BECOMING A SELF-HARMER: A DISCOURSE ANALYSIS

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B.A. (Hons) Psychology

Date of submission: 27 January 2011

Submitted in partial fulfilment of the requirements

for the degree of Master of Arts in Research Psychology

in the School of Psychology

University of KwaZulu-Natal

Pietermaritzburg

Acknowledgements

I declare that this dissertation is my own unaided work. All citations, references and borrowed ideas have been duly acknowledged. The work is being submitted for the degree of Master of Arts (Research Psychology) in the Faculty of Humanities, Development and Social Sciences, University of KwaZulu-Natal, Pietermaritzburg, South Africa. None of the present work has been submitted previously for any degree or examination in any other university.

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Abstract

Self-harm is a behaviour constructed as ostracised and abhorrent in most social discourses. While there is an abundance of available research about self-harm, a distinctive gap in the literature concerns how an individual begins to self-harm. Research has indicated that having a friend or family member who self-harms is the strongest predictor of future self-harm, yet no published studies have sought to explain this in detail. This thesis explored how self-harming participants construct their first self-harming experience – a behaviour which appears *prima facie* to be outside of socially accepted conventions, and suggests that this behaviour may become normalised through knowing other self-harmers. It was found that both participants had a self-harming friend prior to the onset of their self-harming behaviour, and that both participants confided in someone who subsequently began to self-harm. Participants positioned these two categories of individuals in different ways. Participants relied on a 'victim' discourse to establish their self-harm as meaningful in a way which limited any blame or stigma attributable to them, but which subsequently limited their agency in their narratives. The discourse of attention-seeking heavily influenced participants' narratives, and was acknowledged as the dominant discourse self-harmers must contend with in presenting their behaviour as meaningful and rational.

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Chapter One: Introduction

Self-harm is a complex, multi-dimensional, and often misunderstood phenomenon. It can be defined as a self-directed, intentional act which negatively affects the individual's health but lacks suicidal intention, and is socially or culturally unacceptable (Plener, Libal, Keller, Fegert & Muehlenkamp, 2009; Turp, 2003). In the past, many studies have explored different treatment options for self-harmers with the aim of eradicating this behaviour – the authors Hepp, Wittmann, Schnyder and Michel (2004) provide an overview of twenty-five such studies. This predominant focus on eradication has, however, led to criticisms that such research individualises and pathologises self-harmers, and neglects to address the reasons individuals engage in these behaviours (McAllister, 2003; Morison, 2006). Hence, a newer trend in self-harm research has sought to locate the phenomenon of self-harm within its social context, as a meaningful act which manages the self-harming individual's environment (Morison, 2006). This holistic approach thus takes into account the broader socio-political context of a self-harmer and is cognisant of how society shapes this experience.

In conducting the literature review, it was found that very few studies have explored how and why certain individuals begin to self-harm in the first place. Recent studies (Craigen & Foster, 2009; Klonsky, Oltmanns & Turkheimer, 2003; Whitlock, Eckenrode & Silverman, 2006), have found that self-harm is increasing in prevalence, despite its reputation as a stigmatised and abhorrent behaviour. This increasing prevalence suggests that a predominant focus on treatment development is not adequate, but, rather, that an increase in preventative research is necessary, in order to more effectively curb the increasing incidence rate. Research has suggested that having a friend or a family member who self-harms may significantly increase the risk of subsequent self-harming behaviour (De Leo & Heller, 2004; Hawton & James, 2005; Laloë, 2004); however this has not yet been investigated in detail.

This study was therefore exploratory, and aimed to investigate the first experiences of self-harm from the perspective of social constructionism, in order to gain insight into how

societal discourses shape the way participants construct their experiences with self-harm. Two self-harming individuals were interviewed for the purposes of this study. This study aligned itself with Doyal and Harris (1986) and van der Riet (2008), who argue that all human action is quintessentially social, and that action is subject to group norms and conventions which imbue actions with social meaning and significance. These norms and conventions in turn are shaped by social discourses (van der Riet, 2008).

Therefore, discourse analysis will be used to consider the diverse and often contradictory discourses surrounding self-harm, in order to better understand how individuals construct the narrative of their first self-harming experience. The strength of this approach is that discourse analysis allows participants to describe an intensely personal event (their first experience of self-harm) in a manner which explores how the "larger collective meaning systems" affect the organisation of the narration of these events (Morison, 2006, p. 44). It is hoped that by gaining insight into the construction of these narratives, one will gain better understanding of the societal discourses governing self-harm, countering their individualising tendency.

The aims of this research project were to investigate participants' knowledge and use of societal discourses regarding self-harm, to explore how they positioned themselves within these discourses, to examine how they constructed their first experience of self-harm, and lastly, to find out whether they knew other individuals who self-harm, and how they positioned these individuals in their narrative.

<h1 style="text-align: center;">**<u>Chapter Two: Literature Review</u>**</h1>

2.1 Introduction

Self-harm is a complex behaviour which is stigmatised in most discourses. Medical and clinical discourses dominate society's conception of self-harm (Morison, 2006), and have led to its being viewed as a pathological behaviour. In Section 2.2 self-harm as a phenomenon will be defined, discussed and explored. In Section 2.3, medico-psychiatric discourses will be discussed, and it will be shown how these discourses individualise and vilify self-harmers. Other discourses that have developed in response to medico-psychiatric discourses will also be discussed. Next, information concerning the first episode of self-harm will be explored, as well as literature on 'quitting', in Section 2.4. Finally, in Section 2.5 the available literature on the 'contagiousness' of self-harm will be examined, and it will be shown that there is a gap in the literature concerning how an individual becomes a self-harmer.

There is a growing trend in the literature to move away from quantitative studies focusing on the classification of self-harm and its treatment options, towards studies seeking to understand self-harm as a discursively constructed phenomenon (Roen, Scourfield & McDermott, 2008). This study will situate itself within these concerns, within a social-constructionist approach.

2.2 Defining self-harm.

2.2.1   Introduction to self-harm: A stigmatised behaviour

Self-harm is a complex, multi-dimensional, and often misunderstood phenomenon, seen as especially distressing to "societies that value life at all costs" (Rayner & Warner, 2003, p. 306), because to deliberately harm one's own body is constructed as going "against core human values" (McAllister, 2003, p. 178). Hence the phenomenon of self-harm is stigmatised, which results in it being treated as a "social taboo" (McAllister, 2003, p. 177). Self-harm is construed as an act which goes against life itself; and often results in fear, anxiety and rejection of self-harmers by community members (Rayner & Warner, 2003; Selleck, Curtis & Caplan, 1984). As a result of this stigma against self-harm, self-harmers tend to reveal strong fears of marginalisation (Craigen & Foster, 2009), and "secrecy and denial are common" (Hawton & James, 2005, p. 892). This has created a great degree of

difficulty for those wishing to learn more about this phenomenon, as self-harmers are often reluctant to come forward and share their experiences. In the past, the easiest access for research purposes to known self-harmers has been through institutions like hospitals, prisons and psychiatric wards. There is hence great difficulty in conducting generalisable research, as institutionalised self-harmers may differ qualitatively to community-based self-harmers – suggested by the fact that therapy programmes developed as a result of this research are often found to be ineffective (Craigen & Foster, 2009; Hepp *et al.,* 2004). It may also account for the high association of self-harm with borderline personality disorder, which will be discussed more fully in Section 2.2.5 (Austin & Kortum, 2004). It is estimated that institutionalised self-harmers may represent just the tip of the iceberg (Fortune, Sinclair & Hawton, 2008), and as a result, more effort is being made by researchers in recent years to access self-harmers in a community setting (Jacobs, 2005; Klonsky *et al.*, 2003). Much research has been completed over the past three decades; and yet we are little closer to understanding self-harmers.

2.2.2   Definitions of self-harm

Researchers recognise the difficulty of defining self-harm – because it is a complex phenomenon occurring in such a variety of forms it is difficult to pin down a universal definition of self-harm (Rayner & Warner, 2003). The debate over how to define self-harm is reflective of underlying ideological positions held by researchers, which influences how self-harmers are defined and managed (Morison, 2006).

Typically, the definition of self-harm is formulated to include only "'high visibility' manifestations" (Turp, 2003, p. 9) such as self-cutting, self-burning or self-poisoning. However many authors feel that such a narrow definition excludes certain acts that still constitute self-harm (Fee & Matson, 1992; Turp, 2003; Warm, Murray & Fox, 2003). Turp (2003) and Taylor (2003) emphasise that the *intent* of the individual should be viewed as the key element in deciding whether an act negatively affecting the individual's health was intended by the individual to constitute self-harm.

Problematically, the more self-harm is analysed, the more definitions and explanations it accrues. The debate over how best to describe and define self-harm is lively and ongoing,

however, this debate does contribute to the confusion and misunderstanding surrounding self-harm. For example, McAllister (2003) draws a distinction between the terms 'self-harm' and 'self-injury'. She argues that 'self-harm' is an umbrella term encompassing any act that harms the self without suicidal intent; while 'self-injury' is a type of self-harm leading to "visible, direct, bodily injury" such as self-cutting or self-burning (McAllister, 2003, p. 178). However the term 'self-injury' is used in several psychiatric textbooks (for example, Luiselli, Matson & Singh, 1992), in conjunction with severe psychopathology or intellectual impairment, and thus this term carries increased social stigma (Jacobs, 2005). There are also objections to the terms '*deliberate* self-harm' or '*deliberate* self-injury': Taylor (2003) argues that these terms confer additional suggestions of blameworthiness on self-harmers, which may add to the stigma they already bear. Additionally, while some seminal authors on the topic such as Favazza (1998) and Suyemoto (1998; both as cited in Mangnall & Yurkovich, 2008) use the term 'self-mutilation', this term conveys a sense of greater severity than is generally found in most self-harming acts (Mangall & Yurkovich, 2008). The term 'self-harm' will be used in this research project, as it appears to invoke the least amount of dissent among academics.

Turp (2003) emphasises the issue of cultural acceptability when defining self-harm – that is, what is seen as self-harm in the eyes of one culture may be acceptable in another culture. For example, self-flagellation is acceptable in certain religious communities but is not viewed as socially acceptable in other social or cultural groups (Turp, 2003). Turp defines self-harm loosely as:

> An umbrella term for behaviour:
> 1 that results, whether by commission or omission, in avoidable physical harm to self
> 2 that breaches the limits of acceptable behaviour, as they apply at the place and time of enactment, and hence elicits a strong emotional response (from others) (Turp, 2003, p. 36).

This response she defines further as the "*response* or *imagined* response of individuals exposed to the behaviour concerned" (p. 37, emphasis added). Similarly, Plener *et al.* (2009, p. 1549) defines self-harm as the "direct, repetitive, intentional injury of one's own body tissue, without suicidal intent, that is not socially accepted". Self-harm is generally not

formulated to include behaviours whose primary purpose is "sexual pleasure, body decoration, spiritual enlightenment via ritual, or intent to commit suicide" (Ayerst, 2004, p. 2). While the author concurs with Turp's broad definition of self-harm to include any act which results in avoidable physical harm, for practical reasons this study will focus its attention on self-harmers with visible manifestations of self-harm such as self-cutting or self-burning, in order to generate rich, detailed data (Patton, 1990).

2.2.3   Types of self-harm

Of the visible manifestations of self-harm, self-cutting appears to be the most frequently used method, occurring in at least 70% of self-harmers (Klonsky *et al.*, 2003). Of the other self-harming behaviours available, it was found that "between 21% and 44% of self-harmers bang or hit themselves, and between 15% and 35% burn their skin" (Klonsky *et al.*, 2003, p. 1502). Studies have shown that many self-harming individuals use more than one method of self-harm (Favazza & Contrerio, 1989; Gratz, 2001; Herpertz, 1995; all as cited in Klonsky *et al.*, 2003). Deliberate self-burning has been found to be more common in the Middle East and India compared to the West (Laloë, 2004).

2.2.4   Prevalence of self-harm

A broad range of studies indicate that self-harm is a global phenomenon. A recent German study found that 25.6% of German adolescents had experimented with at least one act of self-harm, such as cutting, severe scratching or hitting oneself (Plener *et al*., 2009). The authors contrasted their results with a comparison sample taken from a study by Muehlenkamp and Gutierrez (2007) which found that 23.2% of American adolescents had engaged in at least one act of self-harm (as cited in Plener *et al*., 2009). In Turkey, Zoroglu *et al*. (2003) found a lifetime prevalence rate of 21.4% in their student sample of 839 (as cited in Plener *et al*., 2009). In Hungary, Csorba, Szelesne, Steiner, Farkas, and Nemeth (2005) found a prevalence of 5.5% in adolescents; in Italy Favaro, Ferrara, and Santonastaso (2007) found a rate of 24% among female young adults (both as cited in Plener *et al*., 2009). In Britain, Rodham, Hawton, and Evans (2004) found a rate of 3.7% in a sample of 6,020 adolescents aged 15 – 16 (as cited in Plener *et al*., 2009). Other studies conducted in the United Kingdom have a higher estimate of between 7 and 14% (Hawton & James, 2005; Skegg, 2005, as cited in Young, Sweeting and West, 2006). In Scandinavia, Sourander *et al.*

(2006) found that 12.6% of girls and 4.6% of boys had experimented with self-harm at 15; while a study by Lundh, Karim, and Quilisch in 2007 found that a much higher rate of 65.9% of adolescents had experimented with self-harm and 13.8% did so repeatedly (as cited in Plener *et al.*, 2009). In New Zealand, Nada-Raja, Morrison and Skegg (2003) found that 20% of their sample of 965 participants aged 26 had experimented with some form of self-harming behaviour without suicidal intent. Additionally, studies such as Chandler, Lalonde, Sokol, Hallett and Marcia (2003); Marshall and Yazdani (1999); and Whitlock *et al.* (2006) found that minority groups such as Asian communities in Britain, Native American adolescents, or Black and Hispanic students in America showed as high if not higher rates of self-harm as Caucasians.

2.2.4.1   Cultural influences on self-harm

These studies may suggest a cultural influence on the incident rates and types of self-harm used in different regions. Culture and societal norms play an ineffable role in self-harm. Just as culture informs us about which acts are unacceptable and thus constitute self-harm, so culture shapes and limits the access individuals have to different forms of self-harm (van der Riet, 2008). For example, in Laloë's study (2004), world-wide patterns of self-burning were analysed for trends. It was found that India, Sri Lanka and Iran contributed half of the world-wide cases of self-burning. In Western countries self-burning cases were far rarer. Where self-burning did occur, self-burners were more likely to be male, in their thirties, and suffering from psychiatric diagnoses such as schizophrenia; compared to in the Middle East where self-burners were more likely to be female, in their twenties, and with low rates of mental ill-health. This suggests that self-burning seems to be more acceptable in Middle Eastern cultures, whereas in Western cultures it is relatively rare (Laloë, 2004). Laloë's study (2004) echoes work by Favazza which has had a major influence on the way we understand self-harm today. Favazza examined self-harming rituals from around the world and throughout history to understand self-harm from a cultural perspective (1988, 1989 and 1996, as cited in Strong, 1998). He found many examples of culturally sanctioned acts of self-harm, which served specific purposes such as signalling adulthood (for example, scarification, female genital mutilation, or male circumcision); the healing of self or others (Shamans and Moroccan Islamic healers use their own blood to heal community members; Western medicine used to rely on bloodletting to cure illness); or for religious purposes

(South American tribes anoint statues of their gods with their own blood; Germanic tribes used to anoint runes with their own blood to give them efficacy; Catholics canonised those who mortified their flesh or who suffered from stigmata); to give only a few examples (Favazza 1988, 1989 and 1996, as cited in Strong, 1998).

