which exposed her skin:

*10: I mean I could never go abroad...I mean because it would look really stupid going around with a jacket lying in the sun or whatever...*

In contrast to this two of the participants said that they did not live a restricted life because of their self-injury. Participant 04 had been on holiday to a warm climate on a few occasions and he did not cover up his arms:

*04: I've been on holiday to X now 3 times, well, no 4 times, and um...I had my arms on show and that and people they don't say anything.*

When asked if he avoided participating in activities because of his scars, participant 05 said:

*05: Mmm....no. ...I'd do them in long sleeves.*

Participant 05 did not feel that he had to live a restricted life because of the appearance of his arms. Furthermore, the scars on his arms did not stop him from giving blood and this was a situation where he knew he would have to expose his scars, with the risk that someone would make a comment about them:

*05: Something that really moved me profoundly earlier this year was I went, I went to give blood and they must have seen the marks on my arms, they could see they weren't recent and they, and they didn't mention them..*

### *Emotional Consequences*

Although some participants experienced positive feelings after 'satisfying the urge', most of the participants suffered negative emotional consequences. In some situations this could make them cut more but in other cases it could make them stop. The properties of the subcategory 'Emotional Consequences' are 'feeling guilty', 'regret' and 'well-being'.

### **Guilt**

The property 'feeling guilty' describes how some of the participants felt after cutting. Guilt was expressed by over half the participants (59.5%, n = 25) in Nixon et al's (2002) study when asked how they felt after engaging in self-cutting. In the present study feelings of guilt appeared to be related to both the self and others:

*05: I don't know if there's - it's probably been guilt on some times at least...*

For the following participant the point where feelings of guilt emerged varied from immediately after cutting to an hour after the episode:

*10: But you do feel guilty.... after you've cut you know. Sometimes it can be straight after you've cut but other times you know it's sort of an hour later and you think oh wait a minute and the guilt starts setting in...*



Favazza and Conterio (1989) discovered that immediately after cutting 66% (N=240) felt better compared to 21% who felt worse, however after a few hours the number of women feeling worse increased to 48% and feeling better fell to 30%. This trend continued when after a few days 50% of women reported feeling worse and only 18% said they felt better. The act of 'satisfying the urge' to cut did not stir feelings of guilt in participant 11 but the effect that her behaviour had on her close family made her feel guilty.

*11: I felt guilty but it wasn't because I had cut myself – it was because I was going to have to tell my husband and it was hurting him or I was going to have to tell my mum and it was hurting her you know? It was guilt for the effect I had on other people not for the effect it had on me....I'd achieved, I had achieved what I wanted to achieve...*

The following participant avoided going to Accident & Emergency because of the fear that the guilt she already felt after cutting would escalate, due to the anticipated negative response from the nursing staff:

*13: That's another reason I won't go (to A&E)– you get certain nurses at certain times and they start having a go at you - and what about your children, and what about this – they are throwing all the guilt at you and then you feel even more guilty and then you want to do it even more....*

As described by the participant above, the danger of feeling guilty about cutting is that it can cause the urge to cut to be triggered again and a vicious circle is created. The following participant often found the guilty feelings difficult to cope with:

*14: ... initially I was getting immediate release from it for maybe like ten, twenty, thirty seconds a minute or something like that and then the guilt would come in and it was totally overwhelming you know...*

Fallon (2003) observed that some participants experienced guilt and embarrassment after cutting and this reinforced feelings of low self-esteem and social isolation.

### Regret

The property 'regret' describes how the physical and social consequences of cutting caused some of the participants to regret 'satisfying the urge' to cut. When the following participants experienced the urge to cut they appeared unable to think clearly about the consequences of 'satisfying the urge'. It was only after they had cut, and noticed the blood or the wound that they started having regrets about what they had just done to themselves:

*05: but also...regret you know....that I have to go round with an awkward arm for a while...*

*06: Well I suppose it's like erm...I mean sometimes I think to myself, why the hell did I do it,*

*10: Oh I shouldn't have done that – what if people see it, what are they going to say and what they're going to think – you know and I'll have to hide it from everybody and that*

One of the participants never regretted cutting herself, and this related to her admission that the guilt she felt for cutting was not because of the actual act, but for the effect it had on her family. As long as she got what she wanted from a cutting episode then she did not feel guilt or regret in relation to her actions:

*11: I don't think I ever regretted doing it.*

### Well-Being

The property 'well-being' illustrates how the participants could simultaneously feel positive and negative emotions for a variety of reasons. Self-cutting is usually engaged in to help a person cope with unbearable feelings, however it is often the case that once the urge has been satisfied, negative emotions emerge:

*11: ...then all the bad feelings after that (relief) set in you know....*



'Satisfying the urge' brought about relief yet this was relatively short-lived before negative feelings arose. Furthermore knowing that self-cutting was an unusual act to perform made her feel low and self-critical:

*11: I would get, I would feel a bit down you know that I knew then that it wasn't normal you know – what was wrong with me you know that I was down and stuff...and it would pull me down – for God's sake 11 what you doing, you can't cope, you know...*

It got to the stage where she felt worse after cutting than she did before she satisfied the urge:

*11: The feelings I had afterwards were worse than actually going without cutting...does that make sense...?*

Although the above participant felt bad about cutting, he still felt better than he did before he satisfied the urge:

*05: I wouldn't be feeling great because of what I'd done...but I'd feel better...*

Participant 14 sometimes felt disgusted with herself whilst cutting and this could prevent her from continuing to satisfy the urge during a cutting episode:

*14: Sometimes when you are cutting yourself and you are just so disgusted with yourself, it can override the impulse to cut you know so – I find that with me anyway in the past...*

The following participant emotionally punished herself for cutting:

*10: I mean there's sometimes I turn round and say to myself – you know you stupid bitch, what the hell are you doing that for you know and sometimes I can't make sense of it myself...*

The emotional consequences of 'satisfying the urge' to cut were not all negative, and some of the participants experienced positive feelings once the cutting episode had finished. Despite possibly suffering from the physical consequences of the act, generally participant 05's emotional well-being was transformed from the negative state which triggered the urge to cut, into a more positive frame of mind:

*05: After, usually I felt...much better em.....usually I'd feel calmer...*

Having the courage to actually engage in cutting made the following participant feel good:

*07: Yeah, um...and also that you had the nerve to go through with it and you felt good that you could actually do something, be successful at something I suppose...*

Similarly participant 10 felt happy that she had satisfied the urge, especially because she had cut a large area of skin and this meant she now had less of an urge to harm herself:

*10: I'm quite happy that I've done it, well I suppose happy with having actually done that – the fact that I'm not having to go and do it every ten/fifteen minutes...*

Again with participant 08 it appeared as though because he had cut, the urge disappeared from his thoughts and he felt he could unwind:

*08: ...and in a way once you'd done it you felt you could relax – that was it over and you could curl up in your bed and whatever...*

Simpson (1975) stated that people who engage in self-cutting may feel so relaxed and calm after cutting that they fall asleep.



## **Chapter Summary**

The manner in which the participants satisfied the urge to cut varied, with some participants cutting at the same depth over time and others increasing or decreasing the severity. The frequency in which the urge was satisfied was also changeable depending on the participants' circumstances. Most of the participants appeared to go through stages where they cut very frequently and then had times when their cutting was more sporadic. The frequency and severity of cutting was at times influenced by the choice and availability of cutting tools. Not being able to satisfy the urge due to circumstances beyond their control sometimes made the participants feel worse, and most of them felt more comfortable if they could easily access a cutting tool. The cutting tool was important because it was the means by which the participants' could satisfy the urge to cut and benefit from the effects of cutting. The participants reported a number of functions of the cutting act including, feelings of physical and emotional release, communicating feelings and controlling emotions.

In addition to the difficulties of having to live with the urge to injure themselves, if the participants satisfied the urge it often made life even harder to cope with due to the consequences of their actions. The participants not only suffered physically in terms of scarring, pain and infections, they also had to live with the emotional consequences in terms of the guilt they felt, and their social lives were affected due to trying to keep their behaviour a secret. However, at the same time 'satisfying the urge' was perhaps their best option because they needed to cut in order to get through the day. The next chapter will explore how participants managed to resist the urge to cut through adopting

various strategies to prevent them from cutting. In addition, the circumstances under which the urge lay dormant will be described.

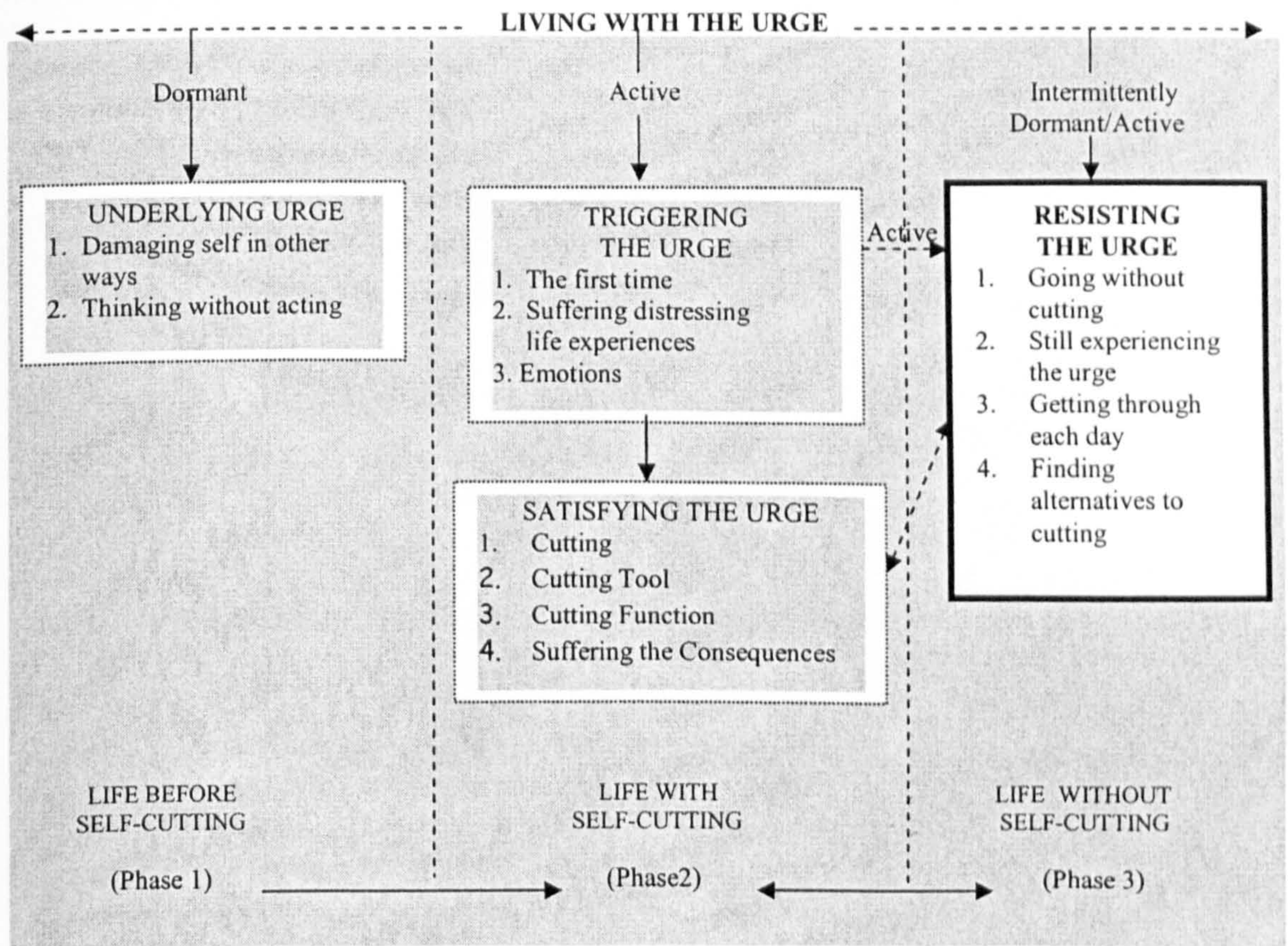
## Chapter 8

### Life without Self-Cutting: Resisting the Urge

#### Introduction

The final phase in the process of *'living with the urge'* relates to how the participants variously attempted to live without cutting. During this phase the participants try to *'resist the urge'* to cut themselves through various means. The main category *'Resisting the Urge'* also describes the circumstances in which the urge lay dormant and did not feature in the participants' lives. The urge was therefore experienced as being either dormant or active during the final phase and depending on how the participants responded to the urge they either remained in the phase, life without cutting (*Resisting the Urge*) or reverted back to the second phase, life with cutting (*'Satisfying the Urge'*). The position of the main category *'Resisting the Urge'* in relation to the other main categories is presented in figure 8.1. The subcategories of *'Resisting the Urge'* are: *'Going without Cutting'*, *'Still Experiencing the Urge'*, *'Getting through each Day'*, and *'Finding Alternatives to Cutting'* and these are presented in figure 8.2 along with their properties and dimensions.





**Figure 8.1: The main category ‘Resisting the Urge’**

**Going without Cutting**

The subcategory ‘Going without Cutting’ illustrates how the participants managed to live without cutting through ‘resisting the urge’. Although self-cutting served a number of important functions for participants (see Chapter 6 for ‘function of cutting’) this did not necessarily mean that they wanted to continue to rely on it during difficult periods. The issues behind going without cutting and living a life free of self-injury are far from being simplistic and are in fact very complex. The properties of ‘desire to stop’, ‘letting go’, ‘motivations for resisting’ and ‘time without cutting’ demonstrate why the



# Resisting the Urge

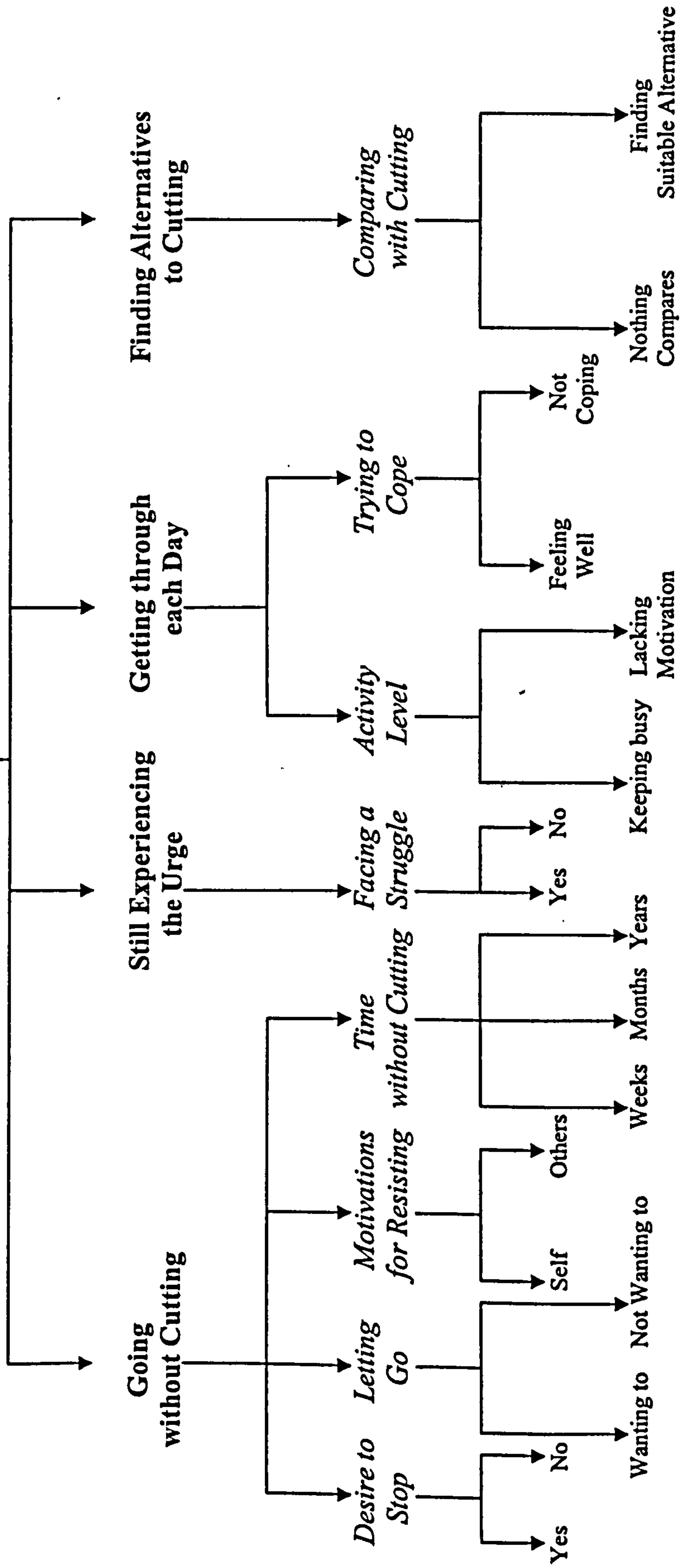


Figure 8.2 Resisting the Urge (subcategories, properties and dimensions)

participants wanted to stop cutting but highlight the concurrent difficulties they faced living without or conceiving living without cutting. The complexity of how such issues interplay provides the true context within which serious attempts to understand self injury need to be considered.

### *Desire to Stop*

The property 'desire to stop' describes the wish to cease cutting which was prevalent amongst the majority of the participants. Participant 08 explained that although cutting helped some people to cope in certain situations, in his experience, he found that most people felt happy if they managed to stop self-cutting:

*08: ...the bit about saying it's a positive mechanism of looking after you doesn't necessarily mean you want to carry on doing it..... Certainly I know people who when they get periods when they no longer feel the need to self-harm, they're so glad... Most of the people I meet say, would say that they would prefer not to do it um...I think...no ideally there would be a life where you didn't have to have that mechanism of expression or control or whatever it is...*

Most of the participants in this study wanted to stop cutting and despite the fact a number of them had lived without cutting for varying lengths of time, they were still reluctant to say that they had given up the act. This is consistent with the findings of Bywaters and Rolfe (2002) where one of the participants said, "You can never say



you've stopped, but you can say 'I haven't done it for a while'. Stopped is such a final word" (p. 35). Briere and Gil (1998) explain that many people who self-injure perceive cutting to be partially out of their control and would give up the behaviour if they could. For example, despite not cutting for a number of months participant 06 still lived with the expectation that she would one day give in to the urge again and cut herself. When asked if she thought she could stop cutting she replied:

*06: No, no....erm well, mm I don't know mm, I mean I think that maybe I might be disappointed if I start again you know but I'm going to try and eh – oh I don't know I think you know I probably will but I just can't say to people – I'm going to stop, that's it...*

Similarly, participant 10 explained that she could not commit to giving up cutting:

*10: ...you can't guarantee that you're going to stop...if you do it again, aye or you try. I mean me I am trying to stop myself from cutting...*

Participants 11 and 14 tried to cope without cutting by living from day to day, focusing on the day ahead and trying not to cut for that period of time. Each day they 'resisted the urge' and did not engage in cutting, counted as a personal achievement for them:

*11: Like I could never say that I am never going to cut again so I mean I just say the rest of the day I am not going to cut and that's the way I get through it and even now more than 24 hours is too much you know I can't do it... that's another 24 hours I've not done it...*

Participant 14 preferred to say that she had not cut for three years instead of saying that she stopped cutting three years ago:

*14: ... it is extremely difficult to give up cutting and that's why I say to myself and people I talk to – well I haven't cut myself for three years, I take each day as it comes because you never know what's going to happen you know – you really never know what's going to happen...*

She explained how upsetting it was to start cutting again at a time when she had thought that she had given up the act:

*14: ...when I was younger I used to say right – I've not cut myself for years, fantastic I've stopped cutting and it's such a great disappointment and...erm... ..it is really heartbreaking actually you know, it's really, really upsetting when you start cutting yourself again erm...and it's actually difficult to cope with....*

Participant 05 denied himself the opportunity to cut at a time when he really needed to because he had committed himself to giving up the act. At that time this participant felt more vulnerable because he had to find another way to cope with how he was feeling and consequently he ended up engaging in an act which was more risky:

*05: There was a time when I said I wouldn't cut myself again and it was during that time I took two overdoses so now I never say never...*

As a result of the above experience, participant 05 decided not to make such claims about stopping cutting, and like the other participants he instead chose to live with the possibility that he might cut again if the need ever arose.

Some of the participants highlighted how difficult they found it to live without cutting by comparing 'Going without Cutting' to giving up addictive behaviours such as smoking and drug-taking:

*11: I mean I've, I gave up smoking 12 weeks ago and I actually found it easier to give up smoking than I did to give up the cutting....*

It is interesting that participant 11 talked about "giving up" smoking 12 weeks ago instead of saying that it was 12 weeks since she last smoked. When describing cutting she would not commit to saying that she had given up and instead talked



about the last time she cut herself which did not seem so final. This highlights how difficult it was for participant 11 to end her relationship with cutting and interestingly she used a term common to people who are withdrawing from drug addiction to describe her struggle:

*11: ...ten minutes was what I could handle and then...I put it to twenty, thirty but it was hard-going you know and it is almost like going cold turkey....*

Unlike drug withdrawal, abstaining from cutting does not appear to cause any physical symptoms, however participant 11 reported feeling like she went through a psychological process similar to people trying to give up drugs. Another participant highlighted a difference between giving-up smoking and trying to stop self-cutting, and like participant 11 implied that smoking was easier to abstain from:

*08: It's, it's not like smoking where you become an ex-smoker and eventually you might say – actually I'm not only someone who doesn't smoke, but I'm someone who doesn't like smoking...*

Participant 08 suggested that it is not as easy to say that you are a former self-cutter as for example a former smoker. Some ex-smokers often dislike smoking and he implied that this was not the case for people who were trying to give up self-cutting, in that it would appear he could not ever imagine having those kinds of feelings towards the act. A participant in Alexander and Clare (2004) suggested that it was

difficult to resist the urge to cut because of the function of the act: “because this process was such a powerful way of dealing with intense emotions, it was difficult even after long periods free from self-injury to resist slipping back to self-injury in times of crisis or stress” (p. 79). Participant 14 also talked about self-cutting in terms of how it became a habit because of its effectiveness at meeting her needs, and this made it difficult to abstain from the act. This situation also applies to other habit-forming behaviours such as smoking, drinking and taking drugs.

*14: Yeah it's, it's a very difficult thing to give up because I mean especially if you have been doing it for years and years and so many people have been – I mean doing it for years before you finally realise you are doing it you know and it's just...it's very habit-forming you know because it is such a great release you know...*

Participant 14's explanation of why cutting is so difficult to give up is similar to that of a participant in Harris' (2000) study: “I really would like to stop self-harming but feel I can't because I am addicted to it. I couldn't live without the release it gives me. The buzz you get from it. If I could find a way of coping without harming myself, it would be fantastic” (p. 169). Furthermore Briere and Gil (1998) point out that the apparent effectiveness of self-cutting in reducing tension could make it difficult for people who self-injure to give up the behaviour despite its negative consequences.