Plener *et al*. (2009) suggest that the global variations (as described in Section 2.2.4) in rates of self-harmers may be due to cultural differences, but may also be due to methodological differences between studies. Non-standardised data collection and a lack of cross-validated assessment tools present difficulties in generalisibility (Plener *et al*., 2009). Researchers may also have relied on differing conceptual understandings of self-harm which could affect their findings (Plener *et al*., 2009). Additionally, different age groups are sampled from, and there may be further differences in quality of life and economic standings between participants which have not been made explicit by these authors. These factors limit broad generalisations from these studies. That said however, it *is* clear that self-harm is a global phenomenon. Additionally, there is evidence that it is increasing in prevalence, as higher rates have been found in younger generations (Craigen & Foster, 2009; Klonsky *et al*., 2003 [who cites Briere & Gil, 1998; Shearer, 1997; Soloff, Lis, Kelly, Cornelius, & Ulrich, 1994; Zlotnick, Mattia, & Zimmerman, 1999]; Whitlock *et al*., 2006). This increasing prevalence presents an urgent call for a deeper understanding of the phenomenon of self-harm.

It has been suggested by authors such as Černá and Šmahel (2009), Plener *et al*. (2009), and Whitlock *et al.* (2006), that this increasing prevalence may be due to increased Internet access. Plener *et al*. (2009, p. 1556) suggest that self-harmers "tend to use the internet more and more to make use of chat rooms". In chat rooms, self-harmers can reach out to other self-harmers while maintaining anonymity. While this provides self-harmers with a network of social support, this may also result in a spread of self-harm if use of these chat rooms serves to normalise self-harming behaviour (Whitlock *et al*., 2006).

2.2.4.2   Self-harm in youth sub-cultures

In addition to cultural influences, as discussed above, self-harm may also be influenced by subcultures, particularly certain youth sub-cultures. Young *et al.* (2006) compared self-harming acts and suicide attempts with adolescents' self-identification with different youth

cultures. The authors noted that Goth subculture had been identified with self-harm in the media but that the "evidence for this was sparse", resulting in the motivation for their study (Young *et al*., 2006, p. 1058). Goth subculture was defined by the authors as "a subgenre of punk with a dark and sinister aesthetic" (Young *et al*., 2006, p. 1058). A variety of youth subcultures were considered in their study, including Goth, punk, heavy metal, mosher, nu-metal, skater, grunge, retro, indie, rave, club, garage, hip-hop, and pop. A high association with Goth subculture was identified as being the best predictor of self-harm and suicide attempts, with a prevalence of 53% for self-harm and 47% for attempted suicides. The authors acknowledged that the causal mechanisms between Goth subculture and self harm remain unclear, but postulated two potential explanations. The first was that the high incidence rates of self-harm and attempted suicide could be due to modelling mechanisms – in other words, members of the Goth subculture may emulate peers or icons who self-harm and so begin to self-harm themselves for normative reasons. The second reason may due to selection, where young people "with a particular propensity to self-harm (are) attracted to the subculture" (Young *et al*., 2006, p. 1060). The authors felt that it was most likely that both mechanisms were in play, and called for replications of their study to be made in alternate locations to see if this phenomenon is widespread and persistent (Young *et al*., 2006).

A relatively new sub-culture that needs to be considered is the 'emo' subculture. This sub-culture, whose name arises from an abbreviation of 'emotional music' is constructed as being characteristically depressed, melancholy and teeming with teenage angst, as opposed to being positioned as 'dark and sinister' like the Goth subculture (Definis-Gojanović, Gugić & Sutlović, 2009). The 'emo' subculture has also been linked by the media to the phenomenon of self-harm (Černá & Šmahel, 2009; Definis-Gojanović *et al.*, 2009) and tends to be disparaged by other youth sub-cultures. Few academic studies have considered this link: Martin (2006) suggested membership of the emo sub-culture may predict suicidal and self-harming behaviours; while Černá and Šmahel (2009) suggested this link may exist but found no conclusive evidence for it. Definis-Gojanović *et al.* (2009) reported that the Russian Government is working on a draft proposal to regulate 'emo' websites and ban children dressed in the 'emo' style from school. This demonstrates that even without confirmatory research, the image of the depressed, 'angst-ful', self-harming teenager exists already in

societal discourses (Černá & Šmahel, 2009), and as such is a topic ripe for consideration by researchers.

2.2.5 Link to psychopathology

As mentioned above, researchers and clinicians have in the past had more access to self-harmers in clinical settings such as hospitals, prisons or mental institutions. This has resulted in self-harm's close association with clinical disorders and psychopathological disturbances, in particular borderline personality disorder (Craigen & Foster, 2009; Klonsky *et al.*, 2003).

Borderline personality disorder is defined as a "major mental disorder characterised by instability in interpersonal relationships, affect, self-identity, behaviour and cognition" (American Psychiatric Association, 1994, as cited in Brown, Linehan, Comtois, Murray & Chapman, 2009, p. 815). The prevalence of borderline personality disorder has recently been estimated at 5.9% of the general population, and is associated with a high risk of self-harm and suicidality (Brown *et al.*, 2009). It has been found that up to 10% of individuals with borderline personality disorder have died by suicide (Paris *et al.*, 1987; Pompili *et al.*, 2005; Stone *et al.* 1987; all as cited in Brown *et al.*, 2009); approximately 75% of individuals with borderline personality disorder have attempted suicide (Frances *et al.*, 1986; Shearer *et al.*, 1988; Stone *et al.*, 1987; all as cited in Brown *et al.*, 2009); and 69 – 75% of borderline individuals have engaged in an act of self-harm at least once (Clarkin *et al.*, 1983; Grove & Tellegen, 1991; Stone, 1993; all as cited in Brown *et al.*, 2009). Thus, a strong association seems to have been established, through research, between borderline personality disorder and self-harm and suicide attempts.

However research has also shown that borderline personality disorder is not the only diagnosis which self-harming behaviour may fall under – self-harm has also been linked to a number of other clinical diagnoses, namely dissociation (Briere & Gil, 1998; Brodsky, Cloitre & Dulit, 1995; Nijman, Dautzenberg, Merckelbach, Jung, Wessel & Campo, 1999; Shearer, 1997; Turell & Armsworth, 2000; van der Kolk, Perry & Herman, 1991; Zlotnick, Mattia & Zimmerman, 1999; Zweig-Frank, Paris & Guzder, 1994a and 1994b; all as cited in Klonsky *et al.*, 2003); anxiety disorders (Briere & Gil, 1998; Simeon, Stanley, Frances, Mann, Winchel & Stanley, 1992; Turell & Armsworth, 2000; all as cited in Klonsky *et al.*, 2003; Stanley,

Gameroff, Michalsen & Mann*,* 2001); psychopathy (Swogger, Conner, Meldrum & Caine, 2009); and post traumatic stress disorder (Shearer, 1997, as cited in Klonsky *et al.*, 2003). Self-harmers have also been identified who form part of non-clinical populations (Klonsky *et al.*, 2003).

While these findings seem quite well established, Klonsky and his colleagues highlighted the fact that these studies were generally conducted on "clinical populations disposed to major forms of psychopathology", which may have inflated the association (Klonsky *et al.*, 2003, p. 1502). They decided therefore to conduct their study on self-harm and psychopathologies on a non-clinical population. They found that self-harmers in their sample reported more personality pathology than non-self-harmers, including features from all the DSM-IV personality disorders except for obsessive-compulsive personality disorder. In a different study, Castille *et al.* (2007, as cited in Mangall, & Yurkovich, 2008) also found that their sample of 105 self-harmers displayed a range of diagnoses, namely "mood disorders (56.4%), anxiety disorders (30.4%), posttraumatic stress disorder (4.3%) and eating disorders (4.3%)" (Mangnall & Yurkovich, 2008, p. 179).

Currently the only mention of self-harm in the present version of the Diagnostic and Statistical Manual (the DSM-IV-TR) is as a criterion for borderline personality disorder (Klonsky *et al.*, 2003). This has recently come up for review in the editing of the DSM in preparation for the release of the DSM-V. The work groups working on the DSM-V are currently considering self-harm as a potential new entry to the Manual, with the designation non-suicidal self-injury (NSSI) (Pine, 2009). This is in recognition of an increasing acceptance that self-harm may occur across diagnoses as well as in non-clinical individuals (Klonsky *et al.*, 2003; Pine 2009). However before the potential new entry is finalised, the work groups are calling for establishment of criteria for NSSI, a clarification of the relationship between NSSI and suicidal acts and suicidal ideation, and the creation of measures with which to evaluate and distinguish NSSI from suicidal ideation and behaviour (Pine, 2009).

Until this is accomplished:

> Many researchers study deliberate self-harm as a behavioural phenomenon in its own right, rather than as a symptom of borderline personality disorder. This

approach – studying a particular psychological phenomenon rather than the diagnosis with which it is associated – may be particularly suited to the investigation of behaviours with poorly understood underlying mechanisms. (Klonsky *et al.*, 2003, p. 1501).

2.2.6 Link to childhood abuse

While some studies have reported that "more than half of self-injuring teens" disclose childhood sexual abuse (Austin & Kortum, 2004, p. 521), other studies have found that while self-harm and child abuse may often co-exist, a finding of one does not justify the assumption of the other. In a study of female prisoners, Milligan and Andrews (2005, p. 14) stated that the relationship between child abuse and adult functioning is complex and may involve "intervening psychological and social factors". It has been found that not all children respond in the same way to abuse; rather that abuse may lay down the foundation for adult psychopathology, of which self-harm may form a part (Milligan & Andrews, 2005). McAllister (2003, p. 179) states that while there is as yet "no direct link to childhood abuse", a popular opinion is that "traumatic events (in general, whether occurring in child- or adulthood), not just child abuse, can lead to self-harm". Turp (2003, p. 16) explains that the verb "to traumatise" comes from the Greek "to pierce", and any negative event, whether "the piercing effect of a thousand small pinpricks" or a "few major, more obvious cuts and blows" to the psyche can result in trauma. In a series of interviews, Taylor (2003, p. 86) found that only 20% of his participants gave childhood reasons for their self-harm; compared to 40% who "identified experiences of rejection in adulthood" as a main cause. In their meta-analysis, Klonsky and Moyer (2008) found that there is little proof in the existing literature for the claim that childhood sexual abuse plays a primary role in the development and maintenance of self-harming behaviours. Rather, they argue that "childhood sexual abuse accounts for no more than 5% of the variance in the development of self-injurious behaviour" (Klonsky & Moyer, 2008, p. 168). Warm *et al.* (2003) found that self-harming participants who had been exposed to sexual abuse felt it was a contributing factor to their self-harm, while self-harmers with no history of sexual abuse believed the two to be unrelated. Kinyanda, Hjelmeland and Musisi's (2005, p. 2) study, conducted in Uganda, found self-harm to result from the "complex interaction of the psychosocial, cultural, environmental and biological systems of the individual". To summarise, abuse in childhood

lays the foundation for many problems later in life, one of which may be self-harm; likewise, not all victims of child abuse become self-harmers (Austin & Kortum, 2004).

2.2.7   Link to suicide

2.2.7.1   The stigma of suicide

Suicide may be defined as an active or passive action by an individual to him or herself with the intent that it will result in his/her death; and death is the result (Maris, Berman & Silverman, 2000). According to Clarke (1999), suicide is stigmatised by Western civilisations for religious and political reasons. Most recently, the social sanction against suicide has been institutionalised by medicine and psychiatry, with the result that the suicidal person has come to be positioned as "mentally disturbed, a danger to him or herself, and an appropriate object of 'care'" (Clarke, 1999, p. 457).

2.2.7.2   Prevalence of suicide

Suicide is the third leading cause of death globally in young people aged 15 to 35 (Borowsky, Ireland & Resnick, 2001; Calder, 2004; Price & Carney, 1982; Simpson, 2009). Statistics have suggested that one in five adolescents have thought about committing suicide, more than one in six have made plans to commit suicide and one in twelve has made a suicide attempt in the past year (Simpson, 2009). Previous suicide attempts are the most strongly correlated predictors for future suicide attempts (Borowsky *et al.*, 2001). In South Africa, suicide is also the third leading cause of death, after homicide and accidents (Calder, 2004). The age group found to be most at risk for suicidal behaviour in South Africa is the 15 – 25 year old group (Bhamjee, 1984; Edwards *et al.*, 1981; Pillay & Pillay, 1987; all as cited in Pillay, 1989).

2.2.7.3   Suicide and self-harm

In considering the relationship between self-harm and suicide, authors tend towards one of two schools of thought; believing either that suicide and self-harm are two distinct phenomena, conducted for different psychological motives; or that self-harm and suicide fall into the same range of behaviours which exist on a continuum. These schools of thought utilize different terms in referring to self-harm, depending on their perception of its relationship to suicide.

The first school of thought regards self-harm and suicide as distinct phenomena, conducted with different motives. Authors favouring this view refer to 'self-harm' as 'self-harm' or 'non-suicidal self-injury', and see these acts as a coping mechanism or a *prevention* of suicide (Austin & Kortum, 2004; Mangall & Yurkovich, 2008). Self-harmers commonly describe their acts as 'anti-suicide', using self-harm as a "coping mechanism to avoid suicide by channelling destructive impulses into self-harm rather than self-destruction" (Mangall & Yurkovich, 2008, p. 177). Additionally, a self-harmer may use self-harm in order to remind him- or herself that he/she is alive. Antecedent emotions which threaten to overwhelm the individual may result in a feeling of depersonalisation (a state of psychological numbness) as a defence mechanism against these emotions (Brown & Pedder, 1991; Simpson, 1980). Self-harm in these instances provide a means of terminating this feeling of numbness and provides reassurance that he/she is real. However, the consequent shame of this stigmatised act of self-harm – while originally conducted without suicidal intent – may lead to greater grief, hopelessness and sense of diminished self-efficacy, and in effect transform the individual's motivations from being self-harming (or self-soothing), to suicidal (McAllister, 2003). The key to this argument is an emphasis on determining the individual's intention at the time, and classifying their act accordingly. Authors supporting this differentiation between self-harm and suicide include Austin and Kortum (2004), Eastwick and Grant (2004), Favazza (1996), Marshall and Yazdani (1999), McAllister (2003), Muehlenkamp, Swanson and Brausch (2005), Rayner and Warner (2003), Taylor (2003) and Turp (2003).