The above section highlighted the problems associated with 'resisting the urge' and trying to live without cutting, and this was something nearly all of the participants yearned for. One of the participants however did not think she would stop cutting and unlike the majority of the participants she did not want to give up the act:

*13: sometimes you don't even want to stop...*

*13: And I don't seem to care that I haven't, that I, that I'm not able to stop...*

When asked if she ever thought she would stop cutting she said:

*13: (Sighs), frankly no – it's the only thing helps...*

This participant could not find another way to meet the needs that cutting served for her, so therefore did not want to give up this sole means of making herself feel better. Like participant 13, some of the participants in Hodgson (2004) also reported that cutting was the only behaviour which successfully relieved stress, anxiety and negative feelings, so as a result they did not think that there was anything wrong with cutting.

### *Letting Go*

Although most of the participants had the desire to stop cutting, and felt great disappointment if they started cutting again, at the same time they wanted to have the



opportunity to cut if they needed to. Taylor (2003) found similar conflicting feelings in one of his participants who described cutting, as something that he wanted to stop but he also believed the act was necessary. The property, 'letting go' illustrates how most participants in this study seemingly did not want to completely let go of cutting, and they liked the security of knowing where their cutting tools were in case they experienced the urge to cut themselves. Knowing that they had access to a cutting tool if needed appeared to give the participants a feeling of comfort, which may explain why they were reluctant to say that they had stopped cutting. In the following quote, participant 08 captured this reluctance by giving a reason for why he did not feel able to completely free himself of cutting:

*08: I had bought some razor blades and basically it was very much the temptation that I wanted to self-harm and I needed the security of knowing I could if I got to the point where I could no longer cope – to me it is a safety mechanism so I keep my razor blades hidden in the house from (family).*

He referred to the storing of his blades as a “safety mechanism” and he felt secure knowing that he could use them if the urge was triggered. It would appear that the danger for him would be feeling that he could not cope, and then not having any blades available to help him feel better. Understandably he would prefer not to go through life relying on his blades:

*08: ...even the fact you've got your safety bits – it would be nice not to have that.*

Whilst talking to other people whom he knew self-injured participant 05 discovered:

*05: ...it turned out we all knew where our blades were even though we hadn't done it for some time...*

Again another participant talked about the calming effect of having access to a razor and knowing that she has one can prevent her from cutting:

*10: I find if I've got, if I've got a razor no matter where I am, if I've got a razor I'm fine. Sometimes it can stop me cutting for days on end.....*

Like participant 08, participant 10 also described her blades in terms of safety and likened being in possession of a razor to a “safe haven”. Having the knowledge that she could ‘satisfy the urge’ to cut if needed seemingly caused her to feel safe within herself:

*10: You think – I need it, I need you know – to me it's more, if the razor is there it's like a safe haven....*

Collins (1996) described self-cutting as a 'defence' which may have functioned as a survival strategy for many years, and suggests that letting go of the behaviour therefore might seem intolerable for people who have perceived cutting as a 'safety shield'. Collins (1996) explains how self-cutting has been described as a life-raft, and if people who self-injure are without this life-raft then what is there for them to hold on to? Although the following participant had not cut for approximately one year she still felt uneasy if she did not have access to cutting tools:

*11: But I still panic if there's nothing about you know?*

Participant 13 likened her cutting tools to something which gave comfort:

*13: I would feel a bit insecure, insecure because I wouldn't have it there; it's almost like a comfort thing...*

In contrast to the above participants, participant 14 voluntarily restricted access to her favoured cutting tools, making it more difficult for her to cut if she experienced the urge:

*14: Yeah well I try to keep the blades out of my house...because I just get so.....impulsive sometimes you know erm and...I worry that if I have them there ready to use I would just go and pick them up and just use them so a way of trying to stop is this way of me trying to stop doing it you know...*



### *Motivations for Resisting*

The property 'motivations for resisting' describes how most of the participants were motivated into 'resisting the urge' to cut for reasons relating both to the self and others. The following participants tried to give up cutting because of factors relating to the cutting act and how it affected them personally:

*05: ...there's a lump there that I really don't like. The lump's the thing that bothers me the most and prevents me from carrying down that, that path more...and also I think it's because it's one on top of another, it makes me feel that you know if it carried on I'd get more lumpy.*

Participant 05 had a build up of scar tissue on his arm which caused a lump and he found it unsightly. This prompted him to try to resist cutting because he did not want to run the risk of another lump appearing on his arm. In addition to this he also found that cutting did not meet his needs as previously and this motivated him to 'go without cutting':

*05: Yes, I, I another reason I tried to stop was in the end I sort of felt it stopped helping....*

Participant 08 stopped cutting after a distressing incident where he could have really damaged himself. This incident appeared to be significant in that he decided not to cut any further. From then on he seemed more able to 'resist the urge' and not

engage in cutting. If he had chosen to carry on cutting then his life might have taken a very different path:

*08: I stopped, I, I thought, well I sat there for ages but I had the choice – I can make it much worse or I can get down and see if someone will help me and I threw the razor blade away and got down....Life was much, still remained really, really hard but I had...I had to have the opportunity to really damage myself because of the things I thought were happening to me and I chose not to take it....*

The following participant sometimes questioned the point of cutting because although the act released the sense of ‘badness’ which she felt was inside of her, the ‘badness’ never went away completely. Occasionally, this feeling caused her to ‘go without cutting’ for a few weeks:

*10: Sometimes I think to myself it’s pointless because you’re getting the badness out but when’s it ever going to end...when’s the badness going to stop coming out of me – when do you feel, when do I feel that the badness is going to be gone altogether, I do I, and sometimes I get to that stage and think – it’s a waste of time and I could be like that for two or three weeks whatever...*

The act ended up doing more harm than good for participant 11, and she believed she felt worse after cutting than she would have if she had not 'satisfied the urge' in the first place:

*11: I think.... it is good when it is needed but for me it became too much, er I needed it too much and it was having a bad effect on myself...*

Similarly, participant 14 found that cutting lost its effectiveness in providing relief and she decided that she had to try to stop injuring herself:

*14: And I just found it was such a vicious circle and I wasn't getting as much relief from it as erm....I had been and I just thought I've got to stop doing this you know because it is a vicious circle and no matter what I do it's not working you know so that's why I decided to....get out of that circle....*

Participant 14 also had the realisation that cutting herself was not fair on her own body because she was punishing herself just as other people had punished her in the past:

*14: I always tend to stop because, well – you know, I really shouldn't be doing this - this is you know abusing myself – I'm getting abused by other people but you know I shouldn't be abusing myself you know – so I'm doing their dirty work for them...*



Furthermore, participant 14 said she had gone as far as holding a blade to her skin but the fact that she did not want to enter the world of cutting again, stopped her from engaging in the act:

*14: I mean I have broken the razors and got the blades out and been poised to do it but – I can't go down that road you know erm so that stops me...*

Likewise participant 11 reminded herself of how well she had been coping in recent years and this mindset stopped her from giving in to the urge. She was aware that it would be a struggle to resist cutting, but she also knew that a failure to do so would set her back emotionally and this prevented her from satisfying the urge:

*11: ...but I've just thought again about how well mentally I've been over the last year or two you know and I think no because it's just going to drag me down you know. I've just got it in my head now that I can't do it...but it is hard....*

Some participants were also motivated to go without cutting because of the negative effect their behaviour was having on other people such as family and friends. The problems associated with trying to hide the behaviour from others caused participant 05 to realise that he did not want to live like that anymore:

*05: Well, it, it was partly an incident with um.....my daughter who was a baby at the time, I was down where she lives babysitting and her auntie who I'd never met. It was a very hot day so I'd taken my jacket off. I had a dressing on my arm, and her auntie who I'd never met before came round and we were talking away for a minute and I had my arm hidden behind the baby, and I just thought – that's when I thought, this can't go on...*

Participant 07 described how she was now able to resist the urge to cut and it was mainly the thought of upsetting her husband that stopped her from engaging in the act. She did however admit that if cutting was more socially acceptable then she would not have any problems in injuring herself when distressed, using the example of people who get drunk to cope with how they are feeling:

*07: I don't see any harm in it and...the only thing that's stopping me now is that I know it would hurt my husband and it's not accepted socially and I'm able now to control it and not do it but if it was something that was more socially acceptable like if you're upset you can go and get plastered that night or whatever um...it's something that I still get the urge to and it would still help me as it were....*

Alexander and Clare (2004) discovered that for the participants in their study, having an awareness of the impact of their cutting behaviour on friends and family strongly motivated them to find alternative ways of coping. This was apparent in the case of

participant 08, who reported that the distressing impact which cutting had on his loved ones was what stopped him giving in to the urges. He explained that if it was not for his family then he indicated that he could quite easily engage in cutting:

*08: I think if I didn't have people who would be damaged by me cutting then I would cut...erm even though I can't see any reason to do so erm...*

He described how cutting in hospital was far easier to do because he was not worried about the impact it had on the people within that context. However when the context changed to that of his loving family, then he was more motivated to stop cutting despite the fact it was often an emotional struggle:

*08: ...and I think that's, that's perhaps an issue you need to know that – in hospital I would have had no problem at all about self-harming but with someone who could sort of cut through the world I was in and even if it did involve tears and so on that sort of stopped me doing it*

Furthermore, when the mental illness which he suffered from, interfered with his perception of reality, it put a tremendous strain on his wife and she found it difficult to cope with this. Participant 08 lives with the devastating possibility that his family might leave him if he becomes unwell again, and the prospect of this happening stops him from surrendering to the urges:



*08...and ultimately that led up to (wife) more or less delivered an ultimatum that if I did self-harm, actually even if I got ill again that she would divorce me um which sounds awful but...so that always, that always really affected me....if you think what she was going through. She was not only looking after me, she was being a wife and she was being a mother and she was seeing an absolutely horrendous aspect of what I am because it is very, very frightening....in a way that's been my guiding, not sure if benchmark defines, if I go out of normality to the extent that I become ill then there's always the threat that I won't have a family left and that, that stops me giving into the thoughts that would encourage self-harm because it would be so easy to do um...and I don't know, I don't think she would divorce me now but that's always been a part of it.*

Participant 11 also realised that her cutting was affecting her family more negatively than it was affecting herself and this prompted her to try to 'resist the urge':

*11: No I mean I decided that enough was enough, that.....I was hurting my family too much, more than I was hurting myself too much erm....*

Caring relationships also appeared to help the participants in Weber's (2002) study stop cutting. For example, one woman reported that when she got the urge to cut she thought about the people she would hurt and this enabled her to resist cutting.

### *Time without Cutting*

The length of time which the participants had gone without cutting varied from a matter of weeks to a number of years, and they all had experienced intermittent periods where they 'resisted the urge' to cut. At the time of interview most of the participants were living without cutting and had been 'resisting the urge' for at least 5 months. There were however a few participants who had cut more recently. For example, the following participant had been an inpatient at a psychiatric hospital for nine weeks, and she was pleased with her progress in that she had only cut herself a few times during this period of time:

*10: Two or three times and I've been in 9 weeks.....and to me that's excellent, it's brilliant, I think it's great to know that I haven't cut.....*

Participant 10 talked more about going without cutting in the short-term as opposed to the long-term, but in relative terms any period of time where she 'resisted the urge' to cut was an achievement for her:

*10: It can be, it can, it varies with me. I mean if I sort of put it off three or four days – I know it probably sounds daft saying that.....you know – you're a self-harmer, you're cutting, some people expect you to be cutting every day or whatever...but I can put it off for six or seven weeks and think – oh you know I haven't cut myself for six or seven weeks...It does make me feel better*

*but then the next day could be – that's it, I've had it, where's the razor, and just start.*

Participant 13 had not cut for approximately ten weeks and in comparison to her usual cutting rate this was considerable progress:

*13: Now the last time I self-harmed or last time I cut is April I think. It's good going for me because I am usually at it all the blooming time....*

The following participant had 'resisted the urge' to cut for 8 months, a slightly longer period of time than the above participants had managed. She was pleased that she had been able to live without cutting for that length of time:

*06: ...but last time I cut myself it was... I think it was January this year, I've not cut myself since...*

*06: I mean I know I've been actually good, I haven't you know cut for a while....*

At the time of interview, the following participants had spent the longest periods of time without cutting and had 'resisted the urge' for at least one year:

*05: ...I haven't done it for over a year now...*



*11: Since I've come through the counselling I've cut I think about four or five different times which is not a lot for ....for me...but I mean in the last two years I've only cut four or five times...and I would say maybe in the last.....year I haven't cut at all...*

Participant 14 described how pleased she was at managing not to cut for such a long period of time:

*14: ....um I haven't cut myself now for, I'm not quite sure but it's at least three years...I am very proud of myself for not cutting myself for three years*

Given the fact that the participants felt pleased that they had managed to 'resist the urge', emphasises just how difficult it is for them to try not to cut. The sense of an internal battle is highlighted in the following quote from a participant in Sutton (1999): "As the times increased when I was able to overcome the urges, I gradually came to realise that I was winning through" (p. 70). Despite the fact the participants had periods where they successfully 'resisted the urge' to cut and did not engage in the act, their lives were still affected by the urge in that some of the participants were waiting and expecting the urge to return, and become a feature in their lives again.

### **Still Experiencing the Urge**

The subcategory, 'Still Experiencing the Urge' explains how the process of 'resisting the urge' did not run smoothly for the participants, and although some of the participants were living without cutting they were still living with the urge. Even the participants who had been living without cutting for the longest period of time at interview, still often experienced the urge to injure themselves. The property, 'facing a struggle' describes the difficulties which the participants appeared to have when the urge to cut appeared again.

### *Facing a Struggle*

Most participants 'faced a struggle' with the urge in terms of trying not to satisfy it and only one participant appeared able to 'resist the urge' without too much difficulty. The following quote illustrates that despite not cutting for a considerable amount of time, participant 14's life was still affected by the urge:

*14: ...but no I would say the urge is definitely less, sometimes it rears its ugly head and is very, very strong erm but I am coping very well...*

Participant 14's phrase "rearing its ugly head" used to describe the reappearance of the urge highlights the extent of participant 14's dislike of the experience. Sutton (1999) included the personal story of Ann and like participant 14 Ann talked about the persistence of the urge in a negative way: "Sometimes I could ignore my urge for a few days, even weeks, but I felt that it was still there taunting me, knowing that

sooner or later I would not be able to resist the urge to cut myself any longer” (p. 77). The following quote illustrates how close participant 14 has come to ‘satisfying the urge’, although she is at a stage where she is able to ‘resist the urge’ and not give in to it:

*14: ...and you know I'll say to myself – I really feel like cutting myself and I'll struggle with it for a bit and then I'll come down the town and go in and out of different chemists and I'll, I'll look at the blades and I'll look at the shop (laughs) – you know it's really about trying to stop myself you know...trying to talk myself out of it yeah. Erm and then you know I'll buy the blades maybe sometimes and I'll erm have them in the house and I'll be just like looking at the packet and I'll open the packet and...and I'll be like, right okay...and erm and I'll open the packet and say right I've opened the packet now but no I'm not going to touch that razor blades, I'm not going to break it open and you know....*

Participant 14 likened the urge to cut to the urge to smoke in terms of both urges still being present in the lives of ex-smokers and people who used to self-injure. She said that the issue was whether this urge could be conquered whenever it reappeared:

*14: It's interesting looking at smoking you know – it's a bit like an ex-smoker you know erm (laughs) – once you smoke you're never really safe from*



*smoking (laughs) you know it's always there at some point the urge – it's whether you can overcome it at particular given times...*

Participant 07 still experienced the urge but as reported in Chapter 4 she found that it was not as strong as the urges she had previously experienced:

*07: I still sort of quite frequently get the feelings...*

Although participant 11 was glad of the break she has had from cutting, she still struggled to live with the urge:

*11: ...but the thing is I wouldn't say it gets any easier the longer you don't do it you know like? I think I am really lucky, you know it has been a year....a lot of people don't get that kind of respite erm but it doesn't, when you get the urges it doesn't get easier. I think a lot of people think the longer that you sort of abstain then the easier it gets but unfortunately....no...*

Participant 11 explained what it felt like to struggle against the urge:

*11: I quite often have an argument with myself you know because part of me wants to, part of me doesn't you know and it can quite often be....like no, no and that can be quite hard to cope with as well...*

The part of participant 11 that wants to cut appears to be competing with the part of her that wants to 'resist the urge', and participant 11 found this conflict emerged when she felt stressed:

*11: Over the last fortnight it's been really stressful....and twice I've thought about it...if I get really stressed and I start feeling panicky that's a danger for me....*

Participant 08 had gone as far as buying razor blades when he started experiencing the urge to self-injure again:

*08: Lately self-harm has become more of an issue – I haven't been doing it but certainly last summer I was talking to my, was it last summer – maybe it was a bit earlier than that – I was talking to my psychiatrist about ideas of self-harm because I had bought some razor blades...*

At the time of interview, the following three participants, particularly 10 and 13 had spent less time without cutting than the above participants and they appeared more likely to fail to 'resist the urge' and end up 'satisfying the urge':

*06: Well I mean I've still got the urges to do it...I haven't you know cut for a while.....but I hate that when you've got the urges....*

*10: ... the whole time you are keeping yourself busy that thought is still there....and you know – I need to cut, I need to cut but it's like you're putting it off.*

*13: The urge is always there....*

Although participant 05 still experienced the urge to cut he did not find it as difficult as other participants to 'resist this urge':

*05: It is not so much a struggle for me...*

Participant 05 was at the stage where he did not have to fight against the urge and it was fairly easy for him to ignore it. He explained that he now perceived cutting as something that would not be beneficial to him anymore:

*05: It, it's still, well for me it still can be but it is dismissed quite easily...just really for one reason...I feel convinced that it wouldn't do any good now...*

### **Getting through each Day**

The subcategory, 'Getting through each Day' explains how the participants tried to live without cutting. In order to 'get through each day' the participants reported trying to adopt various strategies to occupy their time; however they did not always have the motivation to keep busy. Furthermore, they found it easier to 'get through



the day' when they were coping better with life because often then the urge did not feature. Participants reported that the urge was more likely to become active when they felt low and their coping skills deteriorated. The properties, 'activity level' and 'trying to cope' highlight what helped or hindered the participants when trying to 'get through each day' without cutting.

### *Activity Level*

The property 'activity level' describes the varying levels of activity amongst the participants. Some participants found that by keeping themselves busy they were distracted from thoughts of self-cutting which made it easier to 'get through each day'. However, other participants lacked the motivation to keep busy and as a consequence had too much time to reflect on past events, the way they felt about themselves or life in general. This appeared to make it more difficult for the participants to 'resist the urge' to cut.

The participants had various ways of keeping themselves busy with routine activities such as carrying out household chores, going to work, and taking part in voluntary work. Participant 05 found that on certain occasions he did not have enough time to think about or engage in self-cutting because he was so busy:

*05: Yeah. I mean there's been times where I didn't, there's been times where I didn't self-harm because I, erm, because I was too busy the rest of the week.*

However he felt it was important to find a happy medium between doing too much and not having enough to do because both situations could affect him negatively:

*05: Yeah, I, I, I've found it you know I've got to keep a balance um....I deteriorate if I've got too much on but also if I've got nothing on.....So um.....I think it's best for me how it is now, I've got one thing on most days...*

Similarly, participant 08 talked about being too busy to cut himself. His time was occupied with work and family, and by engaging in activities such as watching the television his attention was diverted away from self-cutting:

*08: I've got other options I think – I am busy for a start, I am busy working so creating the busy-ness doesn't allow the time to damage myself and being around my family means I can't do anything then anyway. And you know sometimes things like watching the telly it – you know I am too busy watching telly I can't do that now (laughing)...it is something like that.*

Keeping busy was an effective distraction from cutting for a participant in Weber (2000): “If I stay busy and don't think about hurting myself I go through the whole day” (p. 122). Participant 11 occupied her time by cleaning the house or she engaged in activities with her child, and she found that this helped divert her attention from thoughts of self-cutting:

*11: Well....it used to be a good way for me you know like the house would get laldy (cleaning frenzy) or the bairn would be taken out a walk or you know...*

However, in recent months she had become physically unwell which meant she was restricted in terms of the level of activity she could undertake. This made it more difficult for her to keep busy and take out her feelings on household activities such as cleaning:

*11: I find it harder now because I still get, well I call it a nervous energy where I get panicky...and I haven't got the energy to do, you know before I was hurrying about the house cleaning and you know....*

Participant 07 felt better if she had a routine to keep her busy. For example, when she had to feed, wash and put her children to bed. The times she found most difficult were when she had to think of ways to occupy her children and she had no routine to help her get through:

*07: I mean routine kept me going....the 3pm to 5pm that was absolute purgatory in trying to occupy the children and sometimes social work would come in and that was great. If they didn't come in that was difficult – then 5 o'clock, it would hit 5 o'clock and you'd know it's supper, bath, bedtime story, bed and you could go into that and you could do it pretty much with your eyes shut so come 5 o'clock it wasn't better but I could get through it...*



Unlike most of the above participants, participant 13 was not purposively trying to 'resist the urge' to cut by engaging in activities to keep her busy. When she realised that she had not cut for a while as a consequence of being so busy, it made her want to cut herself:

*13: ...but the thing is I've been so busy and I've had so many distractions which is what tends to, I suppose helps really.... and then I find myself thinking about it and I think well I haven't done that for ages, and I really want to do it, I've got to do it*

On the other hand there were times when the participants lacked the motivation to carry out various activities, which would have helped them to occupy their time and displace thoughts of self-cutting. When feeling low, it was difficult to concentrate on tasks or activities like watching television or reading books. One participant even said that when feeling very low nothing helped make him feel better:

*05: But sometimes if I'm in that sort of mood you know nothing normally.....will help you in that sort of mood. Television will induce despair and all the books looks boring...*

Participant 04 also found that the low mood he sometimes experienced made it difficult for him to focus on activities which had been suggested to him by healthcare professionals:

*04: Well they've said, they have said like you know – why don't you go out for a walk or put the radio on or put the television on but I can't do those sort of things because I don't have, I don't have the concentration sort of thing. When I'm feeling low all my concentration and motivation and everything just goes out the window like you know....*

The one activity which participant 04 found helped pass the time was sleep as obviously it does not require motivation or concentration. Although he was in his bed for long periods of time he was not necessarily asleep:

*04: I don't have the interest in watching it (TV) and eh most days um – well just to, just to get from one day to the next sort of thing I tend to sleep a lot.*

Passing the time through sleeping also helped participant 05 in terms of occupying his time until the later weekend opening hours of the voluntary organisation which he attended:

*05: ...when this place was open, it didn't open until 2pm and if I woke up about 9ish which is often when I get up you know it's seven hours til it opens so I try to sleep later....*

It appeared as though remaining in bed was the favoured option for some of the participants when they had low motivation. It further helped if they were able to sleep:

*06: Well uh huh constantly in bed all the time, you know, up all night, you know – you try to get to sleep but you can't...*

*07: luckily my smallest one was 18 months old and she would go to a child minder so I did have like 9 until 230pm/300pm free of children which I would sleep or try to sleep*

### *Trying to Cope*

The property 'trying to cope' highlights that when the participants were coping better with life and felt emotionally well, the urge to self-injure was much diminished or eliminated. 'Trying to cope' also explains what happened when some participants found life difficult to cope with. When the participants felt well it appeared as though the urge was lying dormant and it did not feature in their lives within that context:



*04: when I'm feeling quite well about myself I tend to, those thoughts tend to be away from me sort of thing like, you know.*

Like participant 04, participant 14 found that when she was in a positive frame of mind and felt good about herself, the urge to cut seemed to lie dormant:

*14: ... sometimes the urge isn't there at all. Sometimes you feel very positive and you know you really feel – yeah I am a viable person and I don't need to do this to myself, you know and erm...*

Participant 08's self-cutting behaviour decreased in frequency and then disappeared when he met his future wife, fell in love and travelled the world with her. Life was easier to cope with because he was in a happy relationship and was taking part in exciting activities which were far removed from the realities of ordinary everyday life:

*08: And yes it slowly diminished, there were lots of things going on, it did diminish. I met X, I don't know when – it's the person I am married to now and I'd not been self-harming for at least two or three months before I met her and certainly once I met her the whole concept of it disappeared – just being in love and skiing, and sailing across the Atlantic and stuff – and it wasn't a feature.*

Participant 08 started cutting again after the above period in his life. However he subsequently arrived at a stage where he was able to 'resist the urge' as he felt happier. Although the urge did not disappear completely from his life, it played a more minor part:

*08: And it slowly died down....now how did it die down – I slowly became happier. Self-harm became a sort of part of my life but not so central.*

Participant 07 explained that she felt well generally and she was managing to cope, yet she was unsure whether this situation would exist if she was not on medication:

*07: I'm on a higher medication than I've ever been on and although I'm feeling well I don't know, um but I'm coping very well with everything else apart from household stuff but I'm feeling on the whole fine.*

It was important to participant 07 that she was able to get through the day but she revealed that she did not always take pleasure from what she was doing:

*07: I mean the main thing is though that I get through and most of the things I can get through and enjoy or not necessarily enjoy but get through...*

At the time of interview, participant 14 commented that she was going through important changes in her life at that moment and she was happy with the progress she had made:

*14: I'm working through it a lot and at the moment there is a actually a lot of changes in my life at the moment and erm it's a really big watershed erm sort of time for me so I think I've made a lot of progress but....*

She explained that generally she felt that was coping well:

*14: ...erm but I am coping very well...*

There were times however when the participants found life difficult to cope with. For example, participant 04 lost interest in everyday activities and found it difficult to cope by himself and this resulted in him neglecting his basic needs:

*04: Sometimes I find the world so difficult to deal with that I can't cope with things on my own. I can't cook, I can't clean, I don't look after myself, I let myself go, I don't shave, I don't wash and so erm there are times that I feel that I'd like to be looked after 24 hours a day, 3 meals a day...*



Similarly, participant 06 sometimes went through periods where she had difficulty coping and isolated herself in her flat. She reported that she would stop caring about everything, including her personal hygiene:

*06: I'm like I won't bother with anybody – if the phone goes I won't answer because when, that time I was not well, I mean the hygiene was like, when I was living on my own that goes out the window, and I was completely like I didn't give a shit about anything you know and I thought.....and cos basically I would be in the flat for weeks and weeks, I'd be like stocking up, making sure I've got everything....*

Although participant 07 felt that she was generally coping quite well, she admitted that she was not dealing as well with household tasks:

*07: ...but I'm not coping very well with homey stuff*

### **Finding Alternatives to Cutting**

Giving up cutting did not necessarily mean that the underlying problems that triggered the urge to self-injure had gone away. The subcategory, 'Finding Alternatives to Cutting' explains how participants needed to find ways of dealing with situations where previously they would have cut themselves. The property, 'comparing with cutting' describes the difficulties faced by some of the participants in finding an effective replacement.

### *Comparing with Cutting*

Most of the participants searched for alternatives to cutting as a strategy to avoid giving in to the urge to cut or to prevent the urge to cut reappearing. However the overriding message from the participants appeared to be that nothing compared to cutting, and they had great difficulty finding alternatives that matched up to the effectiveness of the act. In saying that, some participants did find adequate alternatives to cutting however it appeared to be the case that they had to settle for second best. Not being able to find a less-destructive way of meeting the need that cutting served perhaps explains why participant 13 did not want to give up cutting:

*13: To be perfectly honest there isn't anything that tops it at all (speaking softly)*

The participants described how healthcare professionals would suggest alternatives to cutting but often the suggestions angered them.

*07: One of the things in hospital that really used to annoy me is several times, and you'd even get written things about alternatives to self-harm that other people have come up with, and you had sort of like punch a pillow or...and it was like – get real it's, that's not going, not going to do it um....and it was like the blood.....that I wanted... um....the blood and the hurting and it wasn't a matter of like punching a pillow, it wasn't a matter of getting rid of frustration or anything like that – it didn't have the same effect.*

*And it really used to annoy me the amount of time they sort of suggested things....*

Participant 07 described what was effective about cutting for her – the blood and the hurting, and if the suggested alternative did not serve this function and enable her to draw blood or hurt herself, then she could not see the point in trying it out. Similarly, participant 14 explained that burning did not match up to cutting in terms of meeting her needs because of the absence of blood:

*14: Burning isn't as effective for me you know because obviously you are not going to bleed...*

Participant 08 also reasoned why the suggested alternatives did not compare to cutting in that they did not involve damaging the self, which for him was an important part of cutting:

*08: If you want to express that sort of deep, darkness then there's probably no other way to do it you know – a story or a literature or talk or whatever wont do it and you know hitting beanbags is just ludicrous....(laughs) but it doesn't have the same thing because it needs to be something that damages you because it's part of it...*

Participant 14 also expressed difficulties in finding another coping method:



*14: ....it's very difficult to find another way of.....erm.....dealing with things, coping with things...*

Briere and Gil (1998) suggest finding alternatives to cutting which perform similar functions (reducing distress) but which are less harmful, for example physical exercise, distraction via television or reading or contacting friends when the urge to cut becomes intense. Not all of the participants experienced difficulties in finding suitable alternatives to cutting. One participant found martial arts helped her deal with her feelings:

*11: I used to like take pillows and punch them, then I started the martial arts which I found was a very good alternative – it never gave you the same release but it came pretty close, you know the shouting, kicking and punching (laughs)...and it's because it is controlled as well you know it meant that I didn't get really worked up and like harm myself – I liked the way that it is controlled and it did give me a buzz but I had to stop it because of X....*

Martial arts gave this participant the opportunity to release her anger in a controlled environment and although it did not quite match up to the effectiveness of cutting it appeared to help meet her needs in a less destructive manner. Nixon et al. (2002) also discovered that people who self-injure reported engaging in physical activity in addition to other activities such as writing, talking, playing an instrument and

generally keeping their hands occupied when trying to 'resist the urge' to cut.

Participant 14 found that an effective way of 'resisting the urge' to cut was engaging in a behaviour which to her was very harmful. She replaced cutting with an act which also met the need of damaging herself but she found that health professionals did not understand or appreciate her explanation:

*14: and, erm, also something which hasn't been picked up although I've mentioned it to erm different mental health professionals is that....well I am vegan and it is a very strong thing in my personality - something I really deeply believe in and er, eh I sometimes eat meat erm that's one of the ways I found actually of not cutting myself...yeah erm and....it's not really understood by the people I've talked to - they're like oh what's wrong with eating meat you know and eh...it's a big thing to me - it's actually very, very harmful to me you know - I get very upset about it you know... but erm I try and think of it as a better way, a better way of coping with it than cutting myself you know but I am not really sure about that though....*

Within the context of being a vegan, the rationale for participant 14 choosing to eat meat as a way of damaging herself is not difficult to comprehend. Eating meat goes against participant 14's beliefs and by doing so it felt like she was harming her body. It is a less destructive act than cutting however participant 14 is not sure if it is really a better way of coping. She also discovered that expressing herself through art helped

to release her emotions and she tried to engage in this alternative behaviour instead of cutting:

*14: Yeah sometimes erm....I'm an artist so I paint and draw and...I haven't really done very much recently, I haven't really painted very much for the last few years at all erm but eh...I use that as a way of getting my emotions out in a controlled manner, erm in a respectful and honourable manner erm....instead of cutting myself, so I do that now...*

Similarly, participant 05 could distract himself from cutting by expressing himself through writing:

*05: ...and also sometimes I have a least on occasions I've successfully distracted myself from something erm.....like for instance writing eh.....eh I do writing almost exclusively, almost exclusively though when I'm not feeling too good...*

It appeared that the above alternatives to cutting were successful because they met the same needs as cutting, for example martial arts allowed participant 11 to get rid of her anger, participant 14 felt that she was damaging herself through eating meat, and she could release her emotions through painting. Similarly, participant 05 used writing to release his emotions. Like some of the participants in this study, Abrams and Gordon (2003) discovered that writing, art and creative expressions were popular alternative



coping methods for the women in their study on self-injury. However, the women reported struggling to make use of the positive coping methods instead of self-cutting (Abrams & Gordon, 2003).

### **Chapter Summary**

'Resisting the urge' to self-injure seemed problematic for most of the participants in this study. Deciding to give up cutting was not a straightforward action in that the participants had conflicting emotions about the behaviour. Although most of the participants wanted to stop cutting for reasons relating to the negative consequences of engaging in the act, they also wanted to feel they could cut if they needed to again in the future. It appeared as though they felt more vulnerable by denying themselves the opportunity to 'satisfy the urge'. In order to live without cutting some of the participants felt better knowing they had access to cutting tools and this often stopped them from cutting.

Going without cutting did not mean that the participants were free from the self-destructive urges and it was important for them to find alternative ways of coping with such urges. If the urge was triggered then the participants often tried to 'resist the urge' to cut by engaging in other behaviours. Some of these alternative behaviours involved damaging the self in other ways however some participants found less destructive ways of coping such as martial arts or painting. There appeared to be a fine line between 'resisting the urge' and 'satisfying the urge' in that some of the participants came so close to failing to 'resist the urge' to cut. As having

to struggle against this urge made life especially difficult for the participants, being able to resist it for as long as some of the participants managed emphasises the great extent to which they wanted to be able to live without cutting.

## **Chapter 9**

### **Discussion**

#### **Introduction**

Researchers and clinicians as far back as the late 1930s have referred to an 'urge' when discussing cutting or when reporting how patients describe their self-cutting (e.g. Menninger, 1938; Graff and Mallin, 1967; Grunebaum and Klerman, 1967; Siomopoulos, 1974; Schwartz et al. 1989; Himber, 1994; Hartman, 1996; Stanley et al. 2001; Davis & Karvinen. 2002; Nixon et al. 2002). In spite of this, there appears to be no studies to date which focus on the 'urge to cut' from the perspective of people who self-injure. The 'urge', as a concept, has been explored in relation to smoking, drug and alcohol abuse (e.g. Tiffany, 1990; Paty, 1997; Rohsenow & Monti, 1999; Drummond & Phillips, 2002) however in the present study it emerged that the 'urge' is also very relevant to people who cut. This study explored the experiences of self-injury and how people who engage in self-cutting shared and responded to an 'urge'.

The findings further our understanding about the phenomenon of self-cutting, by highlighting how both the urge and cutting behaviour have the potential to dominate the lives of people who self-injure. This study emphasises that it is not only the act of cutting which needs to be understood, but also the urge to cut within the context of the everyday lives of people who are currently self-injuring, or who have self-injured

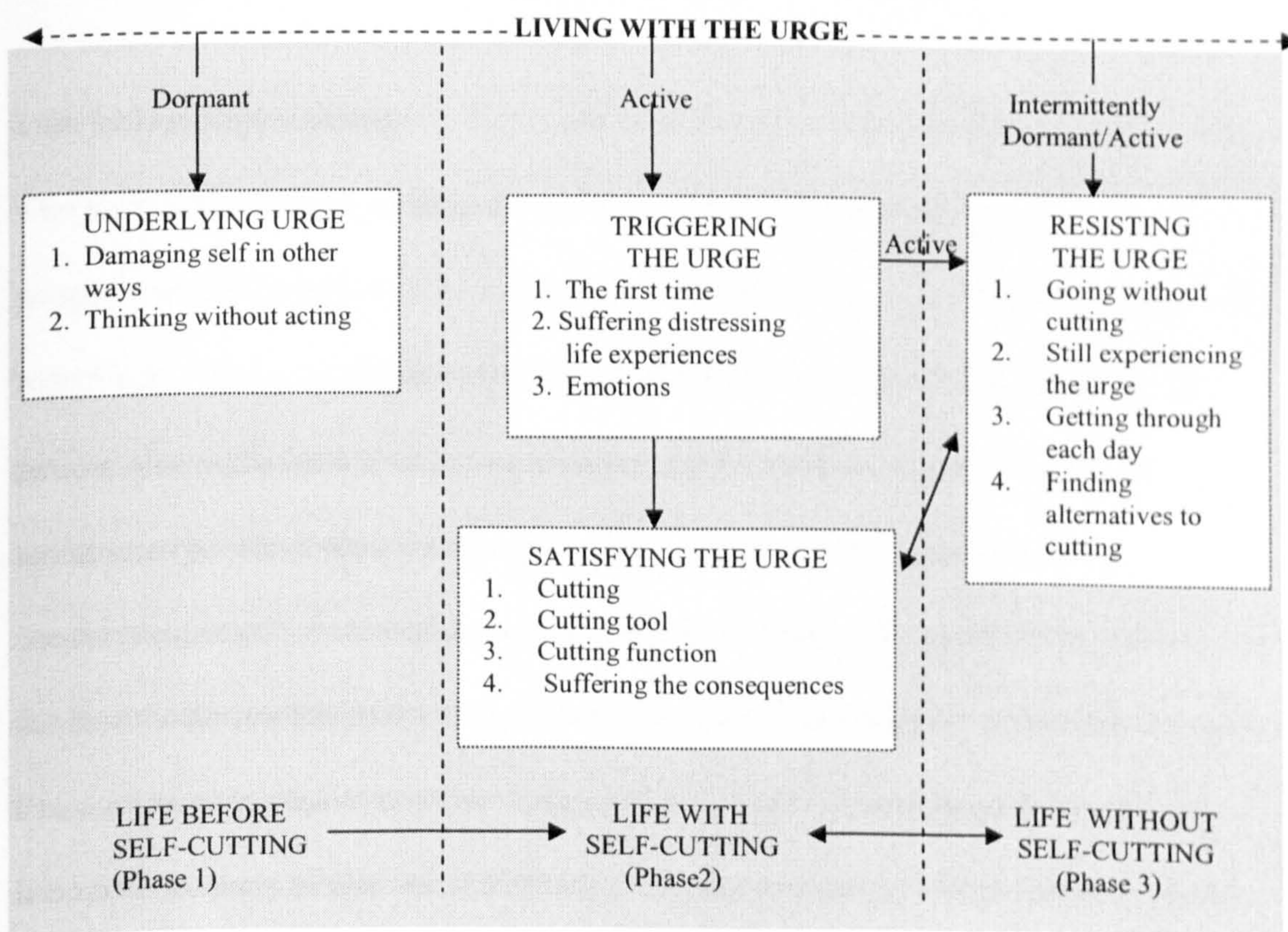


in the past. It is necessary to look beyond the cuts and scars which people inflict upon themselves in order to discover how and why they engage in self-cutting. The experiences and perceptions of the participants in the present study illuminated an often unpredictable and complex relationship, which people who self-injure have with cutting. Although the participants at times found cutting and its consequences difficult to tolerate, they also needed the behaviour to help them cope with negative feelings and distressing past experiences. As a result, the participants often battled with the urge to cut in terms of either satisfying or resisting the urge. This has implications for designing effective treatment approaches, which take into account the conflicting feelings which people who self-injure have about the behaviour.

A substantive theory is therefore proposed which asserts that people who self-injure face a paradox of finding it very difficult to live with self-cutting, and simultaneously facing the challenge of life without self-cutting. This paradox can be understood within the context of *living with the urge* to cut, a process which begins before the onset of cutting in the form of an *underlying urge*, and continues not only while people are cutting but also when they are trying to live without cutting. From the first time the urge to cut is *triggered* and the world of cutting is entered, the urge seems to reappear intermittently, and people who self-injure face the struggle over *satisfying* or *resisting* the urge. Even when the participants managed to resist the urge they still seemed to live with the possibility that they might end up satisfying it again, and their lives were still clearly affected by this ever present urge. The experience of the core category, '*living with the urge*' varies depending on the type, nature, intensity and



intermittency of the urge both across and within the main categories: *Underlying Urge, Triggering the Urge, Satisfying the Urge and Resisting the Urge*. It is evident how the core category weaves through the main categories via the experiences highlighted in the subcategories and their properties (Holloway and Wheeler, 2002). The relationship between the core category, *Living with the Urge* and its main categories is presented in Figure 9.1.



**Figure 9.1: Living with the Urge**

This discussion aims to illuminate and embed the proposed theory in relation to previous research by highlighting each phase of cutting (see figure 9.1), relating key concepts and experiences to appropriate literature, and thereby increasing our



understanding of cutting. In addition, the discussion goes on to identify areas in practice, education and research for development, building upon findings from the study and related more directly to the understanding of practitioners. Ultimately the discussion provides a voice for people who engage in self-cutting. Each phase of *'living with the urge'* is discussed separately, with subsections highlighting key experiences which help to increase knowledge and comprehension in relation to cutting behaviour.

### **Life before Self-Cutting**

The substantive theory, as described above, clearly illuminates how difficult it is for people who self-injure to break-free from self-cutting once they start engaging in the behaviour. However, an important contribution of the theory is the finding that people who self-injure also appear to demonstrate pre-cutting, self-destructive tendencies of which they are not fully aware, suggesting the existence of an *'underlying urge'*. Focus on an *'underlying urge'* potentially presents an opportunity for healthcare professionals to prevent the onset of self-cutting in vulnerable people. Pre-cutting experiences however have remained largely unexplored in the research literature in terms of retrospectively exploring the presence of other self-destructive behaviour during this period.

### ***Pre-Cutting Self-Destructive Behaviours***

Nevertheless, there is anecdotal evidence (e.g. Harrison, 1995; Strong, 2000; Turner, 2002) of early harmful behaviours in people who go on to engage in self-cutting. A



small number of studies which have explored the in-depth experiences of people who self-injure (e.g. Spandler, 1996; Hyman, 1999; Sutton, 1999; Harris, 2000) have also briefly referred to the presence of pre-cutting harmful behaviours.

### Accidents

From the few reports in the literature of pre-cutting destructive behaviours most refer to 'accidents'. In the present study several participants described purposively causing accidents such as falling over, although they were unsure at the time why they were behaving in this way. Notably, Pao (1969) in his description of the developmental history of the typical "delicate-cutter" included accident proneness before puberty as a common feature, but he did not elaborate on possible meanings or functions behind the accidents. One quarter of the 240 participants in Favazza and Conterio (1989) also described themselves as being accident-prone but did not report when the accidents happened. It is unclear if, as was the case in the present study, accident-proneness was a feature before the onset of cutting. Arnold (1995a) also reported that it appeared to be a common experience for the women in her study to have started causing fairly minor damage to themselves as children, often through acts which were covered up as accidents. As the women reached their teenage years they progressed to self-cutting. Suspicious-sounding accidents which sometimes turn out to be intentional appear to be common in people who self-injure (Conterio & Lader, 1998).

These early accounts of 'accidents' coupled with the later emergence of self-cutting provide some support for the presence of an 'underlying urge' to self-injure. During

this phase the urge is dormant and vague, manifesting itself in a number of directly and indirectly harmful ways. It is difficult to establish the intensity of the urge given that the participants were unaware of their self-destructive wishes. It appears that only when people have been cutting for a length of time, they are able to look back and realise that they had been harming themselves in other ways prior to the onset of cutting (Spandler, 1996; Bywaters & Rolfe, 2002). For example, in the personal stories of women in Smith et al. (1998) some reported that they had self-harmed in various ways from an early age but had not recognised this at the time. It is therefore useful to discuss the possible meaning within these early harmful behaviours or ‘accidents’, in order to explore how they may lead to the urge to engage in self-cutting.

In one of the earliest publications on self-destructive behaviour, Menninger (1938) highlighted the lack of attention to the self-destructive component hidden within many accidents. He analysed various types of accidents and suggested that some of them appeared to be unconsciously purposive. Menninger (1938) defines ‘purposive accidents’ as: “those occurrences in everyday life by which the body suffers damage as a result of circumstances which appear to be entirely fortuitous but which, in certain instances, can be shown in their natures to fulfil so specifically the unconscious tendencies of the victim that we are led to believe that they either represent the capitalization of some opportunity by the unconscious self-destructive wishes or else were in some obscure way brought about for this very purpose” (p. 202). This description is reflected in the present study with some participants



describing falling over “accidentally on purpose” but apparently not being conscious of the underlying self-destructive urge. Menninger (1938) did not discuss purposive accidents in relation to the onset of self-cutting however he grouped the behaviours together as examples of focal suicide, which describes self-destructive acts that are focused upon specific parts of the body where the life-instinct is victorious over the death instinct.

Kaplan and Pokorny (1976) found that students, who reported prior suicidal behaviour or self-derogation when initially interviewed, were more likely to disclose having had accidents when interviewed again in the future. These findings provide some support for their proposal that accidents represent “unconscious self-destructive urges that are alternatives to conscious self-destructive urges as responses to self-derogation” (p. 120). In other words, if people deem themselves as worthless, accidents may fulfil their unconscious need to harm their ‘worthless’ self (Kaplan and Pokorny, 1976). This is reflected in the present study through the presence of accidents in the early lives of some of the participants, where an ‘underlying urge’ appears to represent an unconscious wish to damage the self. Kaplan and Pokorny (1976) only looked at accidents whereas the present study suggests that there are other behaviours in addition to accidents which indicate an ‘underlying urge’ to cause harm to the self. Alcohol problems, drug abuse, and overdosing featured in the lives of several participants before the onset of self-cutting, and suggest that the urge to cut is at risk of being triggered.