The second school of thought is that suicidal behaviour exists on a continuum, with various increasing degrees of self-harm on the one hand, culminating with completed suicide on the other. Authors of this view tend to use terms such as 'para-suicide', 'suicidal ideation' or 'suicidal behaviour' to refer to self-harming behaviours. These authors include Cooper *et al*. (2005), Firestone (1997), Judge and Bates-Billick (2004), Marfe (2003), Martinez *et al*. (2005), and Nada-Raja *et al.* (2003).

For the purposes of this study the author will align herself with the first view point as discussed above – that suicide and self-harm are two distinct phenomena. Qualitative research (for example, Ayerst, 2004; Marshall & Yazdani, 1999; Sinclair & Green, 2005) with

self-harmers have shown that in most cases a self-harming act is not made with suicidal intent. In Whitlock *et al.* (2006, p. 1945), 66% of self-harming individuals interviewed reported "never having considered or attempted suicide". It is this author's opinion that to view self-harm and suicide as a continuum of behaviours ignores and invalidates the self-harmers' own view of their intent (as expressed in the qualitative research mentioned) and so for this reason this author shall align herself with the argument that self-harming behaviour and suicide attempts are two different phenomena, committed with different intentions (Ayerst, 2004). It must be noted, however, that due to the reasons underlying self-harm, a self-harmer may subsequently become suicidal.

While self-harm and suicide are arguably distinct phenomena, research has shown that some relationship does exist between suicidal behaviours and self-harmers. Statistics show that 35 – 50% of self-harmers presenting to health departments eventually commit suicide (Eastwick & Grant, 2004), although as discussed in Section 2.2.1, this percentage may not represent the self-harmers who never seek medical attention. While research has shown that 80% of self-harmers cease to self-harm within five years of initiating this behaviour (Whitlock *et al*., 2006, as cited in Brown, Williams & Collins, 2007), studies have also suggested that suicide risk levels remain elevated for life (de Moore & Robertson, 1998; Hawton, Zahl & Weatherall, 2003; Zahl & Hawton, 2004; all as cited in Brown *et al.,* 2007).

A study by Hawton, Harriss and Zahl (2006) contributed to our understanding of this complex relationship and suggested that not only are self-harmers more likely to commit suicide, they also face an elevated risk of dying from other causes as well. The researchers followed 11, 583 self-harm patients who had been admitted to hospital between 1978 and 1997 and completed follow-up on 31 December 2000. Of the self-harmers, 89.4% had been admitted for self-poisoning, 7.6% for self-injury and 3% for both methods. This in itself may have influenced their results, as self-poisoning is more likely to have long-term physical effects on health than 'superficial' (that is, bodily or surface) forms of self-harm. That said, however, the study found that when compared to the rest of the population, self-harmers had double the risk of dying from a variety of causes. Death by suicide was 17 times more likely and death by "accidental poisoning" was 15 times more likely than in the general population. The study also found that self-harming individuals appeared to have a

heightened vulnerability to death from most physical illnesses. The authors offered a few explanations for this finding. Firstly they referred to the known association between certain psychiatric disorders with physical conditions, such as lung disease, AIDS and gastro-intestinal ulcers, which could provide an explanation for the presence of self-harm. Another potential explanation is the "excess... of certain behaviours" such as "alcohol abuse, aggression and impulsivity or risk-taking," that increase the risk of both self-harm and physical disorder (Hawton *et al.*, 2006, p. 403). Additionally they proposed that the physical illness may be pre-existent to the self-harming behaviour – the self-harming behaviour may be a means of coping with the physical illness. Or, they suggest, the co-existence of these two factors may be due to the "inverse social class gradient and socio-economic deprivation known to characterise" self-harmers (p. 403). Strengths of this study included the very large database of self-harming individuals, and the long follow up period; however their selection of mostly self-poisoners may have biased their results. In summary, as Plener *et al.* (2009) caution, the relationship between self-harm and suicide is highly complex and is subject to ongoing research.

2.2.8   Addictiveness of self-harm

Self-harm is considered by many to have an addictive nature (Austin & Kortum, 2004; Magnall & Yurkovich, 2008; Nixon, Cloutier & Aggarwal, 2002 as cited in Whitlock *et al.*, 2006; Strong, 1998). Crowe and Bunclarck (2000, as cited in Magnall & Yurkovich, 2008), viewed this attribute as one of the most striking features of repeated self-harming behaviours and suggested it may co-exist with other addictive behaviours (see Section 2.2.9). There is strong evidence that self-harm physically reduces tension (Haines, Williams, Brain & Wilson, 1995, as cited in Strong, 1998 and in Klonsky *et al.*, 2003; Sachsse, von der Heyde & Huether, 2002, as cited in Mangall & Yurkovich, 2008). Coid, Allolio and Rees (1983) found significantly higher levels of enkephalins, an opiate-like chemical reducing pain sensitivity, in active self-harmers (as cited in Strong, 1998). Self-harmers may suffer opiate withdrawal and cravings in the face of trauma and stress, leading to self-harm becoming an addictive coping mechanism (Strong, 1998). There is also some evidence that levels of stress hormones such as dopamine and adrenalin may be raised in self-harmers, which may contribute to a hyper-arousal state where self-harmers feel overwhelmed by anxiety and feel driven to self-harm (Favazza, 1996 as cited in Strong, 1998).

2.2.9 Co-morbidity of self-harm with other addictive behaviours

2.2.9.1 Link to eating disorders

Studies have shown that between 35 – 80% of self-harmers also suffer from an eating disorder (Favazzo & Conterio, 1989; Rosenthal, Rinzler, Wallsh & Klausner, 1972; Simpson & Porter, 1981; Yaryura-Tobias & Neziroglu, 1978; Zlotnick, Shea, Pearlstein & Simpson, 1996; all as cited in Strong, 1998). Self-harm appears to be particularly prevalent among bulimics (Fichter, Quadflieg & Rief, 1994; Mitchell, 1986; both as cited in Strong, 1998).

There appear to be similarities between eating disorders and self-harm – both are behaviours that involve the exertion of control over the body, and the behaviour is often secretive and hidden (Austin & Kortum, 2004). A study by Wildman, Lilenfeld and Marcus (2004) examined a sample of fifty-four women with past or present eating disorders. Of these fifty-four, twenty-seven had a history of suicide attempts and self-harm while the other twenty-seven did not. In their analysis, the authors found that the onset of major depression and anxiety disorders occurred at a significantly younger age in the 'parasuicidal' group than in the 'non-parasuicidal' group (Wildman *et al.*, 2004). Additionally they found that while the parasuicidal and non-parasuicidal women did not differ in their rates of major depression, significantly more parasuicidal women (67%) developed depression before the onset of the eating disorder. Their findings suggested that where major depression or anxiety disorders exist prior to the onset of eating disorders, the individual is at greater risk of developing parasuicidal tendencies (Wildman *et al.*, 2004).

2.2.9.2 Alcohol and drug abuse

Matsumoto *et al.* (2005) and Cuellar and Curry (2007) found extensive co-morbidity between self-harm and the use of psychoactive drugs or marijuana respectively (both as cited in Mangall & Yurkovich, 2008). In 2000, Beasely found that in psychiatric self-harming patients, 71% also misused alcohol and 54% misused illicit substances (as cited in Mangall and Yurkovich, 2008). There is strong evidence to suggest that alcohol intoxication significantly increases risk of suicide attempts and self-harm (Berglund & Öjehagen, 1998; Evans, Hawton & Rodham, 2004; Hufford, 2001; Murphy, 2000; Rossow, 2000; all as cited in Rossow *et al.*, 2007). Adolescents who drink more heavily or more frequently resulting in

intoxication are at a greater risk for suicide attempts and self-harming episodes (Rossow *et al.*, 2007). Sinclair and Green's 2005 study validated these findings. Their ex-self-harming interviewees reported misusing alcohol to escape from difficult emotions, but at the time of the interview recognised that it would set off a cycle of self-loathing which would result in an episode of self-harm. Brown *et al.* (2007) compared present self-harmers with past self-harmers (defined as not self-harming within the previous year) and non-self-harmers. They found that the rate of substance misuse was highest among past self-harmers, which may suggest that they now rely on a different maladaptive coping mechanism in place of self-harm.

2.2.10 Self-harm: Treatment-resistant?

Self-harm has typically been constructed as a 'treatment-resistant behaviour' (Craigen & Foster, 2009; Morison, 2006). Resistance in psychotherapy is often defined as "those aspects of clients' functioning that seek to maintain the status quo in their psychological lives" (Newman, 2002, p. 166). It is characterised by ambivalence (Moyers & Rollnick, 2002): while clients want change, they are also wary of relinquishing "long-standing patterns of functioning" (Newman, 2002, p. 166), which promotes their autonomy (Messer, 2002). This perception of self-harmers as treatment-resistant has been heightened by self-harm's close association with borderline personality disorder, a diagnosis also framed as difficult to treat. As a result of a trend to locate "the problem in pathology, emphasis tends to be on physical treatment and eradicating the behaviour", rather than focussing on a holistic treatment of the self-harming individual (Morison, 2006, p. 7). Once labelled as borderline or self-harming, individuals may be "judged harshly, feared, (and) constructed as chronic and likely not to change" (McAllister, 2003, p. 179).

Craigen and Foster (2009) explored treatment options for self-harmers. They found that while results of studies examining treatment options have been mixed, problem-solving therapies seem to be the most effective in treating self-harm (Craigen & Foster, 2009). This may be because these therapies are able to replace the multiple functions self-harm performs with healthier methods of coping (Walsh & Rosen, 1988). However, they also demonstrated the vital importance of the therapeutic relationship – without trust or understanding from the therapist the effectiveness of treatment is severely reduced.

Craigen and Foster (2009) focussed their study on self-harmers' perceptions of the therapy they received (a focus which, in their opinion, has been rare), and showed the importance self-harmers place on being listened to in a non-judgemental manner, as well as their desire to deal with their underlying emotions and issues rather than just regulating their self-harming behaviours. This study demonstrated that while difficult to treat, self-harmers can be helped through therapy which is grounded in a strong therapeutic relationship.

2.3 Discourses on self-harm

Due to the Westernised favouring of science, medical and psychiatric opinions on self-harm have dominated the public realm and influenced how self-harmers are viewed, treated and talked about. Medico-psychiatric discourses are firmly entrenched in the public mind to the extent that certain discourses, discussed below, persist despite research findings suggesting the contrary. Morison (2006) argued that self-harm is discursively positioned as an individualistic and pathological behaviour, due to its shocking and seemingly inexplicable nature. This individualisation of self-harm leads to a tendency to disregard accounts relying on the insights of self-harmers into their own behaviour, allowing 'experts' opinions to remain uncontested (Morison, 2006). Morison (2006) suggests that, in particular, the denial of underlying suicidal intention renders self-harm even more irrational and frightening in the eyes of non-self-harmers. Medico-psychiatric discourses include discourses of self-harmers as attention-seeking and manipulative, and will be discussed below, along with other discourses that have arisen in resistance.

2.3.1   Medico-psychiatric discourses

Historically, psychiatry arose from medicine, and as a result for many years mental symptoms and strange behaviours were seen to be the result of something physiologically wrong (McAllister, 2003). While more importance has been placed on individuals' intra-psychic difficulties over the past fifty years, psychiatry is still largely informed by an illness model (McAllister, 2003). This means that self-harm is seen to be a symptom of an illness, with the result that a self-harmer is typically labelled with a psychiatric disorder and treated chiefly through pharmaceutics (O'Connor & Armitage, 2003). However, physical treatments such as antidepressants, anticonvulsants, neuroleptics, sedatives, or electro-convulsive treatment have been found to have little, if any, effect on regulating self-harming behaviour

(Marshall & Yazdani, 1999). Critics opine that this model individualises self-harm, instead of viewing it in a broader socio-cultural context (Morison, 2006). This tendency to individualise self-harm neatly deflects any contingencies of blame away from society and places it squarely on the shoulders of the self-harmer (Parker, Georgaca, Harper, McLaughlin & Stowell-Smith, 1995, as cited in Morison, 2006). In medico-psychiatric discourses self-harmers are often construed as either 'victims' or 'villains' (Morison, 2006). Morison's study showed that self-harmers themselves may oscillate between these two positions in their narratives. In the 'victim' discourse, self-harmers defer blame but restrict autonomy, constructing self-harm as unavoidable (Morison, 2006). In the 'villain' discourse, self-harmers claim agency through the "consciously chosen strategy or tool" of self-harming behaviours, with the resultant blame and condemnation for their dissidence or transgression of social norms (Morison, 2006, p. 90).

In the illness model, social expectation demands that those who are sick should actively try to get better (Rayner & Warner, 2003). Those treating self-harmers often feel angry, frustrated and helpless, as self-harm seems to imply a "deliberate infliction of sickness on the self" (Rayner & Warner, 2003, p. 306). This "deliberate infliction" is often construed as being deliberatively manipulative, in order to gain attention and sympathy from care-givers (Morison, 2006). This attitude has unfortunately been commonly reported, and some self-harmers have reported experiencing a poorer standard of care than non-self-harmers on presentation to an emergency room. This poorer standard of care is an attempt by caregivers not to 'reinforce' this 'manipulative' behaviour (Treatment of self-harm guidelines, 2004). Cases have even been reported of self-inflicted wounds being sutured without anaesthetic or being scrubbed with nylon brushes (Shaw, 2002, as cited in Morison, 2006). These responses may reflect the clinician's perception of an ongoing power struggle between themselves and their self-harming patients (Morison, 2006), and so the behaviour is framed as "not serious" or 'time-wasting' by clinicians (Cooper *et al.,* 2005, p. 302).

2.3.1.1   'Attention-seeking' discourse

Self-harming behaviour has been described, both in some clinical research and in popular culture, as 'attention-seeking' (Stanley, Gameroff, Michalsen, & Mann, 2001). Some clinicians have even recommended that "such behaviour should be ignored" (Marshall &

Yazdani, 1999, p. 422), which, in light of the literature on self-harmers' increased risk for suicide and other causes of death (as discussed in Section 2.2.7.3), could be seen as a negligent or harmful approach to assume. Marshall and Yazdani (1999, p. 422) suggest that labelling self-harm as attention-seeking diminishes the phenomenon of self-harm to a dismissible "childish call for attention" that fails to recognise the deeper underlying distress of the self-harmer. Marshall and Yazdani (1999) demonstrate, however, that some of their self-harming interviewees were able to access external means of support such as counselling through their self-harm. In this way the self-harm was a "trigger" to change an unbearable situation, providing a means of communication where none other was seen to be possible (Marshall & Yazdani, 1999, p. 422). While it drew attention to themselves, it was not 'attention-seeking'. Their study was corroborated by Machain (2001, as cited in Ayerst, 2004) who had very similar findings.