## Alcohol/Drug Abuse before Cutting

Von der Stein and Podoll (1999) found that 18 out of 100 males hospitalised for alcohol problems had histories of self-cutting. In 11 out of the 18 male patients the onset of alcoholism was on average 6.5 years before the first episode of cutting. Von der Stein and Podoll (1999) suggest that self-cutting therefore can not be perceived as a predictor for the onset of alcoholism. On the other hand it is also unclear whether alcohol problems can be a precursor to self-cutting, however consistent with several of the participants in the present study, the pre-cutting lives of some of the patients in Von der Stein and Podoll (1999) featured alcohol abuse. In a study of cutting in adolescent females receiving treatment in an inpatient drug program, Schwarts et al. (1989) listed previous self-harm (burns, suicide attempts, skin-picking) and a history of drug or alcohol abuse as risk factors for self-cutting. The relationship between alcohol/drug abuse and cutting requires further investigation in a larger focused sample of people. It is important to establish when drug and alcohol problems start in people who engage in self-cutting and how they develop in relation to the onset of self-cutting behaviour. Given the variable nature of the underlying urge during this early period, the possibility exists that people may alternate between self-destructive behaviours. Connelly (1980) advises clinicians to suspect the presence of a strong underlying self-destructive component, if there are signs of other self-destructive behaviours in people who abuse alcohol.

## Overdosing before Cutting

The present study found that overdosing began before the onset of cutting in some of the participants. Several studies have included statistics on overdosing in people who self-injure when describing the profiles of the participants (Favazza & Conterio, 1989; Warm et al. 2002) but it is unclear when or why the overdoses occurred. It would be worthwhile to ascertain how many people who self-injure took overdoses prior to the onset of cutting and then explore the transition from overdose to cutting within this group. Given the lack of research into harmful behaviours during the pre-cutting phase other sources help highlight this relationship. For example, in a BBC News interview, Sian Davies, a 24 year old with a history of self-cutting described how she took an overdose aged 17 years old, but as her cry for help was not responded to she went on to engage in self-cutting (Davies, 2003).

Not everyone who takes an overdose or who abuses drugs and alcohol will go on to self-injure but if there are other factors present then their vulnerability to self-cutting could be increased. For example, Stanley et al. (2001) found that physical abuse during childhood was significantly more common in patients who attempt suicide and have a history of self-cutting, compared to those who attempt suicide but have never cut themselves. A history of physical abuse coupled with overdosing could therefore alert clinicians that a person is at risk of engaging in cutting, and steps could be taken to try to prevent this from happening. Further exploration of the relationship between pre-cutting self-destructive behaviours and the onset of self-cutting is needed in order to establish how they develop in relation to one other.



There is support for the presence of indirect and directly self-destructive behaviours and harmful thoughts present in the early lives of people who self-injure. However, given the small number of participants in the present study this is an area which requires further exploration. Clinicians, social workers and other professions in contact with vulnerable people would benefit from awareness that accidents can at times be unconsciously purposive, suggesting underlying self-injurious urges which need to be identified before they escalate.

In a group of adolescents, Scott and Powell (1993) found that there were a high number of Accident and Emergency attendances in the years prior to admission for self-cutting. Often these attendances were for no physical reason or for something relatively minor. Scott and Powell therefore advise Accident and Emergency staff to be aware in such cases of the possibility of underlying psychological distress which could in certain cases lead to self-injury. This raises questions about whether there was an underlying self-destructive tendency amongst this group and further questions remain as to why? A variety of behaviours can act as early warning signs in vulnerable people and suggest that they are susceptible to the onset of self-cutting. For example, if people present with drug or alcohol abuse, skin-picking, suspicious-sounding accidents and overdoses this could alert healthcare professionals that they are a potential risk for self-cutting behaviour. It appears that although the underlying urge to cut remains dormant people engage in other harmful behaviours which can act as warning signals. The substantive theory proposed in the present study has utility in highlighting these early experiences and opening up the possibility for intervention



in the lives of vulnerable people, and preventing them entering the world of cutting, a world that is difficult to exit once entered.

### **Life with Self-Cutting**

Building on suggestions that identifying pre-cutting destructive behaviours can help prevent activation of the urge to cut, the second phase illuminates what happens when the urge to cut is triggered for the first time. During the phase, life with self-cutting, the urge is activated from its dormant state and people are consciously living with the urge. This marks the start of a complicated relationship between people who self-injure and the urge to engage in cutting, a relationship which has the potential for changing how they live their lives forever. Knowing what triggers first cutting episodes could provide valuable information in terms of context and meaning, which could in turn help avert the continuation of the behaviour in vulnerable people.

Furthermore this phase also highlights how cutting can become a repetitive behaviour, emphasising the importance of health and social care practitioners providing help for people who self-injure to manage their own lives in relation to living with cutting. In a review of clinical responses to self-injury, Connors (1996b) suggests assisting people who self-injure in understanding their cutting behaviour through identifying types of cutting, triggers, feelings and periods of time when most at risk. With this knowledge, and through further support, people who engage in cutting might be more able to live with and manage their behaviour (Connors, 1996b).

### *Cutting for the First Time*

This section discusses the processes which lead to the first cutting episode with a view to understanding how people who self-injure move to a life with self-cutting. Given the difficulties of trying to help people stop cutting, prevention where possible is crucial. Once entered, it appears very difficult to live with the behaviour: "Cutting takes on a life of its own that is very hard to fight" (Strong, 2000, p. 176). There are few references in the literature as to how people discover cutting for the first time, yet in the present study most of the participants described the circumstances surrounding their first cutting experience, illuminating trigger contexts. Awareness of contexts provides an opportunity for practitioners to intervene early to prevent triggers and help people who cut to self-help by avoiding future triggering situations.

### *Learning about Cutting*

The urge to cut was first triggered in some participants through learning about the behaviour from other inpatients. Arnold and Magill (1996) suggest a number of ways to either prevent or confront the problem of contagion in inpatient settings, for example encouraging patients both individually and as group to talk about their feelings, conflicts and problems in relation to their own situations, each other and staff members. Other strategies include ensuring that the inpatients' needs for support and attention are met, and creating opportunities for the safe release of anger, tension and frustration (Arnold & Magill, 1996). Nijman et al. (2002) state that there has been little research interest in environmental factors which contribute to cutting in an inpatient setting. They found that the risk of self-cutting on psychiatric wards



increased when inpatients felt lonely and isolated in addition to receiving insufficient stimulation or social interaction. Furthermore, Nijman et al. (2002) reported that self-cutting incidents peaked between 8pm and 9pm and were more likely to occur in the privacy of the inpatients' rooms. Suggestions for reducing the incidence of self-cutting in inpatients settings include, being aware of patients who are known to self-injure retreating to their rooms during periods of inactivity, and providing stimulating activities in the evenings instead of television being the only option (Nijman et al. 2002). Although these findings suggest that patients do not tend to self-injure in front of others, the possibility exists that other patients could still learn about the behaviour from seeing the results of cutting, and then enquiring about the behaviour. Several participants in the present study reported learning about cutting in this way.

In a review of psychological models of self-cutting, Bennun (1984) describes the group-epidemic model which forms part of the social-learning category. The model proposes that cutting epidemics in hospitals or adolescent units symbolise a rebellion against staff, and that unity amongst the patients can also be used therapeutically in the creation of group workshops. Bennun also highlights the importance of healthcare professionals forming close and trusting relationships with cutting group leaders in order to be accepted by the group. The group leaders are important in instigating positive changes within the group, working under close observation from the staff (Bennun, 1984). Suyemoto (1998) proposes that an environmental model describes how the environmental system (interaction between people who self-injure and their environment) might be a factor in triggering the onset of self-injury and also



in maintaining the behaviour. For example, social learning theory is related to the environmental model and helps explain contagion through the concepts of modelling and reinforcement, in that people in an inpatient setting may witness that self-cutting is rewarded and then copy the behaviour (Suyemoto, 1998).

Another strategy for trying to reduce cutting outbreaks in hospital is to implement no self-harm contracts. Some hospitals insist that inpatients sign no self-harm contracts before they receive any treatment and this has been heavily criticised (Arnold & Magill, 1996; Harrison, 1997; Batty, 1998). For example, Harrison (1997) in her discussions with other survivors of self-cutting describes the strategies used by some women, when faced with the possibility of receiving no support because of their cutting behaviour. They either kept their cutting a secret or relied on other self-harm methods such as drugs, alcohol, starvation or burning. The no self-harm contracts increased feelings of powerlessness in the women and several of them became suicidal as a consequence (Harrison, 1997). Conterio and Lader (1998) insist on the use of no self-harm contracts in their inpatient program in an attempt to minimise the problem of contagion. In contrast, Aldridge (1998) reports how staff on a psychiatric ward where cutting was a problem decided to refrain from trying to stop inpatients from cutting. The staff instead formulated strategies which they could implement if a cutting episode happened. This was just one of many strategies involving staff and patients designed to improve organisation of the ward, resolve policy conflict between medical and nursing staff, and ultimately reduce distress levels and cutting behaviour amongst the patients. Aldridge explains that the levels of distress and

cutting in the ward fell as soon as both patients and staff did not feel as though they were being controlled by each other. Further exploration is needed into how healthcare professionals and the organisation of inpatient settings can help discourage situations in which self-cutting can be learned.

Cutting can also be learned from a family member who is cutting and this was reported in the present study, where one participant described the guilt she felt because her daughter had started cutting. While we know little about this potential, a recent documentary on Channel 4 about a mother with a history of mental illness and self-cutting, showed her fifteen year old daughter who also started cutting. The girl had picked up her mother's habits and she felt afraid because she could not stop cutting (My Crazy Parents, 2004a). Children and adolescents could be vulnerable to self-cutting if exposed to the behaviour from an early age particularly, if like the girl in the documentary, they have experienced chaotic upbringings. Children as young as 6 years old were portrayed in the documentary series as being able to 'discuss' their mother's self-cutting behaviour (My Crazy Parents, 2004b). While increased media coverage on self-cutting helps to increase understanding and awareness about the behaviour, there is also the possibility that the media attention may tempt vulnerable young people into engaging in the act (Derouin and Bravender, 2004) adding to the sources from which cutting can be learned. Future research is required to increase knowledge about family influence in relation to self-cutting and to explore why and what can help in this situation.



## Discovering Cutting by Accident

Some participants in the present study found out about cutting by accident. This is consistent with Favazza and Conterio (1989) where 91% (n =240) said cutting “just happened” the first time, and Nixon et al. (2002) who found that most participants (76.2%, n = 32) claimed that it was their own idea to self-injure for the first time.

While emerging within the current study as part of broader experiences of cutting, future researchers need to give participants the opportunity to specifically talk about how they discovered self-injury for the first time. More detailed data about how the urge to cut is triggered by accident would increase understanding of the context within which the act was discovered, potentially opening up ways of intervening before cutting becomes a way of life.

In one of the few other studies to explore how the urge to cut is first triggered, Hodgson (2004) suggests that some features of cutting are either learned ‘from the self’ or from other sources. Most of the participants in Hodgson’s study discovered cutting through ‘self-learning’ and had never heard of the behaviour before. Self-learning meant that the participants learned about cutting from the self either by accident or by intentionally wanting to damage the self (Hodgson, 2004). One participant discovered cutting through picking at the skin on her wrist and realizing it made her feel better, and this led to a continuation of the behaviour (Hodgson, 2004). In the present study a female participant received cuts to her knuckles when punching a wall and this then triggered the urge to cut which is consistent with Hodgson’s (2004) definition of ‘self-learning’. Other participants in Hodgson’s study initially



learned about cutting from outside sources ('other-learned') such as another person or a book. Hodgson (2004) also points out that whether cutting is learned from the self or from an external source, the process of deciding whether the act is effective and choosing to repeat the behaviour is usually self-learned. This was the case with the present study in that most of the participants learned through experience about what worked best in terms of cutting severity, frequency and choice of tool, and more importantly the function which cutting served for them. Closer examination of the decision-making process involved in establishing the preferred type of cutting, would provide more insight into how cutting meets the needs of people who engage in the act. This information could highlight to health and social care professionals that the types and functions of cutting can be diverse, thereby emphasising the importance of listening to and evaluating individual experiences (Favazza, 1989).

### *Repeated Cutting*

Additional aspects of living with cutting, highlighted by this study, are the processes which perpetuate cutting and the experience of being a person who self-injures and lives with repeated cutting. In the present study the urge to cut continued to be triggered in situations where this behaviour proved effective in the past, such as when the participants felt angry or were in a low mood, or when memories of distressing past experiences came to the surface. Although at times participants found the behaviour difficult to live with they also depended on cutting, both needing and wanting it in their lives. Similarly, Bywaters and Rolfe (2002) found that for the participants in their study, the emotional relief which cutting provided was one of the

main reasons for repeating the behaviour. This relates to an affect regulation model which explains how self-cutting can be reinforced internally through the feelings of relief it provides, therefore maintaining the behaviour (Suyemoto, 1998). Affect regulation is the most commonly cited function of cutting in the literature, and given the positive effect the behaviour has on emotions the chances of repeating the behaviour are increased (Briere & Gil, 1998). Conversely, Briere and Gil (1998) also discovered that some participants continued engaging in cutting despite the behaviour causing an increase in negative emotions, and call for more research which explores other potential reasons for repeated cutting in this group. Tantam and Whittaker (1992) propose that repetition of self-cutting is made more likely by the persistence of original circumstances, by beliefs about cutting, by the emotional responses produced by cutting, by medicalisation and by the positive mood induced by cutting. These factors all appeared to contribute in varying degrees to the repetition of cutting in the present study, however it is not clear what Tantam and Whittaker mean by 'medicalisation'.

In contrast, a few studies on adolescents found that cutting was a temporary behaviour which they engaged in for a limited length of time (Suymeoto & MacDonald, 1995; Ross & Heath, 2002). We do not know if they managed to maintain a life free from both cutting and urges to engage in the behaviour. In the present study the participants were all adults, most of whom had been cutting intermittently since adolescence. If the participants had been interviewed at a much younger age when they were going through a 'non-cutting' period they too might



have claimed to have stopped cutting. It appeared to be the case that as the participants grew older, they realised that their cutting behaviour had the potential to return and were therefore more reluctant to say they had stopped.

Sansone et al. (2002) explored self-injury across the life cycle amongst psychiatric inpatients, with and without borderline personality disorder. Participants had to retrospectively report episodes of self-injury across their life cycle. The findings demonstrated that self-injury in patients with borderline personality increased until the period between 18 and 24 years old, and then continued until at least age 59 years old. Participants over this age were not included in the study so it is unclear if self-injury is still present in this older age group. In the non-BPD group self-injury was still present across the life-cycle but to a lesser extent. Sansone et al. (2002) propose that not all patients with BPD demonstrate behavioural “burn-out” and this applies to hospitalised patients in particular. Dubo et al. (1997) also found that in people with BPD, self-cutting increased from childhood until adulthood with the mean duration of the behaviour lasting 9 years. The proposed theory illuminates the ‘staying power’ of self-cutting in a person’s life; however more research is needed over longer periods of time.

### **Repetitive Self-Mutilation Syndrome**

Favazza and Rosenthal’s (1993) ‘repetitive self-mutilation syndrome’ (discussed in Chapter Two in relation to psychiatric diagnoses) suggests that cutting becomes a repeated behaviour due to an inability to resist an impulse to cut. The present study



also illuminates how people who self-injure 'live with the urge' to cut and they often struggle with the urge in terms of either satisfying it or resisting it. Cutting often occurred, as a result of the participants giving in to the urge or 'impulse' as Favazza and Rosenthal (1993) prefer to describe it. However in contrast to Pattison and Kahan (1983), Lacey and Evans (1986) and Favazza and Rosenthal (1993), the present study does not see failure to resist the urge to cut as the sign of a psychiatric disorder. Instead, giving in to the urge to cut is conceptualised by the participants as an indication of underlying distress at the time of cutting within the context of their current and past life experiences, moving us closer to a more grounded explanation of why the urge is difficult to resist. The proposed theory suggests the urge to cut continues to be triggered when the participants are faced with experiences, feelings and contexts where cutting helped them cope in the past. Instead of viewing cutting as a symptom of a disorder, health and social care practitioners should take context and meaning into consideration when exploring cutting as a repetitive behaviour.

### *Self-Cutting and Addiction*

Further support for the relevance and utility of the concept of 'an urge' is found within research relating to the field of addiction, with studies on gambling, smoking, drinking and drug-taking all investigating urges in relation to these behaviours (e.g. Shiffman et al. 1997; Fouquereau et al. 2003; Raylu & Oei, 2004). Tiffany (1990) reports that the concept of 'urge' has been considered important in relation to addictive behaviours from as early as the first studies into addiction. Space does not permit a full exploration of the urge within other fields, however reference will be

made to studies which have direct meaning to the theory proposed in the present study.

Key findings from the proposed theory, which have most resonance regarding the experiences of addiction, relate to the main categories, 'satisfying the urge' and 'resisting the urge'. For example, although people who self-injure appear to depend on 'satisfying the urge' to help them control their emotions or cope with past experiences, at the same time they find cutting difficult to live with because of its associated negative consequences such as guilt, scarring and stigma. Furthermore, when people who self-injure are trying to live without cutting, they still experience urges to cut and often struggle over whether to satisfy or resist the urge. The following section highlights aspects of 'satisfying the urge' as similar to experiences of addiction, and the subsequent section explores parallels between 'resisting the urge' and addictions.

### Addictive Aspects of Cutting

It is not surprising that given the many references to the urge by people who self-injure, coupled with the repetitive nature of cutting, that the behaviour has been described as being similar to an addiction (Favazza & Conterio, 1989; Tantam & Whittaker, 1992; Himber, 1994; Faye, 1995; Karwautz et al. 1996; Solomon & Farrand, 1996; Spandler, 1996; Alderman, 1997; Nixon et al. 2002). Self-cutting and the urge can take over the lives of people who self-injure in a similar way to addictive behaviours like gambling, drinking and drug-abuse. For example, Favazza and



Rosenthal (1993) report how cutting becomes “an overwhelming preoccupation in some persons who describe themselves as being addicted to the behaviour and who may adopt an identity as a ‘cutter’. In such persons the self-mutilative behaviour seems to assume an autonomous course” (p. 136). Interestingly, a national newspaper recently contained an extract from a diary of a person who engages in cutting and in one of her entries she likened herself to someone who abuses drugs: “I feel I am losing myself to this self-harm, and it is so frightening. I am like a drug user, ever trying to get a fix, ever trying to get as big a hit as the last time” (Frith, 2004).

Notably, several of the adolescent inpatients in Simpson and Porter (1981) reported similar reasons for their heavy drinking, drug abuse and self-injury, for example “to feel good” or “to make the feelings go away” (p. 432). Lacey (1993) found that some of the participants in his study likened the peaceful state, and relief of tension they felt after cutting, to the feelings they experienced after consuming too much alcohol or drugs.

Nixon et al. (2002) found that self-cutting has many of the characteristics common to addictive behaviours as set out in the DSM IV. For example, the participants reported in a questionnaire that “the behaviour continued despite acknowledging it was harmful; tension level reappeared if self-cutting was stopped; and the urges to cut were upsetting but not enough to stop. Self-cutting also caused problems socially and the frequency and intensity of cutting increased in order to achieve the same effect” (p. 1341). All of these characteristics were evident to varying degrees in the



experiences of the participants in the present study. In keeping with Nixon et al. (2002), an important feature of the proposed theory is that although cutting caused problems for the participants, they found it difficult to give up the behaviour.

For example, the negative physical, social and emotional consequences of 'satisfying the urge' to cut were often not enough to stop the participants from engaging in the act. This indicates just how important a function cutting served for them and highlights the reinforcing quality of the behaviour akin to addictions. One aspect of this is for example, the emotion management quality which gambling has for some people who repeatedly engage in the behaviour. Ricketts and MacAskill (2004) found that in a group of problem gamblers, gambling influenced their emotional state in that they used the behaviour to control negative emotional states. Unlike self-cutting the main cost of gambling was financial but like cutting this ultimately impacted on emotions and relationships. Due to the effectiveness of gambling in managing their emotions, the gamblers reported being able to withstand high financial and relationship costs (Ricketts & MacAskill, 2004).

Similarly, people describing themselves as being addicted to exercise admitted that on occasion they exercise more frequently than is physically beneficial. Despite this admission, none of the participants stated they would stop exercising if advised by a doctor, unless they were in agreement with the doctor's opinion (Cox & Orford, 2004). Given how effective exercise was at regulating the participants' mood, they reported being afraid about stopping exercising (Cox & Orford, 2004). The

reluctance to give up a behaviour which is potentially damaging therefore appears to be common in people who self-injure, individuals who excessively exercise, and those who have gambling problems.

Furthermore, several participants in the present study and in the literature (Himber, 1994; Spandler, 1996) reported having to increase the frequency and severity of their cutting over time to fully satisfy the urge. Karwautz et al. (1996) state that this represents a 'marked tolerance' to the behaviour which is one of the criteria for psychoactive dependence. Heather and Robertson (1997) define tolerance as "the phenomenon whereby increasing doses of a drug are required to produce the same effect" (p. 120). This may reflect reasons given by participants in the present study for increasing the severity and frequency of their cutting. Heather and Robertson (1997) propose that tolerance is to some extent a psychological phenomenon, and can therefore be demonstrated in such behaviours as gambling where the amount of the bet is increased over time, and jogging where the running distance is gradually increased. They acknowledge that there are similarities between tolerance to these behaviours and to drugs and alcohol, but suggest that there are differences between them in the process of tolerance development (Heather & Robertson, 1997).

This could be because unlike drug and alcohol abuse there is no interaction with an external substance in gambling, exercising and self-cutting. They could be classified as examples of behavioural (non-chemical) addiction which is defined by Marks (1990) as "behavioural excesses that have no external substance as a goal" (p. 1389).



For example, behavioural addicts attempt to change their emotional state mainly by engaging in a behavioural routine such as washing, without taking any chemical substance (Marks, 1990).

Clinicians and therapists need to be aware that in some people the frequency and severity of cutting can increase over time in order to achieve the same outcome. A person who presents as someone who cuts superficially may not initially appear at risk. This situation, however, has the potential to change, therefore increasing the vulnerability of the person. In the present study most participants reported increasing the severity or frequency of cutting for reasons relating to the effectiveness of the act. There were however a few participants who referred to specific triggers, for example one participant cut more severely when suffering from hallucinations and delusions, and another explained that her cutting escalated when she moved away to college. More research is needed into both why and when people increase both the frequency and depth of their cutting behaviour. An important point to remember is that people who self-injure do not usually want to kill themselves when cutting, but obviously as the severity increases, so do their chances of inflicting severe damage. With this in mind the National Self-Harm Network (2000) produced an information booklet for people who self-injure, which explains how to keep the damage to a minimum when cutting. The use of self-help strategies will be discussed further in the 'Implications for Health and Social Care Practitioners' section later in this chapter.

Conversely, some participants in the present study maintained their cutting behaviour



at the same superficial rate. They appeared aware of their own boundaries in terms of how deep they were able to cut. In such cases they could be considered less of a risk, especially if the therapist has been in contact with them for a long enough period of time and is confident that they would never extend their boundaries. This is more likely to be the case if contexts and triggers have been discussed. Understanding how the 'urge' is experienced differently for individuals who cut, suggests that clinicians need to adopt a flexible approach to self-injury and accept that each case will be different in terms of context, meaning, cutting process and function.