2.3.1.2   'Manipulation' discourse

Additionally, self-harm is often positioned as manipulative (Stanley *et al.*, 2001). By construing self-harm as manipulative, it becomes an act which is morally reprehensible as it is disrobed of meaningfulness and authenticity (Groves, 2004). Terming it as such posits all blameworthiness for the situation on the self-harmer, transforming those around them into victims, held hostage to the self-harmer's behaviour. This discourse negates any intra-psychic meaning on behalf of the self-harmer and forms part of the villain discourse, as described by Morison (2006).

2.3.2   Psychiatric 'survivors': Survivor and feminist discourses

A backlash against these medico-psychiatric discourses, as described above, occurred in the late 1980's and early 1990's. A number of ex-self-harmers became activists against the individualising and stigmatising nature of these discourses. Members of this movement decried the "psychiatric taxonomy" which they believe attaches mere psychiatric labels to self-harmers. They claim that all clinicians achieve with labels is to ensure that the self-harm and its underlying causes are not dealt with. Rather, this movement calls for services which provide a dialogue with counsellors, in order to adequately work through underlying issues resulting in self-harm (Pembroke, 1994 as cited in Cresswell, 2005).

It has been typically reported in the past that there is a higher prevalence of self-harm in females than in males (Jarvis, Ferrence, Johnson & Whitehead, 1976; Klonsky *et al.*, 2003; Plener *et al.,* 2009). This prevalence, however, may have been inflated, as self-harming men presenting to hospitals are more likely to be misdiagnosed as sustaining accidental injuries than women are. Other studies have found no gender differences in rates of self-harm (Briere & Gil, 1998, as cited in Klonsky *et al*., 2003; Brown *et al.*, 2007; Gratz, 2001, as cited in Klonsky *et al*., 2003; Klonsky *et al*., 2003; Lloyd-Richardson, Perrine, Dierker, & Kelley, 2007, as cited in Plener *et al*., 2009; Lundh, Karim, & Quilisch, 2007, as cited in Plener *et al*., 2009; Nijman *et al*., 1999, as cited in Klonsky *et al*., 2003; Soloff, Lis, Kelly, Cornelius, Ulrich, 1994, as cited in Klonsky *et al*., 2003; Stanley *et al.*, 2001; Young, van Beinum, Sweeting, & West, 2007). Young *et al*. (2007) found inconclusive differences in the rates of self-harm across gender, but did find a gendered difference in methods of self-harm used. Their research suggested that females are more likely to use methods like self-cutting or over-dosing on tablets, while males are more likely to use more violent methods such as self-burning, self-hitting or self-punching (Young *et al*., 2007). This finding is paralleled in research on gendered differences in methods of suicide (Hawton & Harriss, 2008; Maris *et al.*, 2000; Qin, Agerbo & Mortensen, 2003). This may be reflective of social stereotypes regulating gender-appropriate behaviours in the presentation of distress, so powerfully entrenched that it governs even socially unsanctionable behaviour such as self-harm or suicide (Morison, 2006).

Despite these research findings suggesting the contrary, self-harm is persistently constructed to be a female malady (Cooper *et al.*, 2005; Groves, 2004). Groves (2004) discussed how male self-harming prisoners are gendered as female and are seen as weak and manipulative by fellow inmates and wardens alike. Feminist discourses suggest that self-harm may have less to do with gender issues and more to do with issues of *power* and *resistance*, by providing a vehicle in which to express anger, distress, resistance to oppressive situations or a voice to experiences of injustice - regardless of gender identity (Groves, 2004; McAllister, 2003; Taylor, 2003). In feminist discourses, feelings of invalidation and silenced anger or frustration dominate self-harmers' accounts and they describe self-harm as a surrogate voice to replace the loss of verbal communication (Cresswell, 2005). As Ross, an ex-self-harmer, states: "Undoubtedly there is a link between self-injury and the way

girls and women are 'meant' to behave. We are taught from very early on that it is 'unladylike' to scream and get angry" (Ross, 1989, as cited in Cresswell, 2005, p. 267).

The idea that self-harm is more common in women than men may be sustained because women are socialised to deal with emotional pain inwardly, while men are more likely to act out emotional pain, and hence the idea that a self-harmer is female seems more acceptable to society (McAllister, 2003). However male self-harmers are increasingly recognised as part of the self-harming population, and this may be due to an increase in men's emotional literacy, or to society's decreasing tolerance of 'acting out' behaviours. This would result in men being socialised to direct their anger inwards, as women have been taught to do (Favazza, 1996, as cited in McAllister, 2003). Feminist discourse suggests that rather than focus on gender, we should consider self-harm as a form of resistance used by both men and women (McAllister, 2003). Under this explanation, self harm becomes a maladaptive means of dealing with significant problems, rather than being construed as a significant problem itself (Marshall & Yazdani, 1999). This is a more positive construction, as it positions self-harm as something which can be overcome when replaced with more positive coping mechanisms – rather than being seen as a behaviour which is 'treatment resistant'.

2.4 The self-harm trajectory

2.4.1   The first experience of self-harm

Young *et al*. (2007) found in their survey of 1,258 18 – 20 year olds, that those who had self-harmed had mostly begun to do so out of a need to deal with difficult emotions. Their study was in line with others suggesting that self-harmers may have limited coping skills or face high levels of stress or anxiety, which results in a reliance on self-harm to deal with these emotions (Child and Adolescent Self-harm in Europe Study, as cited in Young *et al.*, 2007; Rodham, Hawton, & Evans, 2004; Warm *et al.*, 2003).

Most of the research reviewed for this study tended to be either quantitative, with a focus on prevalence and types of behaviours exhibited; or qualitative, with fewer studies that focused on psycho-social reasons for self-harming or the experiences of self-harmers. A number of antecedent states have been identified as important precursors to an act of self-harm, such as depression (Briere & Gil, 1998, as cited in Klonsky *et al*., 2003; Herpertz, 1995,

as cited in Klonsky *et al.*, 2003; Stanley *et al.*, 2001); tension and anxiety (Andover, Pepper, Ryabchenko, Orrico & Gibbs, 2005, as cited in Mangall & Yurkovich, 2008; Brain, Haines & Williams, 1998, as cited in Klonsky *et al.*, 2003; Briere & Gil, 1998, as cited in Klonsky *et al.*, 2003; Klonsky *et al.*, 2003; Marshall & Yazdani, 1999; Sachsse, von der Heyde & Huether, 2002 as cited in Mangall & Yurkovich, 2008; Wildman *et al.*, 2004); hostility and impulsivity (Herpertz, Sass & Favazza, 1997, as cited in Mangall & Yurkovich, 2008; Ross & Heath, 2003, as cited in Mangall & Yurkovich, 2008; Jacobs, 2005); and disassociation, derealisation and depersonalisation (Hall Ray, 2007; Mangall & Yurkovich, 2008); but there was little to no information regarding *why* an individual first resorts to self-harm, which depicts a curious absence in the literature (Levesque, 2010). The question raised is why particular individuals resort to self-harm, while others experiencing similar emotions or those with similar experiences do not do so. This will be explored further in Section 2.5.

2.4.2   After the act of self-harm

As discussed above, self-harmers often report finding relief from overwhelming emotions, such as anger or anxiety, after an act of self-harm (Heath, Toste, Nedecheva & Charlebois, 2008). As Mangall and Yurkovich (2008) report, neurobiological evidence has suggested that self-harm provides a *physical* release of tension and therefore may be a physiologically effective coping mechanism against a build up of stress. Sachsse *et al.* (2002, as cited in Mangall & Yurkovich, 2008) found that a self-harming woman's cortisol levels were regulated through acts of self-harm – which suggested proof to the claim that self-harm helps reduce levels of stress. This physical effect may form part of the reason why self-harm is an addictive behaviour, as discussed in Section 2.2.8. In addition to relieving anxiety, self-harm is also associated with reducing other negative emotions such as anger, frustration and guilt (Young *et al.*, 2006).

2.4.3   'Quitting'

Sinclair and Green (2005) found that the resolution of adolescent distress and an increased sense of control over their lives was one key factor in assisting self-harmers to stop self-harming. Participants described their life at the time as "chaotic" and their emotional experiences as invalidated by a lack of communication or as being treated as "unimportant" (Sinclair & Green, 2005, p. 1112). Two other key factors they identified in the resolution of

self-harming behaviour were the recognition of alcohol as a key factor in maintaining self-harming behaviour (resulting in future abstinence from alcohol), and receiving psychological treatment for depression, resulting in a reduced need for self-harm as a coping mechanism. Young *et al*. (2007) confirmed these findings and also found that the most common reason for 'quitting' was cited as recognition of the futility of self-harm, as well as a realisation of how much it hurt others. Additionally, in some cases the self-harm was just a 'phase' which individuals outgrew once they developed better coping strategies. This was confirmed by Whitlock *et al*. (2006), who found that 80% of self-harmers quit within five years of initiating self-harming behaviours. However, studies have indicated that negative emotions remain higher in self-harmers than in non-self-harmers, even after the discontinuation of self-harm, and suicide risk levels remain elevated for life (Brown *et al.*, 2007). Young *et al*. (2007) found the *least* commonly used explanation for 'quitting' was receiving outside help from professionals or friends.

2.5 The contagiousness of self-harm

Self-harm is increasingly recognised as a highly communicable phenomenon. This phenomenon was defined by Walsh and Rosen (1988, p. 79) as "a sequence in which one individual inflicts self-injury and then others in the immediate environment imitate the behaviour". Imitation may be the result of peer modelling, due to a witnessed reduction in stress, attention from others, or a reported lack of pain, which may result in an inclination to experiment with self-harming behaviour (Walsh & Rosen, 1988). Peer hierarchies may also play a role in encouraging the 'spread' of self-harm. The 'contagiousness' of self-harm has been well established in institutional settings (Matthews, 1968; Menninger, 1935; Ross & McKay, 1979; all as cited in Hall Ray, 2007). In these contexts self-harming behaviour has served certain objectives, such as coping with institutional life, manipulation of institution authorities, competition (proving who is the 'most unhappy' or 'most authentic' self-harmer), or as a means of reinforcing group identity (Hall Ray, 2007).

While its 'contagiousness' has been a well established phenomenon in institutional settings such as psychiatric homes and prisons (Rosen *et al.*, 1990; Ross & McKay, 1979, both as cited in Hall Ray, 2007; Walsh & Rosen, 1988), few authors have sought to explain this aspect of self-harm in non-institutionalised settings, despite an increasing recognition that

self-harm contagion may also be in action among non-institutionalised self-harmers. In some cases where the contagion effect has been observed, an individual will 'set off' a series of self-harming episodes among several others. However research (such as De Leo & Heller, 2004; Hawton & James, 2005) has also suggested that simply knowing a self-harmer increases one's likelihood of becoming a self-harmer, suggesting that self-harm contagion may occur on an individual basis and not just in 'epidemic' proportions. Sufficient explanations of the mechanisms and reasons for this phenomenon have yet to be made, and very few studies have considered non-institutionalised settings.

Two studies were found that looked specifically at self-harm contagion in terms of an 'epidemic'. The first was that of Fennig, Carlson and Fennig (1995, as cited in Hall Ray, 2007), who analysed a non-institutional context of self-harm contagion, namely an outbreak of self-harm in a junior high school in the United States of America. They found that the majority of adolescents engaging in self-harm in this instance were "socially popular, excelled academically and did not exhibit overt symptoms of psychological disturbance" (as cited in Hall Ray, 2007, p. 35). The 'leaders/initiators' of the self-harming behaviour were found to exhibit greater levels of anxiety and depression and exerted an influence over their peers. The second study, conducted on the internet as a potential source of contagion, found over 400 pages pertaining to self-harm (Whitlock, Powers & Eckenrode, 2006, as cited in Hall Ray, 2007). While it was found that these websites offer support for marginalised self-harmers, they also provide an opportunity for negative influence from others. The authors suggest that these websites, as well as the way self-harm is dealt with in the media, may normalise self-harming behaviour, which results in increased rates of experimentation.

Several studies were also found that dealt with self-harm contagion on an individual level, albeit only briefly. These included Young *et al*. (2006) who, in an attempt to explain their finding of a high correlation between Goth subculture and self-harm, suggested that peer modelling and/or selection may play a role in this high prevalence rate (See Section 2.2.4.2). Hawton and James (2005, p. 892) briefly mention that "knowing others who self-harm may be an important factor". De Leo and Heller (2004, p. 142) found that "exposure to self-harm in family and in friends" had the strongest association with self-harm. Laloë's (2004)

comparative study on patterns in self-burning suggested that a copycat phenomenon may exist (Laloë, 2004).

As there is a limited amount of information available on the 'contagiousness' of self-harm, it may be useful to consider the literature available on the 'contagiousness' of suicide, which is more extensive. As discussed above in Section 2.2.7.3, the relationship between self-harm and suicidal behaviour is complex, although it appears some form of relationship does exist. Thus it may be useful to consult the available literature on suicide contagion to inform our understanding on the question of contagion in self-harming behaviour.

2.5.1   Suicide contagion

The concept of suicide contagion is rooted in epidemiology and behavioural psychology (Maris *et al.*, 2000). It refers to a phenomenon where suicide appears to be 'contagious', in that there is a stimulus suicide, followed by further suicides and attempted suicides in apparent imitation, in amounts higher than the 'normal' suicide rate (Maris *et al.*, 2000). Suicide contagion is also referred to as suicide modelling or suicide imitation (Maris *et al.*, 2000). Where three or more suicides take place in a restricted physical locality (such as small communities, schools or family units), and within a brief period of time, this is known as suicide clustering (Agerbo, Qin & Mortensen, 2006; Gould, Wallenstein, Kleinman, O'Carroll & Mercy, 1990; Qin *et al.*, 2003; Wilkie, Macdonald & Hildahl, 1998). The rate of suicide clusters is reportedly 2 – 4 times more frequent in adolescents and young adults, with reduced rates in individuals of 24 years and upwards (Gould *et al*., 1990; Wilkie *et al*., 1998). It has also been observed that the greater the overlap in similarities between the "copying individual and the stimulus suicide" (Wilkie *et al*., 1998, p. 827), or the "greater the stimulus or the longer the exposure to the stimulus", the more likely that copying of the behaviour will occur (Maris *et al.*, 2000, p. 254). This would suggest that the more intimate the relationship between the stimulus and the copying individual (for example family member or friend), the more likely that copying will take place. It has also been observed that the more praise or glorification the original stimulus suicide receives from the community, the more likely the behaviour will be copied (Maris *et al.*, 2000; Wilkie *et al*., 1998).