In summary, the phase, life with cutting, portrays cutting as a behaviour which can easily become an ever-present feature in a person's life after engaging in it for the first time. The urges continue to be triggered in circumstances where cutting is known from experience to provide relief. It appears to be very difficult to break-free from this process despite the often-negative consequences, and people who engage in self-injury have likened their need to satisfy the urge to cut to that of an addiction. The substantive theory therefore has utility in emphasising to health and social care practitioners that the urge to cut plays a very important role in the lives of people who self-injure, and it should be considered when assessing ways of meeting their needs.

### **Life without Self-Cutting**

The struggle with the urge is further emphasised in the final phase, life without self-cutting, which illuminates how people manage to resist the urge to cut yet are reluctant to disassociate themselves completely from the behaviour. Most studies

into self-cutting focus on the phase, life with self-cutting, and explore correlates of the behaviour or to a lesser extent illustrate the experience of cutting from the perspective of people who self-injure. Few studies concentrate on the experience of life without self-cutting, although some studies refer to possible reasons for stopping cutting. The most informative studies are those which give people who self-injure the opportunity to explain why or how they have managed to refrain from cutting (Weber, 2002; Alexander and Clare, 2004) and this could help plan effective interventions for people who self-injure (Himber, 1994). The present study goes further than this and emphasises the experiences of people who self-injure when trying to live without cutting. Living without cutting emerged as a complex process which involved conflicting feelings, where the participants appeared unable to fully exit the world of cutting. They remained in a world infiltrated by urges to cut and although several participants had managed to resist the urges for many years, they lived with the uncertainty as to whether or not they would one day enter back into a life of cutting.

### *Not Letting Go*

The proposed theory of 'living with the urge' illuminates the struggle which people who self-injure face when trying to live without cutting. At the time of interview, most of the participants in the present study had been living without cutting for periods of time ranging from a few months to more than five years. Notably, all participants talked in terms of the length of time since they last cut rather than suggesting they had stopped cutting. This is consistent with the findings of Bywaters



and Rolfe (2002) and survivor accounts (Hyman, 1999; Sutton, 1999). Furthermore, in a BBC News interview, Sian Davies reported that her last cutting episode was three months ago, but she confessed that she did not ever envisage being able to say that she had stopped cutting permanently (Davies, 2003). This is very similar to how people suffering from addictions describe their behaviour, and it suggests both an unwillingness to let go of the coping method, and a lack of belief that they will be able to live their lives free from cutting, drugs or alcohol. This reluctance is also reflected in people who have problems with gambling. For example, Ricketts and Macaskill (2003) reported that some of their participants would not commit to saying they had given up the behaviour despite not having gambled for a number of weeks: "Because I know I haven't gambled for six weeks and I might not gamble for six months or six years but I will always be a gambler. And all you can do at the end of the day is just take one day at a time. And if you can get through that day give yourself a pat on the back" (p. 393).

Participants in the present study adopted a similar approach of trying to get through each day without looking too far into the future, with each cutting-free day representing an achievement for them. Strong (2000) states that most people who engage in repeated cutting believe that the behaviour is addictive and that it is harder to overcome than addictions to alcohol, drugs and smoking. In keeping with this, a participant in the present study reported that for her smoking was easier to give up than cutting and she even compared the process of 'resisting the urge' to going 'cold turkey', a term familiar to people withdrawing from drug and alcohol addiction.



Marks (1990) likens the urge, which behavioural addicts have to engage in their particular behaviour, and the resultant feelings of discomfort if they are prevented from 'satisfying the urge', to craving and withdrawal experienced by substance abusers.

In one of the few studies to investigate the addictive features of cutting, Nixon et al. (2002) obtained questionnaire data from a group of hospitalised adolescents about their cutting behaviour, including information on the urge to cut. They propose that the frequency of urges to self-injure suggests a significant preoccupation with the act. This is because although 78.6% (n = 33) participants reported daily urges to self-injure, these urges did not always result in self-injury, with cutting episodes occurring most frequently 'at least once a week' (61.9%, n = 26) (Nixon et al. 2002). The participants in the current study had similar experiences with the urge to cut often dominating their lives. When the participants were trying to live a life without cutting they still experienced the urge to cut but attempted to resist it. Unlike Nixon et al. (2002), the present study did not focus on 'episodes' of cutting and was able to explore the nature of 'the urge' in more depth from the perspective of people who had been self-injuring for many years.

During the phase, life without cutting, the urge to cut was both dormant and active, disappearing from the participants' lives when they were coping and felt well; however the urge often reappeared. In keeping with this, Alexander and Clare (2004) found that after a period of 'not cutting' the urge to cut was triggered in their

participants by strong emotions and feelings, with one individual describing the urge “popping its head up” again (p. 79). The reappearance of the urge to cut seemed to be both a problem and a source of comfort for the participants in the present study. Letting go of cutting was difficult for participants and this was reflected in their reluctance to state that they had stopped cutting, and in their tendency to store their cutting tools. Some studies report the type of cutting tool used by the participants (Ghaziuddin et al. 1992; Von der Stein & Podoll, 1999; Horrocks et al. 2003). By contrast very few have explored the actual relationship which individuals develop with their cutting tool. While this was not the main focus of the current study, it has emerged as an area of relevance and is therefore worthy of more focused research. In the present study the participants expressed both positive and negative feelings towards cutting. Some participants emphasised the importance of knowing they could cut if they needed to and referred to the behaviour as a safety mechanism, yet they often condemned the urge when it reappeared.

The paradox of finding it difficult to live with self-cutting, but also finding life a challenge without the behaviour is also reflected in the language used by some of the participants in Hyman (1999). When describing the meaning of cutting, one woman defined self-injury as both a “life-preserver” and a “ball and chain” and similarly another participant referred to cutting as a “friend” and a “demon” (p. 8). Marks (1990) states that problem drinkers, smokers and sexual deviants, can at the same time like and dislike their behaviour. He refers to this experience as ‘pull and push’ where “pull involves a search for a good feeling, and push represents an unmet strong



desire for relief from withdrawal symptoms” (p. 1391). This has resonance for people who are trying to live without cutting where they resist the urge to cut (search for good feeling) and live with their unmet need for relief, often turning to alternative strategies to satisfy the urge.

There is not enough evidence to suggest that self-cutting is an addiction *per se*, with the associated risk of medicalising the behaviour (Babiker & Arnold, 1998) but the processes and experiences appear to be similar. It is important to acknowledge that people who self-injure often feel as though cutting is an addiction. For example the participants emphasised how they appeared to depend on cutting to help them cope with negative feelings and distressing past experiences, how difficult it was to stop cutting once they had started, and how they often struggled against urges to cut.

Conterio and Lader (1998) do not perceive cutting as an addiction and they propose that people who self-injure can get better. They also acknowledge that self-cutting can feel like an addiction but they argue that the behaviour can become a choice for those who engage in it. Conterio and Lader’s (1998) inpatient treatment program runs on the premise that people do not always have to be “self-injurers” and that they do have power to control their actions. A similar viewpoint has been expressed in a controversial newspaper article written by an Accident and Emergency doctor in response to complaints received about the treatment for people who self-injure: “It is hard not to get frustrated: people who self-harm do have a choice, although it may not seem like it at the time. They could not do it, or they could do it and stay at home to



deal with the consequences. Just please don't lacerate yourself, come to hospital and then complain about it" (James, 2004).

This article was met by criticism and disgust from a columnist in the same newspaper who regularly writes about his experiences of depression, and he argued that "no one who has been through the hell and misery of self-harm could say it is a matter of choice" (Johnstone, 2004). Solomon and Farrand (1996) highlight the danger of assuming that people who self-injure have the ability to stop cutting. They distinguish between using self-injury as a way of controlling emotions, and being in control of self-injury in terms of having a choice between engaging in cutting or not. Solomon and Farrand propose that self-injury becomes a forced choice from limited options because often the alternative to engaging in cutting is loss of control and even suicide.

While Conterio and Lader's (1998) proposal about people having a choice over cutting appears logical, in reality the situation is much more complex. For example, the findings of the present study suggest that although there were periods of time when the participants could resist the urge to cut, there were many other occasions when it appeared as though they had no choice but to satisfy the urge. Unlike James (2004), health and social care practitioners need to understand that engaging in self-cutting can not be reduced to the simplicity of a yes/no choice, and that there are many processes and contextual factors which are embroiled in the act of cutting. Furthermore, the theory of 'living with the urge' proposes that people who are

managing to live without cutting appear to be unable to live a life completely free of the behaviour. For example, although several participants had not engaged in the act for a number of years, they still struggled against the urges to cut and stored their tools in a secret place in case they needed them again. In contrast to the viewpoint of Conterio and Lader (1998), who suggest that people who self-injure do not always have to live with this identity, it seemed impossible for the participants in the present study to completely detach themselves from cutting. Given that they still experienced urges to cut and faced the possibility that they might give in to the urge some day, this behaviour was still very much a feature in their lives. Expectations about stopping may put high levels of pressure unduly onto people who cut, with unknown consequences for future self-esteem and behaviour. This is an area which needs further exploration.

### **Implications of Research Findings**

The previous discussion relating to phases of self-cutting, highlighted by the proposed substantive theory, was able to point to a variety of areas where intervention, education, and future research would benefit the lives of people who engage in self-cutting, their families and linked practitioners. This section of the discussion takes these suggestions forward by synthesising their potential utility and relevance, and by making specific recommendations for practice, education and research.

### *Health and Social Care Practitioners*

The substantive theory clearly illuminates the experiences of people who self-injure through emphasising the struggle of 'living with the urge' to cut, and answers the call for research which explores the meaning of cutting for people who engage in the act (Chapter 2). With a view to improving treatment for people who engage in cutting, guidelines have recently been introduced by the National Institute of Clinical Excellence (2004) to encourage good practice in the treatment and management of self-harm (self-poisoning and self-injury), in both primary and secondary care. Unfortunately, according to a review of psychological and pharmacological treatments for people who self-harm (see Hawton et al. 2004), there is a lack of sufficient evidence to determine the most effective intervention. The present study contributes to the dearth of evidence and has potential to encourage health and social care practitioners to tailor interventions to meet needs, and can help people who self-injure manage their lives.

The findings highlight that the urge to self-cut could be lying dormant for a period of time before a person starts cutting, and this has important implications for the early identification of people who are at risk of cutting. Behaviours such as drug and alcohol problems, overdosing and suspicious sounding accidents could be seen as indicators of a desire to harm the self, which have not yet developed into an urge to engage in self-cutting. For example, if Accident and Emergency staff are aware that such behaviours often have an underlying self-destructive component, this should encourage further investigation into the personal and social circumstances of people



presenting with such problems. Accident-prone patients, those who appear vulnerable when presenting after an accident, people who take overdoses or are admitted for alcohol or drug excesses, could be considered at risk for developing cutting, especially if distressing life events such as abuse are disclosed. Furthermore, Gratz et al. (2002) found gender differences in the risk factors for self-injury in a community sample and this has important clinical implications. In the reality of a busy Accident and Emergency department there might not be the opportunity to firstly notice, and secondly explore suspicious cases. Taylor and Cameron (1998) state that by accepting that an injury is accidental, enables staff in a hectic Accident and Emergency Department to avoid the time-consuming process of exploring a patient's underlying distress. Taylor and Cameron emphasise the duty of staff to be suspicious of self-injury and be committed to probing any dubious cases.

Furthermore, Conner et al. (2003) found that there was a large relative risk for suicide in people who had previously attended hospital for injuries arising from undetermined causes. They highlight the problem of patients not disclosing episodes of self-injury and clinicians being reluctant to accept injuries as being self-inflicted. The role of the mental health liaison nurse could prove crucial in both identifying people who are at risk from cutting, and in educating and training relevant hospital staff on the warning signs which can act as precursors to the onset of cutting. Roberts (1997) highlights the importance of mental health liaison nurses in sharing their knowledge on mental health issues with general nurses, and calls for collaborative working in order to achieve this.

Models of early intervention could be developed and tested based on the 'warning signs' highlighted in the pre-cutting phase, and this could help people avoid future triggering situations. Early intervention has proved successful in a range of mental health and quality of life outcomes for people with psychosis (McGorry & Yung, 2003). One example of a potential early intervention is encouraging people who display self-destructive tendencies (other than cutting) to communicate verbally about how they feel, and prevent them going on to express their emotions through cutting. This type of early intervention model could be implemented by not only Accident and Emergency staff but also GPs, social workers and teachers. In early intervention programs with psychosis, GPs and schools provided crucial networks for identifying early warning signals and have yet to be utilised to maximum potential in relation to self-cutting.

The substantive theory offered in the present study highlights how the urge can be triggered for the first time in psychiatric hospital, and this has implications for how in-patient hospital staff work to prevent this from happening. Inpatients with no history of cutting, but who have suffered distressing life experiences which are associated with cutting such as abuse, (Shearer, 1994; Arnold, 1995a; Spandler, 1996; Briere & Gil, 1998; Santa Mina & Gallop, 1998; Low et al, 2000) should be closely monitored and given support to verbally express their feelings (Crowe, 1996). For example, Darche (1990) found a number of variables which differentiated self-injuring from non self-injuring inpatients, such as greater frequency of sexual abuse,



sleep disorders and higher levels of depression, anxiety, hostility and somatic complaints. Darche highlighted the potential value of these factors for identifying individuals who are at risk for self-cutting. Inpatient staff need to be alert to the contagion effect of cutting and safeguards should be designed to minimise the spread of the behaviour amongst vulnerable inpatients. Another issue related to cutting within inpatient settings is the meaning which cutting tools have for people who self-injure. The present study points to the comforting effect of storing cutting tools and the feelings of anxiety experienced when access to tools is restricted. This could have implications for how a hospital stay for a person who self-injures is managed. It is the philosophy of an inpatient unit for self-harm run by Bethlem Maudsley NHS Trust to encourage patients to accept responsibility for their cutting behaviour. Patients are afforded the freedom to engage in the act within established boundaries (Crowe & Bunclark, 2000). The unit's approach centres around harm minimisation instead of abstinence and the patients are given support to tolerate a period of time between the urge to cut and engaging in the act. This gives them the chance to identify and tolerate the emotion and consciously make a decision whether to cut or not (Crowe & Bunclark, 2000). Many of the inpatients have no previous experience of attempting to resist the urge. Gradually over time the period of time before cutting is gradually increased and the inpatients are given support to find healthier alternatives to cutting (Crowe & Bunclark, 2000).

Health and social care practitioners also need to look beyond the interventions and treatments offered within the context of their profession, and acknowledge the utility



of self-help strategies for people who self-injure. It is not possible for practitioners to be able to offer instant support on a round the clock basis, and this is where self-help can provide a lifeline for people in distress, and who are experiencing the urge to cut.

Osborne (2002) reports how the internet is often used at night by people unable to sleep and trying to fight the urge to cut, often in isolation. Internet use is particularly pertinent in light of the central role which the urge to cut plays in the substantive theory. Access to the internet and a supportive network could make the difference between a person satisfying and resisting the urge. Interestingly, the messages posted by people who self-injure on self-injury message boards (e.g. 'Secret Shame'; 'Self Injury and Related Issues') often relate to the urge to cut and the struggle against it. There are numerous messages offering support and encouragement for people who at that time are experiencing the urge to cut. This is potentially an important resource in terms of an out-of-hours support, which for most people is easy to access.

Telephone helplines such as the Samaritans offer a similar support service in terms of 24-hour availability, however unlike the internet there is the chance that the lines could be busy at a time when the urge to cut is strong. The participants in the present study did not talk about whether they had used the internet or telephone as a form of support, but several said how difficult they found periods of time where access to services was limited, for example at weekends or evenings. There is a need for health and social care practitioners to provide information on websites, and telephone helplines for people who self-injure.

### *Education and Training*

Healthcare professionals have long been criticised for failing to meet the needs of people who self-injure, and there have been numerous reports of people having their cuts stitched without anaesthetic and being labelled as attention-seeking (Pembroke, 1994; Harrison, 1995; Spandler, 1996; Harrison, 1998; Harris, 2000). This negativism appears to be a consequence of a lack of training, support and education for people who work in professions where self-cutting is encountered. Taylor (2003) states that his research highlights the importance of service users helping to educate and inform professionals. Furthermore, Reece (1998) argues that the medical model can result in frustration and create difficulties for people who self-injure in coming to comprehend their behaviour. She instead advises healthcare professionals to bear in mind that survivor models can be more relevant and effective for their practice than the medical model. This view is in line with an increasing number of publications being written by service-users with experience of cutting (e.g. Pembroke, 1994; Arnold, 1995a; Harrison, 1995).

Given the conflicting perspectives of professionals and service-users reviewed in Chapter Two, collaborative projects should be encouraged. This could promote shared understanding of the experience of self-cutting and the development of grounded, practical models of support and joint educational delivery. One example of such joint working is The National Self-Harm Network's (2000) self-help booklet for people who self-injure, their families, friends and healthcare professionals. It was written by both survivors and professionals and includes information on such things



as anatomy and physiology, first aid, surgical treatment for scars, skin camouflage and advice on what to do if refused treatment for cutting (National Self-Harm Network, 2000). Instead of focussing on stopping a person who self-injures from cutting, information such as this self-help guide can be made available in order to promote safe-cutting, while at the same time leaving the control with the person and recognising their struggle with the urge to cut.

Suicide policies such as *Choose Life* (The Scottish Executive, 2003) often do not incorporate information on people who self-injure because of the growing awareness that self-cutting is not about suicide. This could mean that health and social care practitioners underestimate the suicidal risk of people who self-injure. Conversely, the pressure of reducing suicide could result in staff being overcautious and misinterpreting the meaning of cutting. Although the act of cutting is not usually engaged in as a form of suicide, practitioners need to understand that suicidal thoughts might still be present in people who self-injure. For example, studies into self-injury have reported suicidal ideation in people who engage in cutting (e.g. Dulit et al. 1994; Stanley et al. 2001).

The substantive theory in the present study highlights the struggle of 'living with the urge' to cut and illuminates a complex process of which health and social care practitioners need to be aware. Knowledge relating to real experiences of self-cutting should result in practitioners having the confidence to ask the right sort of questions in order to explore the nature and cause of a cutting episode. Strategies on how to



deal with the urge to cut need to be developed and explored in both undergraduate and in-service training settings, a necessary precursor to changing practice. Here the links between research, education and practice become crucial.

Education and training on self-injury should emphasise context and meaning surrounding the urge to cut and how it is triggered. Information on the present study was incorporated into undergraduate nurse training at the University of Stirling where students were provided with information on self-cutting, in addition to background information on the study. There was an opportunity for discussion where the students asked questions and related the information to their practice. It is essential for health and social care practitioners to understand the perspectives and life experiences of people who self-injure and accept how cutting is interpreted by them. Training and education which focuses on the experiences of people who self-injure would provide the opportunity for competing perspectives to be shared and challenged.

For example, Forrest et al. (2000) explored how mental health service users could be involved in pre-registration mental health nurse training. They compared service users' views of a 'good' mental health nurse with the views of professionals' thereby highlighting any conflicts. Similar approaches should be incorporated into the training of doctors, psychologists, social workers and teachers in order to bring awareness of the behaviour, its causes, meanings and functions. Practitioners could also be directed towards the numerous self-injury message boards on the internet as a

way of gaining access to the in-depth feelings and experiences of people who cut themselves.

When discussing the need for education and training on self-cutting it is important to not focus purely on healthcare professionals. There are other groups of people in the community who would benefit from knowing and understanding more about people who engage in self-cutting. Given the fact that cutting most commonly begins during adolescence (Favazza & Conterio, 1988; Pattison & Kahan, 1983; Kehrberg, 1997; Babiker & Arnold, 1998; Anderson, 2000), the people who are regularly in contact with this age-group need to be more aware of self-injury. Ghaziuddin et al. (1992) suggest that because the onset of self-cutting is most common during adolescence, successful intervention at this stage may help to limit the scale of the problem of self-injury. In this respect, within a school setting, teachers, learning support staff and school nurses are ideally placed for shared learning opportunities. Learning about self-injury and awareness of the kinds of social issues that can lead to cutting would facilitate working together to prevent the onset of the behaviour through encouraging vulnerable children to express their feelings. This is in agreement with Muchlenkamp and Gutierrez (2004) who state the early identification of young people at risk or who have just started cutting could help prevent repetition and progression of the act.

Rodham et al. (2004) recommend the implementation of mental health awareness programs in schools as a preventative measure. They propose that the programs should focus on addressing problems that lead to self-cutting and increasing awareness of healthy coping strategies. Given that the present study highlights the



presence of purposive accidents in people who self-injure, teachers should be made aware that there could be a self-destructive component behind accidents, particularly in children they consider vulnerable. Nichols (2000) reviews reasons for self-injury in young people, and includes helpful responses which teachers can make in relation to cutting and the feelings which underlie the act. Furthermore, the importance of educating school pupils about mental health issues, including self-injury, should not be discounted.

### **Recommendations for Research**

In addition to suggesting implications for the practice and education of health and social care practitioners, the findings from the present study have pointed to some areas, which warrant further investigation. Indeed, as mentioned earlier there is an important link between research, education and practice. The proposed theory highlights the presence of an underlying self-destructive urge in the pre-cutting lives of people who self-injure. As described earlier this has implications for health and social care professionals in terms of preventing the onset of cutting. Furthermore, given the lack of research into self-destructive behaviours in the years before cutting develops, there is a need for more studies which explore the meaning of accidents, drug and alcohol abuse and overdosing in the pre-cutting phase. In order to increase understanding about the behaviour of people before they start cutting, it is essential to interview people who have recently started cutting (Walsh and Rosen, 1988) in relation to exploring the months or years leading up to the first cutting incident. Studies could determine whether there is an underlying self-destructive tendency in



the pre-cutting lives of people who self-injure, and if so why? It would then be essential to explore where this urge comes from and how it develops.

Given the importance of the urge to the participants in the present study, future research needs to build on these findings in order to understand more about the nature of the urge, and its impact on the lives of people who self-injure. Diaries have been used successfully as a data collection method in health research (Elliot, 1997) and have the potential to yield important information about the experience of the urge to cut. Researchers could ask people who self-injure to keep a diary during which they would record their daily lives in relation to cutting. For example, recording if they experienced the urge to cut, what it felt like, what triggered it, did they satisfy the urge or did they manage to resist the urge. It would also be interesting to ask people who have not self-injured for a number of years to keep a diary, in which they would note occasions, where they experience the urge to cut and how they manage to resist it. Several people in the present study would have fitted within this category in that they still experienced the urge to cut despite not self-injuring for a few years. This would give researchers access to more detailed information which might be lost in a retrospective interview due to time lapse memory problems.

The internet could also be used in a similar way to diaries, in relation to obtaining up-to-date data from the perspectives of people who self-injure. The role of the internet in the lives of people who self-injure merits further exploration, for example focusing

on message boards as a form of peer support, which could be compared with other self-help strategies such as telephone help-lines.