Joiner (1999, p. 89), however, argues that contagion has "not been conceptually well-developed nor empirically well-supported as an explanation for suicide clusters". Instead, Joiner (1999) suggests that individuals predisposed to suicidal behaviour may cluster prior to any suicide triggers, but once a trigger occurs (such as the suicide of a member of the cluster), the suicide risk for all members exponentially increases. Thus, there are two potential mechanisms suggested by the literature on suicide clusters to explain why clustering occurs, namely contagion (modelling/imitation), and selection.

2.5.2   Clustering, contagion and self-harm

The argument for suicide contagion as well as Joiner's (1999) findings on suicide clusters are similar to Young et al.'s (2006) postulation that self-harm contagion could be due to selection (which coincides with Joiner's argument); or due to peer modelling (the more traditional explanation of contagion). Hence, with regard to the literature on suicide contagion and the 'contagiousness' of self-harm, it would appear that two mechanisms may be active in the spread of self-destructive behaviour (including both self-harming and suicidal behaviours). The first mechanism, selection, could occur where individuals who are predisposed to self-destructive behaviour are attracted to each other, and naturally form social networks. Then, once one individual initiates self-destructive behaviour, the behaviour is more likely to spread from friend to friend in a seemingly contagious manner, due to this predisposition (Joiner 1999; Young et al., 2006). The second mechanism, peer modelling, could occur for normative reasons, where individuals copy or emulate such behaviour in order to maintain or demonstrate their membership to certain peer or subcultural groups (Young et al., 2006). Young et al. (2006) suggest that it is likely that both explanations could be applicable; however, this needs to be explored in greater detail to provide confirmation.

To provide conclusive evidence for these mechanisms is unfortunately beyond the scope of this study, which has been designed to be exploratory due to a lack of confirmatory evidence. What can be examined is the discourses self-harmers use in discussions about how they came to self-harm. An exploration of the use of these discourses may suggest evidence of these mechanisms, as discussed above, or alternative hypotheses could be postulated as a result. In considering the use of discourses, it is useful to consider the

'contagiousness' of self-harm from a social psychological perspective, to be discussed in
Section 4.1.

2.6 Chapter summary

A considerable volume of research is available about self-harm. However, there is a gap in
the literature concerning how individuals become self-harmers. Studies indicate that having
a friend or family member who self-harms is the strongest predictor of future self-harm, yet
none have sought to explain this in detail. The literature identifies two potential
mechanisms that may be involved in self-harm contagion, namely peer modelling and
selection. As very little is known about how individuals become self-harmers, participants'
accounts will be examined to see whether evidence may be found for either of these
contagion mechanisms.

It has been shown that medico-psychiatric discourses inform lay discourses which in turn
shape self-harmers' narratives. These discourses also shape and limit the types of behaviour
available to self-harmers. While medico-psychiatric discourses prohibit self-harm by
positioning it as a negative coping mechanism which is feminised, pathologised and
stigmatised; self-harming behaviour is also shaped by the discourses used by self-harmers,
which legitimise it as a coping mechanism providing a means of expressing anger or
psychological pain. Also in purported use are the 'victim' and 'villain' discourses (Morison,
2006), which justify the use of self-harm by either negating personal responsibility for the
behaviour through limiting power over the behaviour (victim discourse), or claiming agency
with resultant blame (villain discourse). These discourses may be drawn from by self-
harmers to justify and explain their behaviour. These legitimising discourses may also serve
to normalise and desensitise self-harm and "disinhibit" non-self-harmers, acting as an
encouragement to others to begin self-harming. As research suggests that the incidence
rate of self-harm is increasing, it is vital to seek to understand how and why this
phenomenon spreads. By considering the different discourses shaping self-harmer's talk
about how they became a self-harmer, it is hoped that light can be shed on self-harm.

Chapter 3: Aims and Rationale

The following gaps have been identified in the literature, as identified in Chapter 2:

- There is very little information on why and how an individual begins to self-harm. While a considerable amount of research has investigated self-harm, there has been a limited focus on how an individual becomes a self-harmer.

- While several authors have briefly mentioned that knowing a self-harmer may lead to an individual beginning to self-harm, this has not been explored in any detail. However, more research has been conducted on the effects of contagion and selection in cluster suicides, which can be drawn from in a consideration of contagion in self-harming individuals.

- Most research in this area takes a quantitative or a qualitative, interpretive, realist approach. A new trend in research on self-harm has been a discursive approach (such as in Ayerst, 2004; Cresswell, 2005; Groves, 2004; and Morison, 2006), which abandons an emphasis on individual focus and a reliance on external truths, and rather looks for the discourses surrounding self-harm, recognising that discourses shape the way we construct ourselves and our behaviour (Potter & Wetherell, 1987). This is still a relatively new approach as applied to the field of self-harm research.

For these reasons a social constructionist approach will be followed. The discourses participants use in talking about becoming a self-harmer and (more generally) their experiences as a self-harmer will be analysed using discourse analysis. Particular attention will be paid to see if medico-psychiatric discourses are drawn on, and also for the use of villain or victim discourses. As this particular area is under-researched, this project will essentially be exploratory.

3.1 Research questions

1 What are the discourses that self-harmers draw on in talking about self-harm (generally)?

2 How do these discourses shape the way self-harmers talk about their own self-harm?

3 How do self-harmers construct the telling of their first experience of self-harm?

4 Are there other self-harmers in their lives and how do participants position themselves in relation to these others?

Chapter 4: Methodology

4.1 Theoretical framework

This study was conducted within a social constructionist approach, and made use of discourse analysis to extract the underlying social discourses participants used in talking about becoming a self-harmer. According to Terre Blanche and Durrheim (1999, p. 152), in social constructionism all representations of reality

> *construct* particular versions of the world by providing a framework or system through which we can understand objects and practices, as well as understand who we are and what we should do in relation to these systems. The manner in which people engage with the world – for example what you can and can't do – is thus structured by the way in which the world is constructed. When we act, what we achieve is to *reproduce* the ruling discourses of our time and re-*enact* established relational patterns (original emphasis).

Social constructionism thus abandons an individualistic approach, and rather focuses on understanding how people's sense of themselves is "produced through talk", which is in turn mediated by social norms and rules (Potter & Wetherell, 1987, p. 102). As van der Riet (2008, p. 548) argues, human action is essentially social, and is shaped by social norms which constrain "what is imaginatively possible within a particular context". Social constructivists commonly rely on discourse analysis to unearth how these 'productions' are shaped by social discourses (Terre Blanche & Durrheim, 1999). Discourses are employed to achieve different effects, and analysis consists of determining what these effects *do* (Terre Blanche & Durrheim, 1999).

Discourse analysts argue that by analysing the use of language, one can "shed light on the creation and maintenance of social norms (and) the construction of personal and group identities" (Starks & Brown Trinidad, 2007, p. 1374). Discourse analysis was chosen as the method of analysis for this study for these reasons, and also because it offers a means of situating intensely personal experiences within the broader social context which invariably gives them shape (Morison, 2006). It aids in countering the individualising tendency of the medico-psychiatric discourses, and instead recognises the phenomenon of being a self-harmer as "irreducibly social; that is, structured and mediated by culturally shared systems of meaning and regulation" (Morison, 2006, p. 46). In this approach, emphasis is shifted away from discovering the individual's intentions behind a particular action, towards

understanding how an individual's action is embedded within a social context. An individual's actions are framed within social structures and conventions, which define how the individual is able to act and talk about these actions. As Doyal and Harris (1986, p. 80) argue:

> The conscious formulation of an intention to perform an action depends upon prior social existence of rules in terms of which actions have their justifications. You can only form an intention to do something that already makes sense to you as something that might be done.

Where a rule governing an action is broken, the action is disrobed of its meaning. The individual may be "stigmatised as irrational, as subject to weakness of will or to some other mental malady" (Rosenberg, 1988, p. 85). This stigma would act as the threat of punishment which guarantees individuals' adherence to social norms (Rosenberg, 1988). Where a rule is broken, individuals are called to account for it in order to defend themselves from the assumption of irrationality. As shown in the literature review, self-harm is marginalised and stigmatised, often viewed by non-self-harmers as lacking in meaning. In our modern Western medicalised society, self-harm is not discursively accepted as part of our lexicon of available actions, and as such is stigmatised. Yet, as described in the previous section, it is increasing in prevalence worldwide. This begs the question why and how self-harm would come to be seen as a behaviour that "makes sense to you as something that might be done" (Doyal & Harris, 1986, p. 80).

It would be highly unethical to study the first act of self harm via observation, so what is left to the researcher is the interview, whereby self-harmers can be requested to describe their first experience of self-harm. Due to the stigma attached to self-harm, it was anticipated that self-harmers would feel a need to account for their self-harming behaviour, through the use of varying discourses to establish themselves as rational and their acts of self-harm as meaningful. By examining these accounts using discourse analysis, this study aimed to explore social norms referred to by participants, examine how participants construct narratives about becoming a self-harmer, and how participants negotiate a meaningful, rational presentation of themselves in the interview. Doyal and Harris (1986) argue that an action comes to be included in an individual's lexicon of actions by learning from others. The authors argue that "you are not born with the ability to act – others have to teach you" (Doyal & Harris, 1986, p. 74). This notion of needing to be taught could be seen as a process

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of disinhibition towards behaviours not generally seen as acceptable, and is mirrored in the exploration of the 'contagiousness' of self-harm in Section 2.5 of the Literature Review. As stated there, this aspect of self-harm has been minimally investigated by researchers. Doyal and Harris's (1986) argument offers a means of understanding how contagion may work, as a means of understanding how an individual comes to self-harm in the first place. As such, self-harmers were invited to talk about other self-harmers they know in order to investigate how they discursively relate their own self-harm with that of others in the interview setting.

4.2 Research design

This research study was qualitative and exploratory and took a social constructionist approach. The topic of interest in this dissertation was exploring how individuals become self-harmers. It was recognised that observing an individual's behaviour in such a situation would be difficult, impractical and unethical; therefore a better means of accessing this data would be after the event occurs, via interviews or surveys. As little research has been conducted on this specific topic, it was decided that the best approach would be exploratory, conducted through interviews with self-harmers. As self-harm is discursively positioned as a dissident and manipulative behaviour, it was anticipated that in an interview situation, despite all interviewer's attempts to create an environment of acceptance and openness, participants would feel a need to *account* for their self-harming behaviour, in order to stave off potential or perceived accusations of dissidence and manipulation (Potter & Wetherell, 1987). Thus, discourse analysis was chosen as the most appropriate method of analysis for this research project, as it allows for an analysis of *how* participants do conversational work in an interview, rather than taking a realist approach to the data. Discourse analysis also allows participants to describe an intensely personal event (their first experience of self-harm) in a manner which explores how the "larger collective meaning systems" affect the organisation of the narration of these events (Morison, 2006, p. 44). Additionally, discourse analysis recognises the interviewer's role in generating data – it is recognised that the discourses and meanings in the interview are "co-constructed between the interviewer and interviewee", who are in turn part of a broader social system (Terre Blanche & Durrheim, 1999, p. 153).

4.3 Sampling

The target population was defined as individuals with a minimum of six months continual experience with direct self-harming behaviours, such as self-cutting, self-poisoning, or self-burning. It was decided to draw on non-institutionalised self-harmers, as there is less data available on these individuals. It was decided to draw on the student self-harming population at UKZN, for convenience, and also because there is a well-established and free means of psychological support readily available to students in the form of the Student Counselling Centre, which can provide participants with professional debriefing after their participation. This would assist in moderating the risk involved with participation in a study of this nature.

Careful attention was paid to sampling methods to ensure that this process was conducted in as ethical a manner as possible. The most ethically sound approach seemed to be to recruit participants from UKZN Student Counselling Centres, as participants would most likely be in counselling and thus risk would be reduced. However, in the recruitment protocol it was also provided that participants could be recruited via snowballing measures, or via advertisement on campus or on Groupwise. The Dean of Student Services was approached for permission to advertise on the premises of the Student Counselling Centres (See Appendix 1). The Dean referred the researcher to the Directors to decide on the issue. The Pietermaritzburg branch was approached first, and permission was given to recruit participants from the Centre (See Appendix 2). The Director suggested that rather than post flyers around the Centre, it would be more ethical to go through the counsellors themselves. It was suggested that the interview schedule and the consent forms could be sent to the counsellors, via the Director, who could then approach their self-harming clients directly. Clients who expressed interest in the study would then be referred to the researcher. In this way, the counsellors could ensure the participants were comfortable with issues to be covered in the interview schedule, and be debriefed properly after the interview took place. This seemed a very good idea, and as the Director seemed confident that several self-harmers were currently receiving treatment, the researcher was confident she would have enough participants for the study and consequently did not approach any of the other Centres. Unfortunately, this planning came to nought as there were no referrals

from the Centre. However, the researcher expresses gratitude to the Dean and especially to the Director for their availability, cooperation and support.

The two participants were unfortunately not recruited through these ethically secure channels, although their recruitment was in compliance with the ethical requirements as specified in the research protocol. Participant 1 was recruited via snowballing procedures – she had previously identified herself to the researcher as an ex-self-harmer, so the researcher approached her, informed her about the study, and asked if she would like to participate. Participant 2 overheard the researcher talking about her study to a fellow Psychology Masters student, and contacted the researcher later to volunteer for participation. While this situation was not ideal, other mechanisms (such as a take-away information form with contact information for therapeutic assistance and an anti-suicide contract– see Appendix 4 and 5) were in place to ensure the recruitment process was not unethical.

While it would have been ideal to have more participants in this study, the minimum desired number of participants was achieved. As this is a qualitative study focussing on an under-researched topic, the emphasis is exploratory, rather than aiming to establish predictive laws. As such, the aim was to explore discourses used by participants and recommend areas for future studies, and thus the number of participants is adequate.

4.4 Data collection

It was arranged, with permission from the Director of the Student Counselling Centre, to host the interviews in the Centre. This would assist participants in maintaining their anonymity in a confidential setting, and would also provide access to professional counsellors in an emergency situation. Participant 1 however, did not want to have the interview in the Centre, and preferred the total privacy of her home. Participant 2's interview was held in the Centre.

First, the participants and interviewer read through and signed the consent form for participation and consent to be audio recorded (See Appendix 3), as well as the anti-suicide contract (See Appendix 5), and participants were given a take-away information sheet

containing emergency contact details (See Appendix 4). Then the interviews were conducted, using a semi-structured interview schedule (See Appendix 6). The interview schedule contained open-ended questions, to provide selected routes of discussion without biasing participants' responses (Smith & Osborn, 2003). Gentle, non-threatening questions were used at the beginning to put participants at ease and build up a rapport (Kelly, 2006). Where necessary the interviewer asked clarifying questions to ascertain what meaning the participant intended to convey (Starks & Brown Trinidad, 2007). The interviewer regularly checked that participants were comfortable "with the level of exploration", and they were informed that participation is voluntary and that they could choose to not respond to certain questions or withdraw at any stage (Kelly, 2006, p. 295).