Studies involving people who have stopped cutting are important because they could provide insight into how people who formerly self-injured managed to exit the world of cutting. In the present study it seemed as though the participants who had not cut for a number of years, were still living with the urges to cut and did not believe that this situation would change. Although this study has begun to highlight how some people who self-injure appear to be unable to break free from cutting and its associated urges, it would be interesting to explore in more detail how people who have not cut for varying lengths of time perceive their identity in relation to cutting.

Another issue worth exploring is what 'being well' means for people who self-injure. Their perspective should be considered when planning treatment goals because the meaning of 'being well' to them could be different to that of a healthcare professional. In order to establish how the meaning of 'being well' differs between people who self-injure and healthcare professionals working with self-cutting, a study comparing their views may be beneficial. Perhaps a successful outcome for someone who is cutting could be that they manage not to cut but still live with the urge to cut, finding alternative ways to satisfy this urge? Is the ultimate goal for people who self-injure, a life where they do not experience urges to cut when faced with the same experiences or feelings that triggered the urge in the past? It could be the case that people in the latter category no longer perceive their identity in relation to cutting.



The role of the cutting tool could also be explored within this context given that it was a source of comfort for most of the participants who had not cut for a length of time, and it appeared to symbolise a link to their coping method. There appear to be no studies which focus specifically on the meaning of cutting tools for people who self-injure and this is an area worthy of research.

The findings of the present study have highlighted feelings and experiences relating to the urge in people who self-injure which are comparable to those experienced by people addicted to drugs, alcohol or gambling. There is therefore a need for studies which compare the concept of the urge within different contexts, for example self-cutting, drug abuse, gambling and alcohol abuse, looking at such factors as the lives of people before they started engaging in the behaviours, their first experience of the urge, if and how they have managed to stop engaging in the behaviour and their hopes for the future. Each behaviour might be able to offer new information or insight into how self-destructive urges can initially be triggered and develop over time. Finally, given that the majority of the sample in the present study were living without cutting at the time of interview, studies focusing on people who are currently cutting are needed in order to consolidate findings around the urge. Future studies into self-cutting will hopefully recognise the importance of the 'urge' and build on the findings from the present study.

### **Chapter Summary**

The theory of 'living with the urge', from the perspective of people who self-injure,



has provided a unique insight into the struggle they face in everyday life. Previous literature on self-cutting hinted at the urge to cut but no studies have explored what it is like to experience the urge. The urge to cut is what links a person's life without cutting to their life with cutting, in that when they are not engaging in the behaviour they still often experience the urge, and struggle over whether to resist it or revert back to their life with cutting. Although most of the participants at the time of interview were in a period of 'not cutting', all of them were unwilling to say that they had stopped cutting and they appeared to face an uncertain future in relation to cutting. It is unclear whether their way of managing to get through life without cutting was by not completely ending their relationship with cutting. It did not seem possible for the participants to say that they had stopped cutting, and for most of the participants it was important for them to know that their favoured cutting tool was safely stored away.

Drawing parallels with the field of addictions, it appears as though the feelings and experiences of people who self-injure are similar to those addicted to drugs, alcohol and gambling. This has implications for health and social care practitioners in terms of understanding and appreciating how agonising it can be for people who self-injure to live with the urge to cut. Help and support based on an understanding of the role which the urge to cut plays in the lives of people who self-injure is an important step in meeting the needs of people who self-injure. It is equally pertinent for health and social care practitioners to be aware that people who self-injure often have conflicting feelings about the act of cutting. Knowing that people can dislike cutting and want to

give up the behaviour, but at the same time not want to let go off cutting because of the positive function cutting serves for them, provides healthcare professionals with a perspective from which to negotiate and plan a suitable support package.

Although this was a small-scale exploratory study, it has presented a new way of viewing what it is like to be someone who engages in cutting, and has opened up a number of interesting avenues for future research. There is a need to explore what factors would enable people who self-injure to commit themselves to saying they have stopped cutting and live a life free of urges, where a knife, razor blade or a pair of scissors do not mean anything other than their intended usage. Given that people who self-injure face a paradox of finding it difficult to live with cutting, but also find life to be a challenge without cutting; interesting questions have emerged from the present study: Are people who self-injure ever able to exit the world of cutting once they enter it? More importantly do they want to end their relationship with cutting, a behaviour which undoubtedly helped them through extremely difficult times, and in many cases has ultimately prevented them from ending their lives?

## **Chapter 10**

### **Conclusion**

#### **Introduction**

This study aimed to explore the experiences of people who self-injure in order to identify and understand the processes involved in self-cutting, and develop a theory which aids this understanding. A grounded theory approach was used to meet the aim of the study, generating data through in-depth interviews with people who engage in self-cutting. The participants shared their experiences of self-injury emphasising both the meaning and function of cutting for them, and the struggle they faced living with the behaviour. Although the experiences of the participants were unique, there were also similarities which emerged during data analysis and were explored with subsequent participants, in keeping with the grounded theory method.

As data generation and analysis developed the aim of the study became more focused, resulting in an exploration of the urge to self-injure and how people who engage in self-cutting respond to this urge. Discussion of the findings offered a substantive theory, asserting that people who self-injure face a paradox of finding it very difficult to live with self-cutting while simultaneously facing the challenge of living without the behaviour. This can be understood within the context of the core category, *living with the urge*, a process which begins before the participants start self-injuring, continues



while they are cutting through to when they are trying to live without cutting. In the findings chapters, the core category, *living with the urge*, is seen to weave through the four main categories (*underlying urge, triggering the urge, satisfying the urge and resisting the urge*) through its corresponding properties and dimensions. The discussion contributes knowledge relating to commonalties between self-cutting and the experience of addiction, issues for prevention, repetitive nature of cutting, the relationship between people who cut and their cutting tools, and ultimately highlights how difficult it is for the participants to break-free from the world of cutting. In addition, implications of the findings for health and social care practitioners, and education and training were discussed, and recommendations for research were made.

### **Choosing Grounded Theory: General Reflections**

In choosing grounded theory it was anticipated that Strauss and Corbin's (1998) procedure-oriented approach would suit my needs as a novice researcher, and to some extent it did. Strauss and Corbin's (1998) approach is well presented, with real examples which enable the reader to follow how analysis has been carried out. In addition they acknowledge that sometimes researchers have to settle for a practical way of conducting research as opposed to an ideal, and this experience was reflected in this study. The circular process of data generation and analysis made it possible to focus on and explore in-depth, experiences that were important and meaningful to the participants.

As well as these positive aspects of using grounded theory there were also negative experiences associated with the method. Initial readings around grounded theory suggested relevance and achievability however applying the method into research practice, was at times confusing, challenging and frustrating. Stern (1994) uses the term “minus-mentoring” (quotes in original) to refer to the situation where researchers learn grounded theory from a book instead of from an experienced grounded theorist. Stern proposes that this can result in the “erosion of grounded theory” (p. 213) and recommends that students who are without a grounded theory mentor at their campus should make arrangements to either phone or visit an experienced grounded theorist. This is in keeping with the present study where a change to a qualitatively experienced supervisor also created the opportunity for contact to be made with an experienced grounded theorist. In addition to email conversations fortunately I was able to visit her for a few days to receive some advice on data analysis. This was a very worthwhile meeting and improved my confidence in using grounded theory.

In terms of ongoing development of skills and knowledge it was also of great benefit to attend an international conference on qualitative health research. This included a poster presentation on ethical issues relating to the current study and participation in a workshop on grounded theory run by Juliet Corbin, a recognised expert in the field of grounded theory. At the conference workshop, group work was carried out on creating concepts and category development and it was good experience to undertake some analysis with other students. Students shared common experiences of going through the same difficulties with grounded theory analysis, and it was reassuring to hear that



others faced similar challenges. Attending the conference and meeting with a grounded theorist made me realise how beneficial it is to discuss data generation and analysis with other people using grounded theory. This ultimately contributed to my confidence in working the analysis.

Based on my own experiences as a novice researcher it is therefore recommended that people using grounded theory for the first time, especially if a student with minimal qualitative research training, find a grounded theory mentor or attend workshops and tutorials on the application of the method. Concurring with Stern's (1994) advice, University departments need to be aware of the needs of new inexperienced qualitative researchers, and provide opportunities for training and discussion with for example accomplished grounded theorists. More generally, ensuring that students have a supportive environment to discuss their research with peers and more experienced researchers should be encouraged. Although books on grounded theory were a valuable learning resource, the most useful learning took place during my interaction with researchers who have first-hand knowledge and experience of using the method. On reflection, this would have been even more valuable if it had happened earlier in the research process.

### **Resonance of the Theory**

Having offered a substantive theory illuminating a paradox in experiences for people who self-injure, this study cannot claim and does not aim to generalise beyond the participants. Nevertheless, the substantive theory has resonance within the literature



relating to the experiences of people who self-injure, practice and beyond. The focus on the urge to cut provides a fresh perspective from which to view what life is like for people who self-injure. It is the task of future studies to take the current findings further through testing this substantive theory. As highlighted in the discussion of the findings (Chapter 9) the substantive theory not only has resonance for people who self-injure in terms of explicating 'the urge', but parallels can also be drawn between self-cutting behaviour and addictions such as compulsive gambling, excessive exercising and alcohol/drug abuse thereby pointing to the transferability of the theory.

Furthermore, very recently D'Abundo and Chally (2004) report findings of their study into the perspectives of people struggling with eating disorders. They focused on the process of recovery and found that many people with eating disorders never fully recover from their eating difficulties. D'Abundo and Chally describe eating disorders as a self-destructive behaviour and although they never referred to 'an urge', similarities to the experiences of the participants in the present study were evident. For example many of their participants with eating disorders still demonstrated a preoccupation with eating, physical appearance and food despite not having engaged in the behaviour for some time. This is comparable with the present study where participants who were trying to live without cutting, still experienced the urge to cut and knew where their cutting tools were stored just in case they needed them. The concept of the 'urge' has relevance for people engaging in all of these behaviours highlighting the scope for the sharing of knowledge and understanding about urges in relation to a broad spectrum of self-destructive behaviours.

## **Informing and Improving Clinical Practice**

Health and social care practitioners need to adopt a flexible approach with people who self-injure, for example not focusing on stopping people from cutting but instead exploring the meaning of cutting within the context of their current and past life experiences. Strategies for supporting people not only when they are cutting but also when they are trying to go without cutting could then be designed according to the particular needs of people who self-injure. Patients/clients are increasingly contributing their views on the delivery of services, indicating increased attempts at empowerment, evident through their writing on experiences. This provides additional impetus for collaborative working.

We have some idea as to what helps people who self-injure, for example information on safe-cutting and access to self-help resources could be given to people who are living with cutting, and who do not feel that they are in a position to try to give up the behaviour. It is important for professionals to establish what the hopes of their clients who self-injure are for the future in terms of cutting and then devise a more appropriate support package based on their goals. It could be that some people want to continue cutting but are trying to limit the damage, others may express the wish to live without cutting through having ways of resisting the urge when it is triggered, or there might be some who strive to live a life completely free of cutting and the urges to engage in the behaviour. An understanding of the urge could be fundamental in all of these goals.



Healthcare professionals could establish the circumstances under which the urge is triggered, and then work with the client to explore the trigger contexts and how situations can be managed without the urge being triggered. Looking at how the urge is satisfied can provide information on cutting strategies in order to ascertain if the person is at risk from severe injury or even death. Strategies for resisting the urge could be identified so that people have alternative options available to them if and when the urge is triggered. The needs and goals of patients struggling with destructive behaviours have the potential to change over time so they should be regularly reviewed, taking into consideration the perspectives of the patient/client. Similar negotiated goals may also be applicable to other experiences such as compulsive gambling, alcohol and drug abuse. Very interesting questions remain as to why and how people start certain behaviours, for example cutting, eating difficulties, gambling. Within the context of this study, issues such as purposive accidents, and seeing others engaging in the behaviour acted as precursors to cutting and may be worth exploring further in other contexts.

In conclusion, although this exploratory study is small, important issues are raised in relation to the experiences of people who self-injure and have resonance beyond the specific field of cutting. The participants appeared to be in a complex relationship with the act of cutting, expressing both positive and negative feelings about self-injury which raises questions about the complexity of mental health experiences. It is this complexity which professionals seemingly find difficult to navigate. This links to recent questions in the literature (alluded to throughout this thesis in relation to cutting)



regarding the dissonance of perspective between patients/clients and professionals. Cutting helped the participants cope with a range of distressing experiences and feelings which makes it understandable why they continued engaging in the act despite its often negative consequences. The urge to self-injure continued to be triggered in situations where it proved effective in the past making it difficult for the participants to leave the behaviour behind. Most participants had tried alternative ways of dealing with the urge however they reported that few if any appeared to compare with cutting. Despite several participants managing to live without cutting for long periods of time they still lived with the possibility that they would again satisfy the urge to cut. This possibility functioned as both a safety-mechanism and a source of distress for a number of participants. For example they knew 'cutting' was there if they needed it and their tendency to hide their cutting tools highlighted their inability to completely let go off this lifeline, yet there was also the sense that most participants yearned to live a life free of cutting, its urges and tools.

This study has pointed to the factors which make cutting so effective as a coping behaviour, with some participants referring to the blood and pain it provides. However further exploration is needed into why people choose to engage in destructive behaviours as opposed to healthier ways of coping, for example were they offered these? In addition more understanding and insight is needed into the reasons why people continue engaging in such behaviours, raising questions as to the most effective time for intervention and why current interventions fail to meet the same needs as cutting does for people who self-injure. During the course of the present study there

has been a noticeable increase in the attention devoted to self-cutting through the media, the rising numbers of studies into the behaviour and the recent launch of the United Kingdom's first National Inquiry into self-harm. Furthermore reports of people who engage in self-cutting being unfairly treated when seeking help for their behaviour, have finally been responded to with the introduction of guidelines for good practice within the NHS (National Institute for Clinical Excellence, 2004). The contribution of the present study is therefore very timely, reflecting the current trend for increasing awareness, knowledge and understanding about self-cutting, and presents evidence which has the potential to close the gap in perspectives between people who self-injure and professionals.

This study concludes, as it opened, with a quote from an individual who self-injures. It provides a powerful reminder of the need for greater empathy for this vulnerable group, but equally of the challenge to train and support health care professionals to respond more sensitively and appropriately. Collectively there needs to be a joint responsibility to provide a much brighter future for individuals who live with the agonising paradox of self injury.

*“I suppose it must be quite hard for somebody who has never gone through such emotional pain to try and understand you know....you have people who want to understand but I think a lot of medical people just aren't interested in trying....to understand you know... I mean I've had a few (diagnoses), some of them looking back have been completely off the wall, and I think no that's not what was wrong...”*



## References

- Abrams, L.S., & Gordon, A.L. (2003) Self-harm narratives of urban and suburban young women. *Affilia: Journal of Women and Social Work*, 18(4), pp. 429-444
- Alderman, T. (1997) *The scarred soul*. Oakland, New Harbinger Publications
- Aldridge, D. (1988) Treating self-mutilating behaviour: A social strategy. *Family Systems Medicine*, 6(1), pp. 5-20
- Alexander, N., & Clare, L. (2004) You still feel different: The experiences and meaning of women's self-injury in the context of a lesbian or bisexual identity. *Journal of Community and Applied Social Psychology*, 14, pp. 70-84
- Anderson, D. G., & Hatton, D.C. (2000) Accessing vulnerable populations for research. *Western Journal of Nursing Research*, 22(2), pp. 244-251
- Anderson, R. (2000) Assessing the risk of self-harm in adolescents: a psychoanalytic perspective. *Psychoanalytic Psychotherapy*, 14(1), pp. 9-21
- Annells, M. (1996) Grounded theory method: philosophical perspectives, paradigm of inquiry and postmodernism. *Qualitative Health Research*, 6(3), pp. 379-393
- Annells, M. (1997a) Grounded theory method, part 1: within the five moments of qualitative research. *Nursing Inquiry*, 4, pp. 120-129
- Annells, M. (1997b) Grounded theory method, part 2: options for users of the method. *Nursing Inquiry*, 4, pp. 176-180
- Arnold, L. (1995a) *Women and self-injury: a survey of 76 women*. Bristol, Bristol Crisis Service for Women
- Arnold, L. (1995b) Ways forward: meeting the needs of women who self-injure. In *Cutting out the pain: Proceedings of the 1995 National Conference, Bristol Crisis Service for Women*, Bristol, pp. 20-24
- Arnold, L. (2000) *Understanding self-injury*. Bristol, Bristol Crisis Service for Women
- Arnold, L., & Magill, A. (1996) *Working with self-injury: A Practical Guide*. Bristol, The Basement Project
- Babiker, G., & Arnold, L. (1998) *The language of injury*. Leicester, The British Psychological Society



- Baker, C., Wuest, J., & Stern, P. (1992) Method slurring: the grounded theory/phenomenology example. *Journal of Advanced Nursing*, 17, pp. 1355-1360
- Barstow, D. (1995) Self-injury and self-mutilation – nursing approaches. *Journal of Psychosocial Nursing and Mental Health Services*, 33(2), pp. 19-22
- Batty, D. (1998) Coping by cutting. *Nursing Standard*, 12(29), pp 25-26
- Bennun, I. (1984) Psychological models of self-mutilation. *Suicide and Life Threatening Behaviour*, 14(3), pp. 166-186
- Benoliel, J.Q. (1996). Grounded theory and nursing knowledge. *Qualitative Health Research*, 6(3), pp. 406-428
- Benton, D. (1996) Grounded theory. In: Cormack, D.S. (ed.). *The research process in nursing*. London, Blackwell Science Ltd, pp. 123-133
- Blumer, H. (1969) *Symbolic interactionism: perspective and method*. Englewood Cliffs, New Jersey, Prentice Hall
- Bohus, M., Limberger, M., Ebner, U., Glocker, F.X., Schwarz, B., Wernz, M., & Lieb, K. (2000) Pain perception during self-reported distress and calmness in patients with borderline personality disorder and self-mutilating behaviour. *Psychiatry Research*, 95, pp. 251-260
- Bolognini, M., Plancherel, B., Laget, J., Stephan, P., & Halfon, O. (2003) Adolescents' self-mutilation – Relationship with dependent behaviour. *Swiss Journal of Psychology*, 62(4), pp. 241-250
- Brannen, J. (1988) The study of sensitive subjects. *Sociological Review*, 36, pp. 552-563
- Briere, J., & Gil, E. (1998) Self-mutilation in clinical and general population samples: prevalence, correlates and functions. *American Journal of Orthopsychiatry*, 68(4), pp. 609-620
- Brodsky, B.S., Cloitre, M., & Dulit, R.A. (1995) Relationship of dissociation to self-mutilation and childhood abuse in borderline personality disorder. *The American Journal of Psychiatry*, 152(12), pp. 1788-1792
- Buston, K. (1997) Nud\*ist in action: its use and its usefulness in a study of chronic illness in young people. [Online] *Sociological Research Online*, 2(3), Available from: <http://www.socresonline.org.uk/socresonline/2/3/6.html>
- Bywaters, P., & Rolfe, A. (2002) *Look beyond the scars: understanding and responding to self-injury and self-harm*. National Childrens Home [Online] Available from: <http://www.nch.org.uk/self-harm>

- Calof, D.L. (1995a) Chronic self-injury in adult survivors of childhood abuse: developmental processes of anger in relation to self-injury (part 1). *Treating Abuse Today*, 5(6), pp. 61-67
- Calof, D.L. (1995b) Chronic self-injury in adult survivors of childhood abuse: sources, motivations and functions of self-injury (part 2). *Treating Abuse Today*, 5(4/5), pp. 31-36
- Carolan, M. (2003) Reflexivity: a personal journey during data collection. *Nurse Researcher*, 10(3), pp. 7-14
- Carroll, J., Schaffer, C., Spensley, J., & Abramowitz, S.I. (1980) Family experiences of self-mutilating patients. *American Journal of Psychiatry*, 137(7), pp. 852-853
- Cassell *Concise English Dictionary* (1994) London, Cassell
- Cescutti-Butler, L., & Galvin, K. (2003) Patients' perceptions of staff competency in a neonatal intensive care unit. *Journal of Clinical Nursing*, 12, pp. 752-761
- Charmaz, K. (2000) Grounded theory: objectivist and constructivist methods. In: Denzin, N.K., & Lincoln, Y.S. eds. *Handbook of qualitative research*. 2<sup>nd</sup> edition. Thousand Oaks, Sage, pp. 509-535
- Chenitz, W.C., & Swanson, J.M. (1986) *From practice to grounded theory: qualitative research in nursing*. Menlo Park, Addison-Wesley Publishing Company
- Chiang, V.C. (2001) Challenges of recruiting a vulnerable population in a grounded theory study. *Nursing and Health Sciences*, 3, pp. 205-211
- ChildLine, (2004) "I feel like I'm invisible": children talking to Childline about self-harm. [In submission to the National Inquiry into self-harm among young people (P. Dow). Camelot Foundation/ Mental Health Foundation
- Chiovitti, R.F., & Piran, N. (2003) Rigour and grounded theory research. *Journal of Advanced Nursing*, 44(4), pp. 427-435
- Christians, C.G. (2000) Ethics and politics in qualitative research. In: Denzin, N.K., & Lincoln, Y.S. eds. *Handbook of qualitative research*. 2<sup>nd</sup> edition. Thousand Oaks, Sage, pp. 133-155
- Clarke, L., & Whittaker, M. (1998). Self-mutilation: culture, contexts, and nursing responses. *Journal of Clinical Nursing*, 7, pp. 129-137
- Clendenin, W.W., & Murphy, G.E. (1971). Wrist cutting: New epidemiological findings. *Archives of General Psychiatry*, 25, pp. 465-469