4.5 Data analysis

The interviews were transcribed in their entirety, using a simplified version of the Jefferson transcription code, as explained in Silverman (2005. See Appendix 7). The transcription included features such as pauses, laughs, elongated syllables or increased pitch which contribute as much to our understanding of "the meaning of the sentence as the words themselves" (Smith & Osborn, 2003, p. 64). By including these features, the validity and reliability of the analysis was enhanced, as will be discussed below in Section 4.6 (Silverman, 2005). Pseudonyms were given to the participants, as well as to anyone else to whom they referred to in detail. Discourse analysis was used to analyse the transcribed interview. Themes arising in the interview, as well as themes suggested by gaps in the literature and according to the research questions (refer to Section 3.1), were identified in the participants' accounts (Starks & Brown Trinidad, 2007). Once themed discourses were identified, the treatment of these themes were considered, to see to what effect these themes and discourses were employed (Terre Blanche & Durrheim, 1999). Attention was paid to *how* each participant positioned herself in relation to other self-harmers, her description of society's conception of self-harmers, and which discourses they used to describe themselves in the interview.

4.6 Validity, reliability and generalisibility

Qualitative research can be inherently subjective; therefore the researcher should aim to remain aware and explicit about his/her own role in shaping the analytic process (Starks &

Brown Trinidad, 2007). Silverman (2005) discusses how to achieve the benchmarks of validity, reliability and generalisibility in qualitative research.

4.6.1 Validity

Validity refers to the 'truthfulness' of the analysis – in other words, how accurately it reflects the social phenomenon it refers to and how credible our analysis of this phenomenon may be (Silverman, 2005). Silverman (2005) warns that one of the greatest threats to validity in qualitative research is the 'siren call' of anecdotalism. Anecdotalism refers to the use of few exemplary examples which may not be representative of the data as a whole, but nonetheless reflect the point the researcher is aiming to make (Silverman, 2005). To defend oneself against this call, Silverman recommends the use of the refutability principle[1]; comprehensive data treatment[2]; and deviant case analysis[3]. The researcher aimed to employ these three techniques in this study to improve the validity of the analysis and provide a more credible account.

4.6.2 Reliability

Reliability refers to the consistency with which data is dealt with, which in turn can increase the validity of the analysis. In qualitative analysis, Silverman (2005) argues, reliability may be achieved by using "detailed data presentations which make minimal inferences" (Silverman, 2005, p. 221). This requirement may be met by giving data extracts as opposed to summarising participant's meaning in the author's own words; including all of the interviewer's comments (including continuers) instead of just the interviewee's response; longer data extracts to give the reader the context of the quote; and inclusion of transcribed pauses, overlaps, false starts and so forth, to increase a reader's insight into the original conversation (Silverman, 2005). In this way, the reader may gain a deeper understanding of the context of the extract, and would thus be able to verify the analyst's interpretation. Hence in the analysis of this study, detailed extracts are provided in order to generate a more reliable and consistent analysis.

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[1] The refutability principle refers to the avoidance of "easy conclusions" and rather a focus on trying to disprove one's theory at every step of the research process (Silverman, 2005, p. 213).
[2] Comprehensive data treatment involves insuring that all aspects of the data are included in developing the analysis (Silverman, 2005).
[3] Deviant case analysis refers to the active search for, and investigation of, anomalies and deviant data so that the analysis covers all the data (Silverman, 2005).

4.6.3 Generalisibility

In quantitative research, the aim is to be able to "say something" about a sample that is representative of the population from which it is drawn, and this is achieved through statistically randomised sampling measures (Silverman, 2005). However, in qualitative approaches sampling is not randomised but rather purposive, to ensure participants have experienced the phenomenon of interest. This means that generalisibility is not strictly achievable for qualitative designs. Rather, it is recommended that qualitative researchers aim to make their analysis *transferable* (Silverman, 2005). In this study, it was aimed to provide transferable findings through the employment of discourse analytic techniques. As research participants are socially competent members of the self-harming population, the discourses they drew on enabled the researcher to explore larger phenomena, such as general discourses surrounding self-harm and of how individuals become self-harmers. In this way it was hoped to provide broader transferability.

4.7 Ethical considerations

The risk to benefit ratio for participants was high in this study, so at every stage of the interview process steps were taken to limit the potential risk to the participants (Wassenaar, 2006). These steps are outlined according to the guidelines in Wassenaar (2006) and Emanuel, Wendler, Killen and Grady (2004).

4.7.1 Social value

Research using discourse analysis to investigate self-harm is rare, and there was virtually no published research that this researcher could find on discourses around *becoming* a self-harmer; hence, by addressing these gaps in the literature the researcher aims to contribute to a new understanding of self-harm, and thus achieve some measure of social value (Emanuel *et al*., 2004). Additionally, Emanuel *et al*. (2004, p. 933) argue that to be ethical, the research should not "undermine the community's existing (health)care services". The researcher addressed this issue by co-ordinating with the Student Counselling Centre and promoting their services where possible to participants of the study.

4.7.2 Scientific validity

According to Emanuel *et al*. (2004), research should be scientifically valid in order to be ethical. In order for research to be considered valid, it needs to accurately reflect the phenomenon it investigates (Silverman, 2005). The researcher aimed to address this by following the guidelines as discussed in Section 4.6.1.

4.7.3 Fair selection of participants

According to Wassenaar (2006), the research should use participants that have been fairly selected. In other words, participants should reflect the target population (in this case, student self-harmers at UKZN), and should not be exploited or recruited merely as convenient. In this case, one participant volunteered, and the other was recruited via snowballing. Participation was completely voluntary, and participants were informed that they could remove themselves from the study at any stage of the research process.

4.7.4 Favourable risk to benefit ratio

Additionally, there should be a favourable risk to benefit ratio for participants (Wassenaar, 2006). As mentioned above, there is a high risk involved in this particular research project, as the topic is sensitive and the participants are vulnerable. Due to the sensitive nature of the topics to be covered, the researcher and the participants signed a Suicide Intervention Contract (See Appendix 5), so that if participants found they were becoming suicidal or distressed at any stage of the research process, or if the researcher became aware of plans to seriously endanger their health, an intervention could be made in order to protect them. It was planned that, where possible, participants already in counselling would be encouraged to schedule an appointment soon after the interview, so that they could be professionally debriefed by a counsellor with whom they had already established a relationship. However, while both participants had been in counselling in the past, they were not in counselling at the time of being interviewed. As a result, at the end of the interview they were reminded of the availability of this facility and were provided with the contact information of the Pietermaritzburg Student Counselling Centre, as well as with 24 hour emergency lines and the researcher's personal contact information. This information was provided on the take-away information cover sheet of their informed consent form (see Appendix 3 and 4). In addition, in order to greater reduce the risk of participation the

participants' names and the names of individuals they referred to were not mentioned in the recordings and pseudonyms were given in the analysis to protect their confidentiality (Wassenaar, 2006). Other potential identifying information such as degrees for which they are registered, year of study, area of residence, parents' occupations and so forth, were kept confidential.

4.7.5 Independent ethics review

This study was independently reviewed and approved by the UKZN HDSS Research Ethics Committee (see Appendix 8 and 10), as well as by an internal departmental committee to ensure that it was ethically sound (Emanuel *et al*., 2004).

4.7.6 Informed consent

Before the interview took place, the participants were informed of the scope of the interview as well as the fact that it would be audio-taped, and an informed consent form detailing that participation was confidential and voluntary, was explained to them and then signed (Wassenaar, 2006. See Appendix 3).

4.7.7 Respect for participants

In this study, particular care was taken to show acceptance and respect to the participants who, as discussed above, may feel strong fears of marginalisation and rejection. At all times, the researcher aimed to consciously treat participants with dignity and not like a 'mine' of information (Kvale & Brinkmann, 2009). Respect was also shown for the participants and the self-harming community they represent, by maintaining their confidentiality and ensuring participants were aware of their right to withdraw if they no longer wished to participate; and by providing participants with information on where they can seek psychological assistance after their participation, if they so wished (Emanuel *et al*., 2004). In terms of the data, electronic data will be stored in a protected file and hard copies of the transcripts will be stored in a locked cupboard for the statutory storage period (five years), after which they will be destroyed. Any identifying data (for example signatures on consent forms) will be stored separately to the interview data, so that they will not be linked in any way. Once the study is completed these too will be destroyed. The study itself will be stored in the UKZN library and will be available to the public.

The future public availability of the study results in the potential for self-identification by participants, if they read the final study. Participants may easily identify themselves, as there were only two participants in the study. As such, there is a risk that upon self-identification possible harm may arise through any disagreement with the author's analysis, or from fear that others may also recognise their identity. However, pseudonyms were used and personal information concerning the identity of the participants were generalised in order to protect their identities from third parties, so there is minimal risk of identification from third parties. Secondly, one could argue that to a certain degree, it is necessary to move beyond participants' understandings in order to produce good interpretive research. Kelly (1999) argues that in order to produce good research, one should not simply impose theoretical understandings on phenomena, nor simply reproduce phenomena uncritically. Rather, he recommends that one take a balanced approach between empathy towards participants (Geertz, 1975); and distanciation (Kelly, 1999). Kelly argues that *both* approaches are necessary: distanciation is vital in order to transcend the limited 'self-knowing' of participants, and *without* empathy, which gives us access to the "intricacies of the subjects' experience" (van der Riet, 2008, p. 549), it is "only our own voices speaking" (Kelly, 1994, p. 11). By balancing these two approaches, one can achieve a deeper understanding of one's data; however according to Kelly (1999, p. 403), these interpretations may "describe people's actions in ways which are unfamiliar to them or which even seem incorrect to them". This does not, however, negate the interpretation's legitimacy, so long as the researcher tries to "remain true to the voices of the researched" (Kelly, 1999, p. 403), according to the techniques discussed in Section 4.6.

As the study will be made public upon completion, there is little that can be done to prevent self-identification, should participants choose to read it. However, by ensuring that participants cannot be identified; by ensuring participants have ongoing access to psychological support services; and by treating participants and all data with respect and non-judgement throughout the data-generation and analytical process; it is hoped that this potential for harm has been reduced. This is on the assumption that harm would result from participants' perusal of the final study: it is also possible that participants may gain a deeper understanding of themselves and their self-harming behaviour. As part of an attitude of

ongoing respect which this researcher has aimed to maintain, there has been no desire to 'abduct' the research findings: participants are welcome to read the final study.

<u>**Chapter 5: Results and Discussion**</u>

In this chapter, the participants will be described and the pseudonyms ascribed to them will be briefly discussed. Secondly, the way that participants position self-harmers as a population, as well as their discussion of general discourses about self-harm, will be analysed. Thirdly, participants' description of their own self-harm, in relation to these general discourses, will be considered. Fourthly, participants' construction of their first experience with self-harm will be examined. Lastly, any reference made to other self-harmers in the interviews will be analysed, with particular attention paid to how participants position these individuals in relation to themselves. These sections were developed from the research questions, as discussed in Section 3.1.

5.1 Description of the participants and pseudonyms

Participant 1 will be referred to as Maggie. She is a 26 year old female student. She describes suffering from high levels of anxiety from childhood, and depression from adolescence. She describes herself as someone who used to engage in bulimic and self-cutting behaviours, but no longer engages in these behaviours. She reports that she has been diagnosed as Bipolar II by a psychologist, and is on medication for this diagnosis. She was recruited via snowballing techniques. Maggie discussed a friend who started self-harming before her – this friend will be referred to as Kate. Maggie also made reference to her mother, who began self-harming after learning about Maggie's self-harming behaviour.

Participant 2 will be referred to as Dana. She is a 23 year old female student. She described herself as having engaged in self-cutting and self-burning behaviours, but has not self-harmed for almost a year. She self-volunteered to participate after hearing about the study via word of mouth. Dana refers to two friends repeatedly in the course of her interview. One friend seemed to play a role in promoting or affirming Dana's self-harming behaviour, and will be referred to as Sarah. Sarah began self-harming after she found out that Dana self-harmed. Dana also refers to another friend, who was described as offering her support and being a positive influence. This friend will be referred to as Tracy. Dana also referred to another two individuals, who were not given pseudonyms: two high school friends who were self-harming before Dana began self-harming.

5.2 General discourses about self-harm

In talking about self-harm in general, Maggie and Dana both assert that self-harmers are generally misunderstood by society; that they are stigmatised and positioned as attention-seeking; and that self-harmers and their privacy should be treated with respect. They refer to the medico-psychiatric discourses which position self-harmers as pathologised and manipulative, but argue the legitimacy of these discourses when applied to self-harmers in general.

5.2.1 Extract 1: Maggie: Attention-seeking versus "multiplicity of reasons"

1	Interviewer:	So you've met people since that are, that also hurt themselves in some kind
2		of a way?
3	Maggie:	Yeah
4	Interviewer:	Okay and (.) can you tell me a little more about that?
5	...	
6	Maggie:	It's amazing how we can all be doing the same sort of thing (.) but (.) there's
7		this vast multiplicity of reasons for why people do it
8	Interviewer:	Mhm
9	Maggie:	And yet people <u>assu</u>me (.) that (.) >everybody does it< (.) for one reason (.)
10		and they tend to (.) bla::nket (.) self-harm with this (.) sort of (.) one
11		assumption
12	Interviewer:	Yeah
13	Maggie:	(.) attention-seeking
14	...	
15	Interviewer:	Do you think that's just how self-harmers are seen by (.) like, non-harming
16		people (.) like hhh (.) I mean, do you think it's changing at all or do you think
17		that people still see it as like an attention-seeking?
18	Maggie:	I really feel like (.) look I THINK that (.) um:: documentaries and programmes
19		on T.V. about it
20	Interviewer:	Mhm?
21	Maggie:	Do help to a certain extent↑ but there's just (.) <u>mass</u>ive ignorance about it
22		and I think that generally, people think that self-harmers are (.)
23		<u>melo</u>dramatic (.) and (.) attention-seeking
24	Interviewer:	Mhm?
25	Maggie:	Um::: I don't think that people understand (.) people who have depress↑ion
26		(.) people who self-<u>harm</u>↑ (.) people who are self-destructive
27	Interviewer:	Mhm?
28	Maggie:	Um::: (.) it's just (.) there's this massive incongruency between paradigms (.)
29		between those with the experience (.) and those without.
30	Interviewer:	Mhm. Do you think that's a thing that needs to be addressed?
31	Maggie:	Yea(h)h. In a big way. It's (.) it's <u>so</u> difficult to (.) speak between the
32		paradigms (.) and to break the stigma
33	Interviewer:	Mhm