- Collins, D. (1996) Attacks on the body: how can we understand self-harm? *Psychodynamic Counselling*, 2(4), Nov, pp. 463-475
- Connelly, J.C. (1980) Alcoholism as indirect self-destructive behaviour. In Farberow, N.L. ed. *The many faces of suicide: indirect self-destructive behaviour*. McGraw Hill: New York, pp. 207-219
- Conner, K.R., Langley, J., Tomaszewski, K.J., & Conwell, Y. (2003) Injury hospitalisation and risks for subsequent self-injury and suicide: a national study from New Zealand. *American Journal of Public Health*, 93(7), pp. 1128-1131
- Connors, R. (1996a) Self-injury in trauma survivors: functions and meanings. *American Journal of Orthopsychiatry*, 66(2), pp. 197-206
- Connors, R. (1996b) Self-injury in trauma survivors: 2. Levels of clinical response. *American Journal of Orthopsychiatry*, 66(2), pp. 207-216
- Conterio, K., & Lader, W. (1998) *Bodily harm: the breakthrough healing program for self-injurers*. New York, Hyperion
- Corbin, J. (1986) Qualitative data analysis for grounded theory. In Chenitz, W.C., & Swanson, J.M. eds. *From practice to grounded theory: qualitative research in nursing*. Menlo Park, Addison-Wesley, pp. 91-101
- Corbin, J., & Strauss, A. (1990) Grounded theory research: procedures, canons and evaluative criteria. *Qualitative Sociology*, 13(1), pp. 3-21
- Cowles, K.V. (1988) Issues in qualitative research on sensitive topics. *Western Journal of Nursing Research*, 10(2), pp. 163-179
- Cox, R., & Orford, J. (2004) A qualitative study of the meaning of exercise for people who could be labelled as 'addicted' to exercise – can 'addiction' be applied to high frequency exercising? *Addiction Research and Theory*, 12(2), pp. 167-188
- Coyne, I.T. (1997) Sampling in qualitative research. Purposeful and theoretical sampling; merging or clear boundaries. *Journal of Advanced Nursing*, 26, pp. 623-630
- Craig, G., Corden, A., & Thronton, P. (2002) Safety in social research. [Online] *Social Research Update*, 29, Available from: <http://www.soc.surrey.ac.uk/sru/SRU29.html> [Accessed 10 June, 2002]
- Crawford, T., Geraghty, W., Street, K., & Simonoff, E. (2003) Staff knowledge and attitudes towards deliberate self-harm in adolescents. *Journal of Adolescence*, 26(5), pp. 619-629
- Creswell, J.W. (1998) *Qualitative inquiry and research design: choosing among five traditions*. Thousand Oaks, Sage Publications



- Crowe, M. (1996) Cutting-up: signifying the unspeakable. *Australian and New Zealand Journal of Mental Health Nursing*, 5, pp. 103-111
- Crowe, M., & Bunclark, J. (2000) Repeated self-injury and its management. *International Review of Psychiatry*, 12, pp. 48-53
- Cutcliffe, J.R., & McKenna, H.P. (2004) Expert qualitative researchers and the use of audit trails. *Journal of Advanced Nursing*, 45(2), pp. 26-135
- D'Abundo, M., & Chally, P. (2004) Struggling with recovery: participant perspectives on battling an eating disorder. *Qualitative Health Research*, 14(8), pp. 1094-1106
- Daldin, H.J. (1988) A contribution to the understanding of self-mutilating behaviour in adolescence. *Journal of Child Psychotherapy*, 14, pp. 61-66
- Daldin, H.J. (1990) Self-mutilating behaviour in adolescence with comments on suicidal risk. *Bulletin of the Anna Freud Centre*, 13, pp. 279-293
- Darche, M.A. (1990) Psychological factors differentiating self-mutilating and non-self-mutilating adolescent inpatient females. *The Psychiatric Hospital*, 21(1), pp. 31-35
- Davies, S. (2003) "I cut myself with knives". [Online]. *BBC News*. Available from <http://news.bbc.co.uk/go/pr/fr/-/1/hi/health/2888029.stm> [accessed 16 May 2003]
- Davis, C., & Karvinen, K. (2002) Personality characteristics and intention to self-harm: a study of eating disordered patients. *Eating Disorders*, 10, pp. 245-255
- Davison, G.C., & Neale, J.M. (1998) *Abnormal psychology*. New York, John Wiley & Sons
- Derouin, A., & Bravender, T. (2004) Living on the edge: the current phenomenon of self-mutilation in adolescents. *The American Journal of Maternal Child Nursing*, 29(1), pp. 12-20
- Doctors, S. (1981) The symptom of delicate self-cutting in adolescents females: a developmental view. *Adolescent Psychiatry*, 9, pp. 443-460
- Drummond, D.C., & Phillips, T.S. (2002) Alcohol urges in alcohol-dependent drinkers: further validation of the alcohol urge questionnaire in an untreated community clinical population. *Addiction*, 97, pp. 1465-1472
- Dubo, E.D., Zanarini, M.C., Lewis, R.E., & Williams, A.A. (1997) Childhood antecedents of self-destructiveness in borderline personality disorder. *Canadian Journal of Psychiatry*, 42, pp. 63-69

- Dulit, R.A., Fryer, M.R., Leon, A.C., Brodsky, B.S., & Frances, A.J. (1994) Clinical correlates of self-mutilation in borderline personality disorder. *American Journal of Psychiatry*, 151(9), pp. 1305-1311
- Dunn, L. (1991) Research alert! Qualitative research may be hazardous to your health! *Qualitative Health Research*, 1(3), pp. 388-392
- Elliott, H. (1997) The use of diaries in sociological research on health experience. [Online]*Sociological Research Online*, 2(2), Available from: [www.socresonline.org.uk/socresonline/2/2/7.html](http://www.socresonline.org.uk/socresonline/2/2/7.html) [Accessed July 2004]
- Fallon, P. (2003) Travelling through the system: the lived experience of people with borderline personality disorder in contact with psychiatric services. *Journal of Psychiatric and Mental Health Services*, 10, pp. 393-400
- Faugier, J., & Sargeant, M. (1997) Sampling hard to reach populations. *Journal of Advanced Nursing*, 26, pp. 790-797
- Favazza, A.R. (1989) Why patients mutilate themselves. *Hospital and Community Psychiatry*, 40(2), pp. 137-145
- Favazza, A.R. (1996) *Bodies under siege: self-mutilation and body modification in culture and psychiatry*. Baltimore, The John Hopkins University Press
- Favazza, A.R., & Conterio, K. (1988) The plight of chronic self-mutilators. *Community Mental Health Journal*, 24(1), pp. 22-30
- Favazza, A.R., & Conterio, K. (1989) Female habitual self-mutilators. *Acta Psychiatrica Scandinavica*, 79, pp. 283-289
- Favazza, A.R., & Rosenthal, R.J. (1990). Varieties of pathological self-mutilation. *Behavioural Neurology*, 3, pp. 77-85
- Favazza, A.R., & Rosenthal, R.J. (1993) Diagnostic issues in self-mutilation. *Hospital and Community Psychiatry*, 44(2), pp. 134-140
- Faye, P. (1995) Addictive characteristics of the behaviour of self-mutilation. *Journal of Psychosocial Nursing and Mental Health Services*, 33(6), pp. 36-39
- Feldman, M. D. (1988) The challenge of self-mutilation: a review. *Comprehensive Psychiatry*, 29(3), pp. 252-269
- Fine, M., Weis, L., Weseen, S., & Wong, L. (2000) For whom? Qualitative research, representations and social responsibilities. In Denzin, N.K., & Lincoln, Y.S. eds. *Handbook of qualitative research* (2<sup>nd</sup> edition). Thousand Oaks, Sage Publications, pp. 107-131
- Finlay, L. (2002) "Outing" the researcher: the provenance, process, and practice of reflexivity. *Qualitative Health Research*, 12(4), pp. 531-545



- Finlay, L., & Gough, (2003) *Reflexivity: a practical guide for researchers in health and social care*. Oxford, Blackwell Science Ltd
- Fontana, A., & Frey, J.H. (2000) The interview: from structured questions to negotiated text. In Denzin, N.K., & Lincoln, Y.S. eds. *Handbook of qualitative research* (2<sup>nd</sup> edition). Thousand Oaks, Sage Publications, pp. 645-672.
- Forrest, S., Risk, I., Masters, H., & Brown, N. (2000) Mental health service user involvement in nurse education: exploring the issues. *Journal of Psychiatric and Mental Health Nursing*, 7, pp. 51-57
- Fouquereau, E., Fernandez, A., Mullet, E., & Sorum, P.C. (2003) Stress and the urge to drink. *Addictive Behaviours*, 28, pp. 669-685
- Frith, M. (2004) When I am sad, I cut...when I am frightened, it quietens my fears. [Online]*The Independent*. Available from: [http://www.news.independent.co.uk/uk/health\\_medical/story.jsp?story=545385](http://www.news.independent.co.uk/uk/health_medical/story.jsp?story=545385) [Accessed 28<sup>th</sup> July, 2004]
- Gardner, A.R., & Gardner, A.A. (1975) Self-mutilation, obsessionality and narcissism. *British Journal of Psychiatry*, 127, pp. 127-132
- Garrison, C.Z., Addy, C.L., McKeown, R.E., Cuffe, S.P., Jackson, K.L., & Waller, J.L. (1993) Nonsuicidal physically self-damaging acts in adolescents. *Journal of Child and Family Studies*, 2(4), pp 339-352
- Ghaziuddin, M., Naylor, T.M., & Ghaziuddin, N. (1992) Mood disorder in a group of self-cutting adolescents. *Acta Paedopsychiatrica*, 55, pp. 103-105
- Glaser, B.G. (1978) *Theoretical sensitivity*. Mill Valley CA, Sociology Press
- Glaser, B.G. (1992) *Basics of grounded theory analysis: emergence versus forcing*. Mill Valley CA, Sociology Press
- Glaser, B.G., & Strauss, A.L. (1967) *The discovery of grounded theory: strategies for qualitative research*. Chicago, Aldine
- Graff, H., & Mallin, R. (1967) The syndrome of the wrist cutter. *American Journal of Psychiatry*, 124(1), pp. 36-42
- Gratz, K.L. (2003) Risk factors for and functions of deliberate self-harm: An empirical and conceptual review. *Clinical Psychology: Science and Practice*, 10(2), pp. 192-205
- Gratz, K.L., Conrad, S.D., & Roemer, L. (2002) Risk factors for deliberate self-harm among college students. *American Journal of Orthopsychiatry*, 72(1), pp. 128-140



- Great Britain. *Children (Scotland) Act (1995)*. The Stationary Office
- Great Britain. *Data Protection Act (1998)*. The Stationary Office
- Green, A.H. (1978) Self-destructive behaviour in battered children. *American Journal of Psychiatry*, 135(5), pp. 579-582
- Grunebaum, H.U., & Klerman, G.L. (1967) Wrist slashing. *American Journal of Psychiatry*, 124(4), pp. 527-534
- Guertin, T., Lloyd-Richardson, E., Spirito, A., Donaldson, D., & Boergers, J. (2001) Self-mutilative behaviour in adolescents who attempt suicide by overdose. *Journal of the American Academy of Child and Adolescent Psychiatry*, 40(9), pp. 1062-1069
- Haines, J., Williams, C.L., Brain, K.L., & Wilson, G. (1995) The psychophysiology of self-mutilation. *Journal of Abnormal Psychology*, 104(3), pp. 471-489
- Hall, W.A., & Callery, P. (2001) Enhancing the rigour of grounded theory: incorporating relexivity and relationality. *Qualitative Health Research*, 11(2), pp. 257-272
- Hallberg, L.R. M., Passe, U., & Ringdahl, A. (2000) Coping with post-lingual severe-profound hearing impairment: a grounded theory study. *British Journal of Audiology*, 34, pp. 1-9
- Harris, J. (2000) Self-harm: Cutting the bad out of me. *Qualitative Health Research*, 10(2), pp. 164-173
- Harrison, A (1998) A harmful procedure....self-harm....no self-harming contract. *Nursing Times*, 94(27), pp. 37-38
- Harrison, D. (1995) *Vicious circles*. London, G.P.M.H. Publications
- Harrison, D. (1997) Cutting the ties. *Feminism and Psychology*, 7(3), pp. 438-440
- Hartman, D. (1996) Cutting among young people in adolescent units. *Therapeutic Communities*, 17(1), pp. 5-17
- Hawton, K. (2000) Deliberate self-harm. *Medicine International*, 28, pp. 83-86
- Hawton, K., & Fagg, J. (1992a) Trends in deliberate self-poisoning and self-injury in Oxford, 1976-90. *British Medical Journal*, 304, pp. 1409-1411
- Hawton, K., Fagg, J., Simkin, S., Bale, F., & Bond, A. (1997) Trends in deliberate self-harm in Oxford, 1985-1995 – implications for clinical services and the prevention of suicide. *British Journal of Psychiatry*, 171, pp. 556-560

- Hawton, K., Fagg, J., Simkin, S., Bale, E., Bond, A. (2000) Deliberate self-harm in adolescents in Oxford, 1989-1995. *Journal of Adolescence*, 23, pp. 47-55
- Hawton, K., Townsend, E., Arensman, E., Gunnell, D., Hazell, P., House, A., & Van Heeringen, K. (2004) Psychosocial and pharmacological treatments for Deliberate self-harm (Cochrane Review). In: *The Cochrane Library, Issue 3*. Chichester, UK: John Wiley & Sons, Ltd.
- Heather, N., & Robertson, I. (1997) *Problem drinking*. Oxford, Oxford University Press
- Herpertz, S. (1995) Self-injurious behaviour: psychopathological and nosological characteristics in subtypes of self-injurers. *Acta Psychiatrica Scandinavica*, 91, pp. 57-68
- Herpertz, S., Henning, S., & Favazza, A. (1997) Impulsivity in self-mutilative behaviour: psychometric and biological findings. *Journal of Psychiatric Research*, 31(4), pp. 451-465
- Hickey, G. (1997) The use of literature in grounded theory. *Nursing Times Research*, 2(5), pp. 371-378.
- Himber, J. (1994) Blood rituals: self-cutting in female psychiatric inpatients. *Psychotherapy*, 31(4), pp. 620-631
- Hodgson, S. (2004) Cutting through the silence: A sociological construction of self-injury. *Sociological Inquiry*, 74(2), pp. 162-179
- Holloway, I., & Wheeler, S. (2002) *Qualitative research in nursing*. Oxford, Blackwell Science
- Honig, A, Romme, M., Ensink, B., Escher, A., Pennings, M.H.A., & Devries, M.W. (1998) Auditory hallucinations: a comparison between patients and non patients. *The Journal of Nervous and Mental Disease*, 186(10), pp. 646-651
- Horfsall, J. (1999) Towards understanding some complex borderline behaviours. *Journal of Psychiatric and Mental Health Nursing*, 6, pp. 425-432
- Horrocks, J., Price, S., House, A., & Owens, D. (2003) Self-injury attendances in the accident and emergency department. *British Journal of Psychiatry*, 183, pp. 34-39
- Huband, N., & Tantam, D. (2000) Attitudes to self-injury within a group of mental health staff. *British Journal of Medical Psychology*, 73, pp. 495-504
- Hurry, J. (2000) Deliberate self-harm in children and adolescents. *International Review of Psychiatry*, 12, pp. 31-36
- Hutchinson, H.A., Wilson, M.E., & Wilson, H.S. (1994) Benefits of participating in



- research interviews. *Image: Journal of Nursing Scholarship*, 26(2), pp. 161-164
- Hutchinson, S. (1986) Grounded theory: the method. In Munhall, P.L., & Olier Boyd, C.J. eds. *Nursing research: a qualitative perspective*. USA: Appleton-Century Crofts, pp. 111-130
- Hyman, J.W. (1999) *Women living with self-injury*. Philadelphia, Temple University Press
- James, R. (2004) Cut it out, please. [Online] *The Guardian*. August 3<sup>rd</sup>, 2004. Available from: <http://www.guardian.co.uk/g2/story/0,,1274725,00.html> [Accessed 30<sup>th</sup> August, 2004]
- James, T., & Platzer, H. (1999) Ethical considerations in qualitative research with vulnerable groups: exploring lesbians' and gay men's experiences of health care – a personal perspective. *Nursing Ethics*, 6(1), pp. 73-81
- Janesick, V.J. (2000) The choreography of qualitative research design: minuets, Improvisations, and crystallization. In Denzin, N.Z., & Lincoln, Y.S. eds. *The handbook of qualitative research*. Thousand Oaks Sage Publications, pp. 379-399
- Jeffery, D., & Warm, A. (2002) A study of service provider's understanding of self-harm. *Journal of Mental Health*, 11(3), pp. 295-303
- Johnstone, L. (1997) Self-injury and the psychiatric response. *Feminism and Psychology*, 7(3), pp. 421-426
- Johnstone, L. (2000) *Users and abusers of psychiatry*. London, Routledge
- Johnstone, N. (2004) Blue notes. [Online] *The Guardian*. August 10<sup>th</sup>, 2004. Available from: <http://www.guardian.co.uk/g2/story/0,,1279638,00.html> [Accessed 30<sup>th</sup> August, 2004]
- Kaplan, H.B., & Pokorny, A.D. (1976) Self-derogation and suicide II: suicidal responses, self-derogation and accidents. *Social Science and Medicine*, 10, pp. 119-121
- Karwautz, A., Resch, F., Wober-Bingol, C., & Schuch, B. (1996) Self-mutilation in adolescence as addictive behaviour. *Wein Klin Wochenschr*, 108(3), pp. 82-84
- Kehrberg, C. (1997) Self-mutilating behaviour. *Journal of Community and Psychiatric Nursing*, 10(3), pp. 35-40
- Kendall, J. (1999) Axial coding and the grounded theory controversy. *Western Journal of Nursing Research*, 21(6), pp. 743-757



- Kenyon, E., & Hawker, S. (1999) "Once would be enough": some reflections on the issue of safety for lone researchers. *International Journal of Social Research Methodology*, 2(4), pp. 313-327
- Kvale, S. (1996) *Interviews: an introduction to qualitative research interviewing*. Thousand Oaks, Sage Publications
- Lacey, J.H. (1993) Self-damaging and addictive behaviour in bulimia nervosa: a catchment area study. *British Journal of Psychiatry*, 163, pp. 190-194
- Lacey, J.H., & Evans, C.D.H. (1986) The impulsivist: a multi-dimensional personality disorder. *British Journal of Addiction*, 81, pp. 641-649
- Langford, D.R. (2000) Developing a safety protocol in qualitative research involving battered women. *Qualitative Health Research*, 10(1), pp. 233-142
- Layder, D. (1994) *Understanding social theory*. London, Sage Publications.
- Lee, R.M. & Renzetti, C.M. (1990) The problems of researching sensitive topics. *American Behavioural Scientist*, 33(5), pp. 510-528
- Lincoln, Y.S., & Guba, E.G. (2000) Paradigmatic controversies, contradictions, and emerging confluences. In: Denzin, N.K., & Lincoln, Y.S. eds. *Handbook of qualitative research*. 2<sup>nd</sup> edition. Thousand Oaks, Sage, pp. 163-187
- Lindgren, B.M., Wilstrand, C., Gilje, F., & Olofsson, B. (2004) Struggling for hopefulness: a qualitative study of swedish women who self-harm. *Journal of Psychiatric and Mental Health Nursing*, 11, pp. 284-291.
- Lipson, J.G. (1994) Ethical issues in ethnography. In: Morse, J.M. ed. *Critical issues in qualitative research methods*. Thousand Oaks, Sage Publications, pp. 333-335.
- Low, G., Jones, D., MacLeod, A., Power, M., & Duggan, C. (2000) Childhood trauma, dissociation and self-harming behaviour: a pilot study. *Psychology and Psychotherapy*, 73, pp. 269-278
- Lynn, F. (1998) The pain of rejection. *Nursing Times*, 94(27), p. 36
- McAllister, M. (2003) Multiple meanings of self-harm: A critical review. *International Journal of Mental Health Nursing*, 12, pp. 177-185
- McAllister, M., Creedy, D., Moyle, W., & Farrugia, C. (2002). Nurses' attitudes to wards clients who self-harm. *Journal of Advanced Nursing*, 40(5), pp. 78-586
- McCann, T., & Clark, E. (2003a) Grounded theory in nursing research: Part 1 - Methodology. *Nurse Researcher*, 11(2), pp. 7-18

- MacDonald, M. (2001) Finding a critical perspective in grounded theory. In: Schreiber, R.S., & Stern, P.S. eds. *Using grounded theory in nursing*. New York, Springer Publishing Company, pp. 113-157
- McGorry, P.D., & Yung, A.R. (2003) Early intervention in psychosis: an overdue reform. *Australian and New Zealand Journal of Psychiatry*, 37, pp. 393-398
- Machoian, L. (2001) Cutting voices: Self-injury in three adolescent girls. *Journal of Psychosocial Nursing and Mental Health Services*, 39(11), pp. 22-29
- Mallory, C. (2001) Examining the difference between researcher and participant: an intrinsic element of grounded theory. In: Schreiber, R.S., & Stern, P.S. eds. *Using grounded theory in nursing*. New York, Springer Publishing Company, pp. 85-96
- Margo, G.M., & Newman, J.S. (1989) Venesection as a rare form of self-mutilation. *American Journal of Psychotherapy*, 43(3), pp. 427-432
- Marks, I. (1990) Behavioural (non-chemical) addictions. *British Journal of Addiction*, 85, pp. 1389-1394
- Melia, K.M. (1996) Rediscovering Glaser. *Qualitative Health Research*, 6(3), pp. 368-378
- Melville, A., & House, A. (1998) Deliberate self-harm. *Health Service Journal*, 108(5633), pp. 34-35
- Menninger, K. (1938) *Man against himself*. New York, Harcourt Brace Jovanovich
- Miller, C.L. (2000) Cue Sensitivity in Women with Cardiac Disease. *Progress in Cardiovascular Nursing*, 15(3), pp. 82-89
- Milliken, P.J., & Schreiber, R.S. (2001) Can you "do" grounded theory without symbolic interactionism? In: Schreiber, R.S., & Stern, P.S. eds. *Using grounded theory in nursing*. New York, Springer Publishing Company, pp. 177-190
- Moffatt, C. (1999) Self-inflicted wounding 1: psychosomatic concepts and physical conditions. *British Journal of Community Nursing*, 4(10), pp. 502-514
- Morse, J.M. (1991). Negotiating commitment and involvement in the nurse-patient relationship. *Journal of Advanced Nursing*, 16, pp. 455-468
- Morse, J.M. (1995) The significance of saturation. *Qualitative Health Research*, 5(2), pp. 147-149



- Morse, J.M. (1998) The contracted relationship: ensuring protection of anonymity and confidentiality. *Qualitative Health Research*, 8(3), pp. 301-303
- Morse, J. M. (2001) Situating grounded theory within qualitative inquiry. In: Schreiber, R.S., & Stern, P.S. eds. *Using grounded theory in nursing*. New York, Springer Publishing Company, pp. 1-16
- Morse, J.M., & Field, P.A. (1996) *Nursing research: the application of qualitative approaches*. London: Chapman & Hall
- Moyle, W. (2002) Unstructured interviews: challenges when participants have a major depressive illness. *Journal of Advanced Nursing*, 39(3), pp. 266-273
- Muehlenkamp, J.J., & Gutierrez, P.M. (2004) An investigation of differences between self-injurious behaviour and suicide attempts in a sample of adolescents. *Suicide and Life Threatening Behaviour*, 34(1), pp. 12-23
- My Crazy Parents (2004a) Channel 4, 16<sup>th</sup> September 2004
- My Crazy Parents (2004b) Channel 4, 23<sup>rd</sup> September 2004
- Nada-Raja, S., Morrison, D., & Skegg, K. (2003) A population based study of help-seeking for self-harm in young adults. *Australian and New Zealand Journal of Psychiatry*, 37, pp. 600-605
- Nadkarni, A., Parkin, A., Dogra, N., Stretch, D.D., & Evans, P.A. (2000) Characteristics of children and adolescents presenting to accident and emergency departments with deliberate self harm. *Journal of Accident and Emergency Medicine*, 17, pp. 98-102
- National Institute for Clinical Excellence (2002) *Self-harm scope document*. London, Oaktree Press Ltd
- National Institute for Clinical Excellence (2004a) *Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care*. London, Oaktree Press Ltd
- National Institute for Clinical Excellence (2004b) *Self-harm: short-term treatment and management*. London, Oaktree Press Ltd
- National Self-Harm Network (2000) *Cutting the risk: Self harm, self care and risk reduction*. National Self Harm Network
- Naysmith, S. (2000) 'When I stab my arteries and it's sore I think, that's okay – I'm scared'. *The Big Issue*, March 16-22, pp. 16-18
- Nehls, N. (1999) Borderline personality disorder: the voice of patients. *Research in Nursing and Health*, 22, pp. 285-293