Maggie establishes self-harmers as a diverse range of people, who rely on "the same thing" (self-harm, line 6) for a "multiplicity of reasons" (line 7). She refers to the discourse arising

from medico-psychiatric discourses that self-harmers are attention-seeking (line 9 – 13). This discourse of attention-seeking is positioned as being oppositional to self-harmers' real motives for self-harm (which can be diverse), and Maggie sets up this label of "attention-seeking" as being an oversimplification of the case. Maggie refers to two different "paradigms" (line 28) – those with experience of self-harm (and thus, she insinuates, understanding and insight into self-harming behaviour), and those without experience of self-harm (who she describes as having "massive ignorance" about it; line 21, and who "generally" think of self-harmers as "melodramatic and attention-seeking"; line 22 – 23). She sets up these paradigms as being massively incongruent (line 28) to each other, with no way to enable each side to understand the other (line 31 – 32). In this way, Maggie discursively establishes self-harm as something that cannot be truly understood from the 'outside'. Maggie continues this distinction between self-harmers and non-self-harmers in the following extract:

5.2.2 Extract 2: Maggie: Self-harmers as 'other' people

1	Maggie:	Y'know, people who self-harm <u>don't</u> <u>do</u> it because (.) they think it's <u>cool</u>. Or
2		they think y'know, it's going to help them get <u>laid</u>.
3	Interviewer:	Ye(h)ah(h)
4	Maggie:	Y'know? They do it because they genuinely have a problem
5	Interviewer:	Mhm
6	Maggie:	Y'know?
7	Interviewer:	Yeah
8	Maggie:	And they <u>need</u> (.) to be (.) treated as such.
9	Interviewer:	Do you think- like how- like in an ideal world, how do you think, they should,
10		like a self-harmer, just, generally speaking, how should they be (.) received
11		then by (.) non-harming people? Like how, ideally, how do you think would
12		be the best way to treat them?
13	Maggie:	Well with more respect.
14	Interviewer:	Okay
15	Maggie:	Y'know? Um::: listening to them, for one thing, would be a good start.
16		Instead of just making assumptions about them.
17	Interviewer:	Mhm?
18	Maggie:	Y'know? Um::: (.) hhh I think that's the main problem I have with it, is just
19		the assumptions that are made.
20	Interviewer:	Yeah
21	Maggie:	But
22	(.)	
23	Maggie:	I dunno, it's just (.) like when you, you see pictures of, of girls (.) with, with
24		scars
25	Interviewer:	Uhuh?
26	Maggie:	(.) y'know? Um: and then it's obvious that she used to self-harm, or does
27		self-harm

28	Interviewer:	Yeah?
29	Maggie:	A::nd (.) y'know people, people think "Oo, y'know, she should cover that" (.)
30		or (.) "she must have <u>issues</u>"
31	Interviewer:	Mhm?
32	Maggie:	Y'know?
33	Interviewer:	Yeah
34	Maggie:	"She must have issues"? >Of course she has issues<! °<u>Everyone</u>° has issues!
35	Interviewer:	Heh heh
36	Maggie:	And those issues are her <u>private</u> issues.
37	Interviewer:	Mhm
38	Maggie:	Y'know? (.) I think that this, this, I think a lack of, of (.) automatic (.) judging
39		(.) would be, would be a good start.

Maggie uses the phrase "y'know" repeatedly in this extract (for example in lines 1, 2, 4, 6, 15, 18, 26, 29, 32, and 38), which suggests she is seeking for approval and/or reassurance from the interviewer that she is being heard and understood. The use of humour in lines 1 – 2 positions the use of self-harm for personal gain (such as to be 'cool' or to attract sexual partners) as ludicrous, thus working against the discourse of self-harm as being meaningless and manipulative or attention-seeking. Maggie talks in the third person throughout this extract (except in line 18 – 19, where she refers directly to her own opinion), and she talks with energy and enthusiasm, as if she is championing the rights of self-harmers. However, instead of saying she personally has a problem; Maggie says "*they* do it because *they* genuinely have a problem" (line 4, emphasis added). Instead of saying *she* deserves to be listened to and treated with respect, she states that "listening to *them*, for one thing, would be a good start. Instead of just making assumptions about *them*" (line 15 – 16, emphasis added). Referring to other self-harmers in this way allows her to distance herself from this experience of being judged or treated with disrespect, presenting it as if this has never happened to her. This distanciation allows her to express views on the topic without being personally implicated in any of these experiences.

"Problems" (line 4) and "issues" (line 34) are described by Maggie to be the root of self-harmers' behaviours. This locates the 'source' of self-harming behaviour within oneself, but out of the individuals' control. Locating the issue in this way is reminiscent of Morison's 'victim' discourse (2006), where self-harmers are positioned as not blame-worthy and powerless over their behaviour. This discourse arose from medico-psychiatric discourses (as discussed in the literature review), and is reflected in Maggie's use of the words "problem" and "issues" to refer to underlying psychopathology in self-harmers. Thus, while she relies

on medico-psychiatric discourses to explain *why* individuals self-harm (psychological problems), she also discursively denies this discourse in relation to its assumption that self-harmers are manipulative attention-seekers.

5.2.3 Extract 3: Dana: Self-harmers as 'other' people

1	Interviewer:	Okay (.) um:: (.) did your, did your thoughts or attitude to self-harm change
2		over time, like as you began to do it more and more?
3	Dana:	Um:::
4	Interviewer:	Like how you thought about it?
5	Dana:	At the beginning I sort of went when I thought it wasn't serious I:: (.) I would
6		think of self-harmers as "other people"
7	Interviewer:	Okay
8	Dana:	Um:: and in a WAY I STILL do↑
9	Interviewer:	Mhm?
10	Dana:	In a way I still don't view myself as like (.) the <u>same</u> y'know
11	Interviewer:	[Yeah]
12	Dana:	[I know] that it's (.) yeah I know it's weird so::: but then if I think about it
13		seriously I think I'm doing the same sort of thing s- and, and that so::: I mean
14		over time (.) from the <u>beginning</u> I knew that it's not effective
15	Interviewer:	Mmm
16	Dana:	Um:: and I still do but at the same time like you just, well I feel I reach a
17		point sometimes where even though you <u>know</u> it seems like the sort of, only
18		option

Dana also sets up a distinction between other self-harmers and herself, as Maggie does, but Dana expresses this more explicitly. Dana states that when she began to self-harm, she "would think of self-harmers as 'other people'" (Line 5 – 6), and then adds "and in a way I still do" (line 8). In other words, Dana positions herself as something 'other' or different to other self-harmers. Her views on how self-harmers are perceived (which will explain this 'othering' of herself from self-harmers) will be discussed in the next extract. Before the interviewer can respond, Dana adds "yeah I know it's weird" (line 12) that she feels like she is not a self-harmer, as she is "doing the same sort of thing" (line 13), which may have been stated to pre-empt the interviewer from making a similar assumption. She immediately adds that "from the beginning I knew that it's not effective" (line 13 – 14). This assertion that she knew self-harm to be an ineffective coping mechanism, is offered perhaps to justify why she sees herself as different to other self-harmers: she *knows* 'better'. In line 16 – 18, Dana justifies why she would continue being a self-harmer even though she claims that she knows better: "I still do (know better) but at the same time like you just, well I feel I reach a point sometimes where even though you know it seems like the sort of, only option". In other words, Dana describes feeling like she has no other option, despite 'knowing better'. This

discursive device is again reminiscent of Morison's (2006) victim discourse, where the participant defers responsibility or blame to sources outside of herself, but in return restricts her own autonomy or power in the situation.

5.2.4   Extract 4: Dana: Self-harmers as attention-seekers and abnormal

1	Interviewer:	Um:: how do you think – you sort of said you didn't want to be seen as like a
2		self-harmer
3	Dana:	Yeah
4	Interviewer:	How do you think self-harmers are generally seen by other people?
5	(.)	
6	Dana:	Um:: (.) as hhh (.) attention seekers↑
7	Interviewer:	Okay
8	Dana:	Um:: as ab<u>norm</u>al=
9	Interviewer:	=Yeah=
10	Dana:	=>Which I know it's< an abnormal behaviour as such, but as ab<u>norm</u>al (.)
11		um:: it goes with the whole "emo" vibe =
12	Interviewer:	=Mhm
13	Dana:	Like (.) y'know dark make-up, dark clothes, like whatever (.) "hate my life"
14		type thing
15	Interviewer:	Yeah
16	Dana:	Um:: so YEAH by outsiders I think they're seen mainly as attention seekers
17		that's what I worried about as well why I wouldn't want people to know
18		because I'd feel like they would think it's just a form of (.) y'know seeking
19		attention
20	Interviewer:	Okay

The interviewer recalls that Dana does not wish to be seen as a self-harmer, and asks her how she thinks self-harmers are seen by society (line 1 – 4). This amounts to asking Dana why she does not want to be seen as a self-harmer. Dana states that she thinks self-harmers are seen as attention-seeking (line 6) and as abnormal (line 8). Dana had earlier defined self-harm as an abnormal behaviour ("basically <u>ab</u>normal sort of behaviours", and included examples such as "excessive nail-biting", "excessive piercings", "head-bashing", as well as self-cutting and self-burning), suggesting that self-harming behaviours are strange and not socially acceptable. In this extract, Dana clarifies that while she thinks the behaviours are abnormal, she does not think self-harmers are abnormal, although she feels society does. In other words she believes society 'others' self-harmers by seeing them as 'not normal' (line 8 and 10). Dana also refers to self-harm's discursive connection to the 'emo' subculture, which she defines as "dark make-up, dark clothes, like whatever, 'hate my life' type thing" (line 13 – 14). She re-iterates that she feels self-harm is seen as attention-seeking in lines 16 – 19, referring to the medico-psychiatric discourse of attention-seeking, which denies self-harm of meaning. Dana reveals in this extract that it is a fear of people knowing she is a self-

harmer and thinking that she is 'merely' doing it for attention that has motivated her to keep it a secret. To be seen as attention-seeking would deny any meaning or significance self-harm may have to Dana – it diminishes the act to something which tries to manipulate others (as discussed in the literature review). When Dana talks about the perception of self-harmers by society, she, like Maggie, presents the medico-psychiatric discourse that self-harmers are attention-seekers, but instead of arguing against its legitimacy as Maggie does, Dana presents her fear of being seen as 'one of them' – a manipulative self-harmer, as her motivation for seeing self-harmers as 'other' people. Dana refers to non-self-harmers as "outsiders" (line 16), which, like Maggie, positions them as unable to understand the self-harming experience from 'the outside'.

5.2.5 Extract 5: Dana: 'Take the log out of your own eye'

1	Interviewer:	Fantastic. Um::: (.) okay um:: (.) Just going back to y'know how self-harmers
2		are seen by other people
3	Dana:	Mm
4	Interviewer:	If there was anything (.) you could say to like change people's attitudes
5		towards self-harm, like what kind of (.) y'know, what [would] you say?
6	Dana:	[Hm:::]
7	(.)	
8	Dana:	Shjoe I don't know. Fi- firstly, it sounds horrible, but firstly I would say in a
9		way that it's not other people's business, like
10	Interviewer:	Mhm
11	Dana:	Um:: I think a lot of people (.) sit on the sidelines judging (.) the abnormal
12		behaviours that others are doing and in themselves like there's probably a
13		lot of behaviours and things that they're doing that are abnormal
14	Interviewer:	Yeah
15	Dana:	.hh So (.) I mean some people might go out and get horribly drunk or, or do
16		drugs and that's also, it's not effective, it's not an effective way of dealing
17		with something
18	Interviewer:	Yeah
19	Dana:	Um:: people y'know <drive fast or whatever> so::
20	Interviewer:	Mm
21	Dana:	It's another sort of method and it's just maybe because it's more visible that
22		people are, are, judge it more, as such.
23	Interviewer:	Mhm
24	Dana:	So yeah (.) I'd say like (.) °I don't know° (.) but yeah basically that I think that
25		people need to look at themselves as well and look at like the behaviours
26		that they're involving themselves in and see whether they're able, in a
27		position to be able to judge as such
28	Interviewer:	Okay

Dana, when asked what she'd change about society's perception of self-harm, gives a similar response to Maggie (in Extract 2): she expresses the desire for more tolerance and acceptance from non-self-harmers. Maggie sets up self-harm as due to psychopathological

issues which are personal and private, and therefore should be treated with a respect for the individual's privacy, and also emphasises the fact that "everyone has issues" (line 34, extract 2). Dana states that most people rely on ineffective, harmful behaviours to deal with problems (line 11 – 13), and gives examples of some of these behaviours (line 15 – 17, line 19). Dana argues that because of this, people should 'take the log out of their own eye before looking for the splinter in someone else's'. Both participants refer to self-harm as something that is private, and suggest that, even if visible, should be respected as a private issue.

5.2.6 Summary

Participants present self-harmers as 'othered' by non-self-harmers: in other words, participants present society as discursively setting up self-harmers as 'the other' – as completely different to non-self-harmers, and, therefore, misunderstood and stigmatised. However, somewhat surprisingly, self-harmers are also implicitly (in Maggie's case) and explicitly (in Dana's case) 'othered' by the participants, in comparison to themselves. Even while 'championing' the cause of self-harmers in general, and arguing for more tolerance and acceptance, self-harmers are presented as "they", instead of 'we': neither participant identifies themselves with the general self-harming population. Both participants refer to victim discourses (Morison, 2006), where blame for self-harming behaviour is deferred, but power over their own situations and behaviour is limited. Both participants also refer to the discourse of self-harmers as attention-seekers, but while Maggie argues the legitimacy of this discourse, Dana presents it as an inevitable association with being a self-harmer, and that she therefore prefers not to think of herself as part of the self-harming population. Both participants also position all individuals, self-harmer and non-self-harmer alike, as having issues (Maggie) or unhealthy coping behaviours (Dana), and therefore that non-self-harmers should not feel they have the right to 'judge' self-harmers.

5.3 How general discourses shape self-harmers' personal accounts

Maggie and Dana both do discursive work to demonstrate that their self-harming behaviour was meaningful and served a purpose in their lives. This serves to justify what may otherwise be seen as an irrational behaviour, and enables participants to negotiate a meaningful, rational presentation of themselves in the interview (Rosenberg, 1988). Both

participants present self-harm as a coping mechanism, and referred to a 'victim' discourse (Morison, 2006), which allowed them to attribute meaning to their self-harm without being seen as socially undesirable. Both participants describe attending therapy briefly, and provide *unasked-for* reasons as to why they discontinued therapy. These reasons provide implicit acknowledgement of the medico-psychiatric norms that those who are ill should try to get better, and provide justification for why they did not attend therapy, assisting participants in maintaining 'face' in the interview (Potter & Wetherell, 1987).