- Neziroglu, F., & Mancebo, M. (2001) Skin picking as a form of self-injurious behaviour. *Psychiatric Annals*, 31(9), pp. 549-555
- NHS Centre for Reviews and Dissemination, University of York, (1998). Deliberate self-harm. *Effective Health Care*, 4(6), pp. 1-12
- Nichols, P. (2000) Bad body fever and deliberate self-injury. *Reclaiming Children and Youth*, 9(3), pp. 151-172
- Nijman, H.L.I., & Campo, J.M.L.G. (2002) Situational determinants of inpatient self-harm. *Suicide and Life-Threatening Behaviour*, 32(2), pp.167-175
- Nijman, H.L., Dautzenberg, M., Merckelbach, H.L.G.J., Jung, P., Wessel, I., & Campo, J. (1999) Self-mutilating behaviour of psychiatric inpatients. *European Psychiatry*, 17, pp. 1-7
- Nixon, M.K., Cloutier, P.F., & Aggarwal, S. (2002) Affect regulation and addictive aspects of repetitive self-injury in hospitalised adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 41(11), pp. 1333-1344
- Norgate, K. (1996) Deliberate self-harm in children & adolescents. *Paediatric Nursing*, 8(6), pp. 16-17
- Novotny, P. (1972) Self-cutting. *Bulletin of the Menninger Clinic*, 36, pp. 505-514
- Olshansky, E.F. (1987) Identity of self as infertile: an example of theory-generating research. *Advances in Nursing Science*, 9(2), pp. 54-63
- Osborne, S. (2002) Self-harm on the net. *Mental Health Nursing*, 22(3), pp. 15-17 & 21.
- Osuch, E.A., Noll, J., & Putnam, F.W. (1999) The motivations for self-injury in psychiatric inpatients. *Psychiatry*, 62, pp. 334-346
- Pao, P.N. (1969) The syndrome of delicate self-cutting. *British Journal of Medical Psychology*, 42, pp. 195-206
- Parker, B., & Ulrich, Y. (1990) A protocol of safety: research on abuse of women. *Nursing Research*, 39(4), 248-250.
- Parkin, J.R., & Eagles, J.M. (1993) Blood-letting in bulimia nervosa. *British Journal of Psychiatry*, 162, pp. 246-248
- Paterson, B., Gregory, D., & Thorne, S. (1999) A protocol for researcher safety. *Qualitative Health Research*, 9(2), pp. 259-269
- Pattison, E.M., & Kahan, J. (1983) The deliberate self-harm syndrome. *American Journal of Psychiatry*, 140(7), pp. 867-872

- Paul, T., Schroeter, K., Dahme, B., & Nutzinger, D.O. (2002) Self-injurious behaviour in women with eating disorders. *American Journal of Psychiatry*, 159(3), pp. 408-411
- Pembroke, L.R., (1991) Surviving psychiatry. *Nursing Times*, 87(49), pp. 30-32
- Pembroke, L.R. (1994) *Self-harm: perspectives from personal experience*. London, Survivors Speak Out
- Punch, K.F. (1998) *Introduction to social research: quantitative and qualitative approaches*. London, Sage Publications
- Raine, W.J.B. (1982) Self-mutilation. *Journal of Adolescence*, 5, pp. 1-13
- Ramos, M. C. (1989) Some ethical implications of qualitative research. *Research in Nursing and Health*, 12, pp. 57-63
- Raylu, N., & Oei, T.P.S. (2004) The gambling urge scale: development, confirmatory factor validation, and psychometric properties. *Psychology of Addictive Behaviour*, 18(2), pp. 101-105.
- Reder, P., Lucey, P., & Fredman, G. (1991) The challenge of deliberate self-harm by young adolescents. *Journal of Adolescence*, 14, pp. 135-148
- Redfern-Vance, N., & Hutchinson, S.A. (1995) The process of developing personal sovereignty in women who repeatedly acquire sexually transmitted diseases. *Qualitative Health Research*, 5(2), pp. 222-236
- Reece, J. (1998) Female survivors of abuse attending A&E with self-injury. *Accident and Emergency Nursing*, 6, pp. 133-138
- Ricketts, T., & MacAskill, A. (2003) Gambling as emotion management: developing a grounded theory of problem gambling. *Addiction, Research and Theory*, 11(6), pp. 383-400
- Ricketts, T., & MacAskill, A. (2004) Differentiating normal and problem gambling: a grounded theory approach. *Addiction Research and Theory*, 12(1), pp. 77-87
- Ritchie, J., & Ashcroft, C. (2004) Exorcising the demons from within: bleeding out pain through acts of self-harm. *Social Work Review*, 16(1), pp. 27-31
- Roberts, D. (1997) Liaison mental health nursing: origins, definition and prospects. *Journal of Advanced Nursing*, 25, pp. 101-108
- Rodham, K., Hawton, K., & Evans, E. (2004) Reasons for deliberate self-harm: comparisons of self-poisoners and self-cutters in a community sample of adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43(1), pp. 80-87



- Rohsenow, D.J., & Monti, P.M. (1999) Does urge to drink predict relapse after treatment. *Alcohol, Research and Health*, 23(3), pp. 225-232
- Rosen, P.M., & Heard, K.V. (1995) A method for reporting self-harm according to the level of injury and location on the body. *Suicide and Life Threatening Behaviour*, 25(3), pp. 381-385
- Rosen, P.M., & Walsh, B.W. (1989) Patterns of contagion in self-mutilation epidemics. *The American Journal of Psychiatry*, 146(5), pp. 656-658
- Rosen, P.M., Walsh, B.W., & Rode, S.A. (1990) Interpersonal loss and self-mutilation. *Suicide and Life Threatening Behaviour*, 20(2), pp. 177-185
- Rosenthal, R.J., Rinzler, C., Wallsh, R., Klausner, E. (1972) Wrist-cutting syndrome: the meaning of a gesture. *American Journal of Psychiatry*, 128(11), pp. 47-51
- Ross, S., & Heath, N. (2002) A study of the frequency of self-mutilation in a community sample of adolescents. *Journal of Youth and Adolescence*, 31(1), pp. 67-77
- Roulston, K., deMarrais, K., & Lewis, J.B. (2003) Learning to interview in the social sciences. *Qualitative Inquiry*, 9(4), pp. 643-668
- Russell-Johnson, H. (1997) Deliberate self-harm in adolescents. *Paediatric Nursing*, 9(1), pp. 29-36
- Samaritans (2000). *Youth matters 2000: A cry for help*. London, Samaritans.
- Sandelowski, M. (1995) Focus on qualitative methods: sample size in qualitative research. *Research in Nursing and Health*, 18, pp. 179-183
- Sansone, R.A., Gaither, G.A., & Barclay, J. (2002) Perceived quality of childhood caretaking among psychiatric inpatients and its relationship to borderline personality and self-harm behaviour. *Child Abuse and Neglect*, 26, pp. 1201-1203
- Santa Mina, E., & Gallop, R. M. (1998) Childhood sexual and physical abuse and adult self-harm and suicidal behaviour: a literature review. *Canadian Journal of Psychiatry*, 43, pp. 793-800
- Schreiber, R.S. (2001) The "how to" of grounded theory: avoiding the pitfalls. In: Schreiber, R.S., & Stern, P.S. eds. *Using grounded theory in nursing*. New York, Springer Publishing Company, pp. 55-84
- Schwandt, T.A. (1994) *Constructivist, interpretivist approaches to human inquiry*. In Denzin, N.K., & Lincoln, Y.S. eds. *Handbook of qualitative research*. 2<sup>nd</sup> edition. Thousand Oaks, Sage Publications, pp. 273-285
- Schwartz, R.H., Cohen, P., Hoffman, N.G., & Meeks, J.E. (1989) Self-harm



- behaviours (carving) in female adolescent drug abusers. *Clinical Paediatrics*, 28(8), pp. 340-346
- Scott, S.W., & Powell, J.C. (1993) Adolescent self-mutilation in a rural area. *Journal of Adolescence*, 16, pp. 101-105
- Scottish Executive (2002) *Our National Health, A Plan For Action, A Plan For Change*. Scottish Executive Health Department, Edinburgh
- Scottish Executive (2002) NHS Circular HDL (2002) 69 "Promoting the Development of MCN in NHS Scotland". Scottish Executive Health Department, Edinburgh
- Scottish Executive (2003) *Choose Life: A National Strategy and Action Plan to Prevent Suicide in Scotland*. Scottish Executive Health Department, Edinburgh
- Secret Shame (self-injury information and support). [Online] Available from: <http://www.palace.net/~llama/psych/injury.html>
- Self Injury and Related Issues (SIARI). [Online] Available from: <http://www.siari.co.uk>
- Shaw, N.S. (2002) Shifting conversations on girls' and women's self-injury: an analysis of the clinical literature in historical context. *Feminism and Psychology*, 12(2), pp. 191-219
- Shearer, S. L. (1994) Phenomenology of self-injury among inpatient women with borderline personality disorder. *The Journal of Nervous and Mental Disease*, 182(9), pp. 524-526
- Shiffman, S., Engberg, J.B., Paty, J.A., Perz, W.G., Gnys, M., Kassel, J.D., & Hickcox, M. (1997) A day at time: predicting smoking lapse from daily urge. *Journal of Abnormal Psychology*, 106(1), pp. 104-116
- Siomopoulos, V. (1974) Repeated self-cutting: an impulse neurosis. *American Journal of Psychotherapy*, 28, pp. 85-94
- Simeon, D., Stanley, B., Frances, A., Mann, J.J., Winchel, R., & Stanley, M. (1992) Self-mutilation in personality disorders: psychological and biological correlates. *American Journal of Psychiatry*, 149(2), pp. 221-226
- Simpson, M. (1975) The phenomenology of self-mutilation in a general hospital setting. *Canadian Psychiatric Association Journal*, 20(6), pp. 429-434
- Simpson, C.A., & Porter, G.L. (1981) Self-mutilation in children and adolescents. *Bulletin of the Menninger Clinic*, 45(5), pp. 428-438
- Smith, G., Cox, D., & Saradjian, J. (1998) *Women and self-harm*. London, The Women's Press Ltd

- Smith, J.A. (1994) Towards reflexive practice: engaging participants as co-researchers or co-analysts in psychological inquiry. *Journal of Community and Applied Social Psychology*, 4, pp. 253-260
- Smith, L. (1992) Ethical issues in interviewing. *Journal of Advanced Nursing*, 17, pp. 98-103
- Smith, S.E. (2002) Perceptions of service provision for clients who self-injure in the absence of expressed suicidal intent. *Journal of Psychiatric and Mental Health Nursing*, 9, pp. 595-601
- Solomon, Y., & Farrand, J. (1996) "Why don't you do it properly?" Young women who self-injure. *Journal of Adolescence*, 19, pp. 111-119.
- Spandler, H. (1996) *Who's hurting who? Young people, self-harm and suicide*. Manchester: 42<sup>nd</sup> Street
- Sque, M. (2000) Researching the bereaved: an investigator's experience. *Nursing Ethics*, 7(1), pp. 23-34
- Stanley, B., Gameroff, M.J., Michalsen, V., & Mann, J.J. (2001) Are suicide attempters who self-mutilate a unique population? *American Journal of Psychiatry*, 158, pp. 427-432
- Stern, P.N. (1985) Using grounded theory method in nursing research. In: Leininger, M. ed. *Qualitative Research Methods in Nursing*. USA, W.B. Saunders Inc, pp. 149-160
- Stern, P.N. (1994). Eroding grounded theory. In: Morse, J.M. ed. *Critical issues in qualitative research methods*. Thousand Oaks, Sage Publications, pp. 212-224
- Strauss, A.M. (1987) *Qualitative analysis for social scientists*. Cambridge, Cambridge University Press
- Strauss, A.M., & Corbin, J. (1994) Grounded theory methodology: an overview. In Denzin, N.K., & Lincoln, Y.S. eds. *The handbook of qualitative research*. Thousand Oaks, Sage Publications, pp. 273-285
- Strauss, A.M., & Corbin, J. (1998) *Basics of qualitative research: techniques and procedures for developing grounded theory*, 2<sup>nd</sup> edition.. California, Sage Publications
- Strong, M. (2000) *A bright red scream: self-mutilation and the language of pain*. London, Virago Press
- Sutton, J. (1999) *Healing the hurt within: understand and relieve the suffering behind self-destructive behaviour*. Oxford, Pathways.



- Suyemoto, K.L. (1998) The functions of self-mutilation. *Clinical Psychology Review*, 18(5), pp. 531-554
- Suyemoto, K.L., & MacDonald, M.L. (1995) Self-cutting in female adolescents. *Psychotherapy*, 32(1), pp. 162-171
- Sword, W. (1999) Accounting for presence of self: reflections on doing qualitative research. *Qualitative Health Research*, 9(2), pp. 270-278
- Tantam, D., & Whittaker, J. (1992) Personality disorder and self-wounding. *British Journal of Psychiatry*, 161, pp 451-464
- Taylor, B. (2003) Exploring the perspectives of men who self-harm. *Learning in Health and Social Care*, 2(2), pp. 83-91
- Taylor, D., & Cameron, P.A. (1998) Deliberate self-inflicted trauma: population Demographics, the nature of self-injury and a comparison with patients who overdose. *Australian and New Zealand Journal of Public Health*, 22(1), pp. 120-125
- Temple, B., & Harris, J. (2000) The devil in detail: producing an account of self-Harm. *The Qualitative Report*, 5(1/2) [Online] Available from: <http://www.nova.edu/ssss/QR/QR5-1/template.html>
- The Camelot Foundation and Mental Health Foundation (2004) *The National Inquiry into Self-Harm among Young People*. [Online]. Available from <http://www.selfharmuk.org>
- Thomas, J., & Retsas, A. (1999) Transacting self-preservation: a grounded theory of the spiritual dimensions of people with terminal cancer. *International Journal of Nursing Studies*, 36, pp. 191-201
- Thompson, A., & Miah, H. (1999) Wounds that never heal. *Community Care*, Nov 18-24, pp.18-20
- Tiffany, S.T. (1990) A cognitive model of drug urges and drug-use behaviour: role of automatic and nonautomatic processes. *Psychological Review*, 97(2), pp. 147-168
- Tsai, A. (2002) Sacred cuttings: self-mutilation and the soul. *Psychological Perspectives*, 43, pp. 82-91
- Turner, V.J. (2002) *Secret scars: uncovering and understanding the addiction of self-Injury*. Minnesota, Hazelden
- Turp, M. (2002) The many faces of self-harm. *Psychodynamic Practice*, 8(2), pp. 197-217
- Tyler, K.A., Whitbeck, L.B., Hoyt, D.R & Johnson, K.D. (2003) Self-mutilation and homeless youth: the role of family abuse, street experiences and mental



disorders. *Journal of Research on Adolescence*, 13(4), pp. 457-474

Usher, K., & Holmes, C. (1997) Ethical aspects of phenomenological research with mentally ill people. *Nursing Ethics*, 4(1), pp. 49-56

Van der Gaag, M., Hageman, M.C., & Birchwood, M. (2003) Evidence for a cognitive model of auditory hallucinations. *The Journal of Nervous and Mental Disease*, 191(8), pp. 542-545

Van der Kolk, B.A., Perry, C., & Herman, J.L. (1991) Childhood origins of self-destructive behaviour. *American Journal of Psychiatry*, 148(12), pp. 1665-1671

Van Moffaert, M.M.M.P. (1990) Self-mutilation: diagnosis and practical treatment. *International Journal of Psychiatry in Medicine*, 20(4), pp. 373-382

Von der Stein, B., & Podoll, K. (1999) Self-cutting syndrome in the history of patients with alcoholism. *Neurology, Psychiatry and Brain Research*, 6, pp. 191-198

Walsh, B.W., & Rosen, P.M. (1988) *Self-mutilation: theory, research and treatment*. New York, The Guilford Press

Warm, A., Murray, C., & Fox, J. (2002) Who helps? Supporting people who self-harm. *Journal of Mental Health*, 11(2), pp. 121-130

Warm, A., Murray, C., & Fox, J. (2003) Why do people self-harm? *Psychology, Health and Medicine*, 8(1), pp. 71-79

Warren, F., Dolan, B., & Norton, K. (1998) Bloodletting, bulimia nervosa and borderline personality disorder. *European Eating Disorders Review*, 6, pp. 277-285

Weber, M.T. (2002) Triggers for self-abuse: a qualitative study. *Archives of Psychiatric Nursing*, XVI(3), pp. 118-124

Wilkins, T.M., & Warner, S. (2001) Women in special hospitals: understanding the presenting behaviour of women diagnosed with borderline personality disorder. *Journal of Psychiatric and Mental Health Nursing*, 8, pp. 289-297

Wimpenny, P., & Gass, J. (2000). Interviewing in phenomenology and grounded theory: is there a difference? *Journal of Advanced Nursing*, 31(6), pp. 1485-1492

Wilson, H.S., & Hutchinson, S.A. (1996) Methodological mistakes in grounded theory. *Nursing Research*, 45(2), pp. 122-124

Winchel, R.M., & Stanley, M. (1991) Self-injurious behaviour: A review of the Behaviour and biology of self-mutilation. *American Journal of Psychiatry*, 148(3), pp. 306-317

- Wise, M.L. (1990) Adult self-injury as a survival response in victim-survivors of childhood abuse. *Journal of Chemical Dependency and Treatment*, 3, pp. 185-201
- Woodruff, M.E. (1999) Flesh made word: cutting back to the mother. *Psychoanalytic Review*, 86(5), pp. 701-708
- Woods, J. (1988) Layers of meaning in self-cutting. *Journal of Child Psychotherapy*, 14, pp. 51-60
- Zila, L.M., & Kiselica, M.S. (2001) Understanding and counselling self-mutilation in female adolescents and young adults. *Journal of Counselling and Development*, 79(1), pp. 46-52
- Zlotnick, C., Mattia, J.I., & Zimmerman, M. (1999) Clinical correlates of self-mutilation in a sample of general psychiatric patients. *The Journal of Nervous and Mental Disease*, 187(5), pp. 296-301

## **Appendix 1**





# PARTICIPANT INFORMATION SHEET

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Dear

My name is Dianne Cameron and I am a research student looking for volunteers to take part in a research study.

- The purpose of the study is to increase understanding of self-injury through listening to the experiences of people who self-injure.
- With your help I hope to understand more about what life is like for people who injure themselves.
- I will be asking about 12 people who self-injure, aged 18 years and over, if they will help me. I will be carrying out interviews for the project until end of July 2003.
  
- If you decide to take part I will ask you to sign the consent form which you will keep along with this sheet.
- Taking part is voluntary.
- You may refuse to take part, or choose to withdraw from the study at any time, without giving a reason. This will have no effect on any healthcare you may currently be receiving or which you may need in the future.
- You are welcome to ask questions about the study and your involvement in it at any time.
  
- You will be asked to describe your experiences of self-injury to me alone.
- The interview will last approximately 1 hour and will take place in a private, quiet setting in which you feel comfortable.
- The interview will be tape-recorded.
- If at any point you feel upset or distressed and would like to stop the interview, I will be happy to do so, and you can make the decision if you wish to continue.
- Support will be available to you if you would like it.
- At the end I will ask if you would mind being contacted again if I have any further questions which I would like to ask you.
  
- All reported information you give me will be treated in confidence. A report will be written based on this study but your information will be anonymous and your privacy will be respected.
- Your name will not be used in any reports as code numbers will be used instead.

- If during or after the interview I have cause for concern for the safety or well-being of you or others, you need to be aware that in your own best interest, and after consulting with you, an appropriate person such as a healthcare professional, will be informed

Although there is no direct benefit to you for taking part, your response will provide a broader understanding of self-injury. This may help researchers and clinicians to develop treatment activities which are more suited to the individual experiences and needs of people who self-injure.

I would be very grateful if you would volunteer to take part in this study. Your help is much appreciated and I thank you for your time and interest.

For further information, please contact me:

For independent advice, please contact:

Dianne Cameron

## **Appendix 2**





# CONSENT FORM (A)

DEPARTMENT OF  
NURSING AND MIDWIFERY

- 
- I have read the participant information sheet about the study on the experiences of people who self-injure.
  - I confirm that it has been explained to me clearly what taking part in this study involves.
  - I understand that confidentiality will be maintained except for circumstances which give the researcher serious cause for concern for the safety and well-being of myself or others. I understand that I will be kept fully informed at all times if the researcher is going to act on these concerns.
  - I understand that I am free to withdraw from the study at any time, without giving a reason, and without affecting my current or future medical care.

**I HAVE UNDERSTOOD MY INVOLVEMENT AND AGREE TO TAKE PART IN THE STUDY**

Name .....

Signature .....

Date .....

For further information, please contact: For independent advice, please contact:

Dianne Cameron

## **Appendix 3**



# CONSENT FORM (B)

DEPARTMENT OF  
NURSING AND MIDWIFERY

## TAPE-RECORDING OF THE INTERVIEW

- I have read the participant information sheet about the study on the experiences of people who self-injure.
- I confirm that it has been explained to me clearly what taking part in this study involves.
- I give my permission for having the interview tape-recorded.

I HAVE UNDERSTOOD MY INVOLVEMENT AND GIVE MY CONSENT TO HAVE THE INTERVIEW TAPE-RECORDED.

Name .....

Signature .....

Date .....

For further information, please contact:  
contact:

Dianne Cameron

For independent advice, please  
contact:



## **Appendix 4**

PARTICIPANT CODE NO:



**UNIVERSITY OF  
STIRLING**

# **NONVERBAL INFO**

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DEPARTMENT OF  
NURSING AND MIDWIFERY

## **BODY LANGUAGE/MOVEMENTS**

## **FACIAL EXPRESSIONS/REACTIONS**

## **Appendix 5**





## GENERAL THEMES

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- Events/circumstances leading up to cutting episodes
- Feelings after cutting
- Keeping self-injury a secret
- Responses from professionals
- Consequences of cutting