5.3.1 Extract 6: Maggie: Constructing self-harm as meaningful

1	Maggie:	But (.) I sort of see self-abuse as >y'know< um self-harm
2	Interviewer:	Mhm
3	Maggie:	That kind of (.) <u>dis</u>respect (.) for oneself (.)
4	Interviewer:	Okay
5	Maggie:	Um are all expressions of (.) of <u>low</u> self-esteem (.) and (.) and de<u>pres</u>sion (.)
6		and they were all ((clears throat)) ways that I, I (.) um (.) allowed myself to (.)
7		to vent (.)
8	Interviewer:	Mhm
9	Maggie:	Those em<u>o</u>tions.
10	Interviewer:	Okay. Did you feel like you couldn't talk, like express those emotions in any
11		other way?
12	(.)	
13	Maggie:	Ye:s↓ (.) I, I hhh especially when I was <u>you</u>↑nger, I, I didn't- but even when,
14		even when I got older, I didn't really under<u>stand</u> (.)
15	Interviewer:	Mhm?
16	Maggie:	(.) What (.) I was feeling (.)
17	Interviewer:	Okay?
18	Maggie:	And I didn't really understa::nd (.) how to <u>cope</u> with it
19	Interviewer:	Okay
20	Maggie:	It really was a crutch, it's a, it's a coping mechanism

Maggie describes her self-harming behaviours as "self-abuse" (line 1) – her self-harming behaviours (self-cutting, bulimia, and alcohol and drug abuse, described elsewhere) were a means of expressing "disrespect for oneself" (line 3). Maggie states that she experienced "low self-esteem and depression" (line 5) but could not identify them as such and lacked the skills to cope (line 14, 18). By positioning these experiences as outside of her understanding, they also become outside of her control. This is another utilisation of the victim discourse (Morison, 2006), providing a vehicle for Maggie to imbue her self-harm with meaning by limiting her agency and avoiding blame for the 'abnormality' of these behaviours. In this way, she presents her own self-harming behaviours similarly to how she presented the self-harm of others in general, as seen in Extract 2. Maggie describes her self-harm as

meaningful, as it provided a vehicle to physically express and gain relief from feelings she could not articulate – self-harm provided her with "a crutch... a coping mechanism" (line 20).

Self-harm is also meaningful for Maggie in another way. Maggie elsewhere describes herself as always being concerned with losing control: "massive obsession with control... Wanting to be able to control myself, wanting to be able to control my body, control my mind, force myself (.) <to be able to achei::ve> (.) anything". Maggie describes herself as a hostage to her own need for control, and in this light her self-harm becomes meaningful, as it gave her the opportunity to experiment with losing control in this one aspect of her life. This is apparent in line 6 – 9: "(her self-harming behaviours) were all... ways that I, I, um *allowed myself* to, to *vent*... those emotions" (emphasis added). Her self-harming behaviour was a private means of allowing herself to lose control by relieving these experiences of low self-esteem and depression without losing face in her personal life. In this way, she attributes meaning and legitimacy to her self-harming behaviour. This is further explained in Extract 7, where her self-harm is more explicitly described as dramatic and out of control:

5.3.2 Extract 7: Maggie: Self-harm as a vehicle for losing control

1	Maggie:	And I used to like (.) you know when kids cry:::, and they clench up
2	Interviewer:	Mm::
3	Maggie:	And they, they, and then they bang their heads against the wall like a
4		tantrum
5	Interviewer:	Yeah?
6	Maggie:	It was kind of like that, like I was throwing a tantrum (.)
7	Interviewer:	Mhm?
8	Maggie:	And then I'd grab like a big knife (.) heh HEH heh heh ah::: I feel so childish
9		now. Or I'd, I'd um:: (.) sometimes um:: grab a glass and smash a glass
10		against the wall
11	Interviewer:	Okay
12	Maggie:	Um:: (.) I think I enjoyed the violence of it
13	Interviewer:	Mhm

Maggie's description of her self-harming episodes further clarifies that self-harm was a way for her to experiment with losing control – the expression "like I was throwing a tantrum" (line 6) implies freedom from restrictive social norms, by evoking the image of a helpless child who is unable to verbally express how they are feeling and so resorts to violent, uncontrolled behaviour. In line 12, Maggie says: "I think I enjoyed the violence of it" – which again suggests that self-harm was a means of experimenting with losing control in private

without actually losing control, thus finding relief from the need to maintain control and normality in other arenas.

5.3.3 Extract 8: Maggie: Collusion with the attention-seeking discourse

1	Maggie:	I don't know if I've ever really thought it through so much that I know
2		exactly (.) what (.) I thought it did for me
3	Interviewer:	Mhm?
4	Maggie:	At the time
5	(.)	
6	Interviewer:	That's okay
7	(.)	
8	Maggie:	All I know is that I had to (.) I had to get the food out
9	Interviewer:	Mhm?
10	Maggie:	And that when I did (.) it physically felt (.) <u>much</u> better (.) a::nd (.) I (.) felt
11		better about myself↑(.)
12	Interviewer:	Mhm?
13	Maggie:	But I also felt bad about myself (.) but (.) I also couldn't stop doing it (.)
14	Interviewer:	Yeah
15	Maggie:	And when I cut myself
16	(.)	
17	Maggie:	I knew that I (.) I also, I felt better about myself (.) for doing it
18	Interviewer:	Mhm?
19	Maggie:	Because I knew that I:: (.) I should do it (.) but I also (.) felt bad for doing it
20	Interviewer:	Mhm? (.) can I ask you, well, what other words besides "bad" would you
21		use?
22	(.)	
23	Interviewer:	Like what kind of synonyms? Like bad as in guilty, or bad as in (.) not good
24		enough, or (.) yeah, what do you mean by bad exactly?
25	Maggie:	°Fair enough° UM::
26	(.)	
27	Maggie:	I think (.) we:::ll (.) When I cut myself I felt
28	(.)	
29	Maggie:	I think I felt kind of stupid (.)
30	Interviewer:	Yeah?
31	Maggie:	I felt like (.) heh heh yo(h)u know what I actually felt, I FELT (.) like, I felt like I
32		was over-reacting
33	Interviewer:	Oh okay
34	Maggie:	I felt <u>bad</u> because I felt (.) <u>weak</u>, I felt (.) that I:: (.) shouldn't need to do this
35		(.) I felt like I was o↑ver-reacting (.) I felt silly↑
36	Interviewer:	Yeah?
37	Maggie:	I felt that I should just suck it up
38	Interviewer:	Yeah?
39	Maggie:	A:nd (.) get on with my life a::nd be a normal person a::nd (.) just (.) y'know
40		be good at everything >and be fine<
41	Interviewer:	Okay
42	Maggie:	Yeah
43	Interviewer:	Yeah

In this extract, Maggie's description of how she felt when she engaged in self-harm is reminiscent of the 'attention-seeking' discourse, as described in the literature. In the beginning of the extract, Maggie is trying to describe what meaning self-cutting and bulimia had for her. By saying she was unaware of her motives (line 1 – 2), Maggie again refers to the victim discourse (Morison, 2006): she describes herself as being *reactive*, where the self-harm made her feel better, so she would engage in it, but it would also make her feel "bad" about herself afterwards (line 10 – 19). When asked for clarification about her use of the word 'bad', Maggie gives a deeper description of what she felt at the time, using phrases such as "felt like I was over-reacting" (line 31 – 32, 35); "I felt weak" (line 34); "I felt silly" (line 35); "I felt that I should just suck it up" (line 37). This description demonstrates a collusion with the medico-psychiatric discourse of attention-seeking (*at that time of her life*), as it is described in the literature: that self-harm is a "childish call for attention" which "should be ignored" (Marshall & Yazdani, 1999, p. 422). This discourse de-legitimises self-harm, stripping it of meaning and increasing the blameworthiness of the self-harmer. By describing her attitude to her self-harm in this way, Maggie positions her self-harm as an illegitimate behaviour, lacking in meaning - which is how she describes viewing it at the time. This may be a reference to the 'villain' discourse (Morison, 2006), as Maggie describes blaming herself for being "weak" and "silly", although this extract does not demonstrate the sense of agency or power typical of the villain discourse.

This begs the question of why she would position self-harm in this way, where in the previously discussed extracts in sections 5.3.1 and 5.3.2, she established it as a meaningful behaviour, effectively discrediting the medico-psychiatric discourse which argues that self-harm is manipulative and empty of meaning. In effect, Maggie sets up a contrast between how she viewed her self-harm at the time (as something which she did not understand and had the power to make her feel both 'good' and 'bad'), with how she views it now (it served a purpose and helped her to cope with difficult emotional experiences). Maggie's use and rejection of the medico-psychiatric discourse suggests that it is firmly entrenched in her understanding of self-harm, which she positions as the discourse she must argue against in order to convey a meaningful understanding of her previous experiences to the interviewer.

5.3.4 Extract 9: Dana: Self-harm as a replacement coping strategy

1	Interviewer:	Okay (.) and um, in terms of your experiences, if you could give it like a
2		definition, how would you define self-harm?
3	(.)	
4	Dana:	Um::: (.) a sort of way of (.) dealing with (.) uncomfortable emotions.
5	Interviewer:	Okay (.) okay
6	Dana:	He he
7	Interviewer:	(.) Um:: what does self-harm mean to <u>you</u>?
8	(.)	
9	Dana:	Um:: sort of like I said, a way of (.) sort of dealing with emotions and (.) a
10		type of, maybe <u>escape</u>↑=
11	Interviewer:	=Mhm
12	Dana:	Um:: so:: (.) yeah, dealing with uncomfortable or heightened sort of
13		emotions or uncomfortable situations.
14	Interviewer:	Okay
15	Dana:	Yeah
16	Interviewer:	Um:: And what role did self-harm – or does (.) self-harm play in your life?
17	Dana:	<u>D(h)id</u>(h) at the moment.
18	Interviewer:	O(h)k(h)
19	Dana:	Um:: (.) yeah as a sort of rel<u>ease</u>↑
20	Interviewer:	Yeah?
21	Dana:	And um:: (.) a replacement fo:r (.) dealing effectively=
22	Interviewer:	=Mhm?
23	Dana:	So:: (.) a replacement for talking about things, or a replacement for sort of (.)
24		getting upset or getting, sort of like crying, or getting physically emotional,
25		like a sort of °replacement for that°
26	Interviewer:	Okay
27	Dana:	Yeah

Dana uses "maybe" and "sort of" to control how the interviewer hears her responses – this lessens or moderates the strength of her words, suggesting tentativeness. Examples of this may be found in line 4, 9, 10, 12, 19, and in 23 – 25. This effect is strengthened by the increase in pitch in "<u>escape</u>↑" (line 10) and "rel<u>ease</u>↑" (line 19). This may have served as a way of offering information, but in a way that she would not be held accountable for if perceived by the listener as 'wrong' or 'socially inappropriate'. Dana states that she used self-harm as an escape which enabled her to postpone dealing with difficult emotions. By positioning these emotions or situations as something she needs to escape from, Dana imbues them with power over her – she cannot deal with/overcome these except through self-harm. She is hence a victim of these emotions/situations – she is disempowered to deal with them more effectively. This is another example of the use of the victim discourse (Morison, 2006). In line 23 – 25, Dana describes using self-harm as a *replacement* for the expression of her emotions. She repeats the word "replacement" three times which emphasises her point: that self-harm provides an 'easier' alternative to dealing with these

emotions. This description of why she engaged in self-harm seems to imply an *aversion* to becoming emotional – she describes relying on self-harm rather than "crying" to ease the discomfort of difficult emotions or situations. Dana's description provides a rationalisation for why she used to engage in self-harm, which in turn imbues it with meaning.

This idea of escaping difficult emotions by engaging in self-harm is also expressed in Maggie's interview, as seen in Extract 10 below. Maggie is explaining why she defines self-harm broadly, to include excessive drinking and drug-taking as self-harming behaviours, along with the self-cutting and bulimia. She states that all of these behaviours served a similar purpose, which was to allow her to "escape" (line 1, 6) from overwhelming feelings of self-hatred and worthlessness (lines 2, 4).

5.3.5 Extract 10: Maggie: Self-harm as escape

1	Maggie:	Y'know it was (.) a similar kind of escape (.) from the feelings (.) and the kind
2		of, the kind of (.) <u>wallow</u>ing in this kind of <u>pit</u> of self-hate
3	Interviewer:	Mhm
4	Maggie:	And this feeling of worthlessness (.) and this oppressive depression
5	Interviewer:	Yeah
6	Maggie:	I think escape is a really good word

5.3.6 Psychotherapy

5.3.6.1 Extract 11: Maggie

1	Interviewer:	Okay (.) okay (.) and then you sort of mentioned earlier therapy and stuff,
2		have you ever been to therapy or was that like an option you'd consider or
3		something?
4	Maggie:	I DID go to therapy for a brief while↑
5	Interviewer:	Yeah?
6	Maggie:	I had um:: I had um quite a severe (.) depressive episode and (.) um::: (.) as I
7		was coming out of that I <started going to therapy> I went for (.) I thi↑nk I
8		went for about four sessions
9	Interviewer:	Okay
10	Maggie:	And it did, it did help
11	Interviewer:	Yeah
12	Maggie:	And then I, I kind of stopped going
13	Interviewer:	Mhm?
14	Maggie:	'Cause I::: (.) I don't know I just (.) I found it quite exhausting, and I ALSO felt
15		like I'd reached a point where I (.) I didn't really feel like I could (.) go any
16		further with the therapist
17	Interviewer:	Okay. Okay. Is it anything you would consider doing again in the future, or?
18	Maggie:	Yeah I ACTUALLY feel like I just needed to take a little bit of a longer break
19		between (.) um:: (.) sessions
20	Interviewer:	Yeah

21	Maggie:	I think to be honest actually I feel bad about using my parents' medical aid
22		fund to (.) to pay for the therapy sessions, so I'll probably go back, when I,
23		when I have a (.) steadier income of my own.
24	Interviewer:	O↑kay (.) cool. Um::: (.)

In this extract, Maggie describes attending therapy for four sessions, which she then discontinued. In the face of anticipated criticisms from the interviewer (despite none being actually offered) about not going, she offers various justifications for this decision. Each offering by Maggie is restricted, prompting frequents responses from the interviewer. Maggie's speech is generally characterised by frequent pauses. However, her explanation of how she came to attend and then discontinue therapy is punctuated with more pauses than usual, which suggests that this may have been an uncomfortable topic for her.

There is a social norm derived from the medico-psychiatric model that sick people are expected to try to get better (see literature review, section 2.3.1; Rayner & Warner, 2003). This norm is reflected in Maggie's assertion of the fact that the therapy "did, it did help" (line 10) which maintains the socially desirable image of someone who wants to get better. However, having admitted that she only went for four sessions, she offers justifications for why, if it was helping, she would stop going. Firstly, she states that she "found it quite exhausting" (line 14), which seems to seek sympathy from the interviewer. She offers an explanation in line 18 to 19, suggesting that in future she should schedule sessions further apart. Secondly, Maggie says that she "reached a point where I (.) I didn't really feel like I could (.) go any further with the therapist" (line 15 – 16). This offering places the blame with the therapist rather than with Maggie, although it is hesitantly presented as evidenced by the pauses in her speech. Thirdly, Maggie states that she felt guilty for dependency on her parents' medical aid for her sessions, and states that "I'll probably go back, when I, when I have a steadier income of my own" (line 22 – 23). This explanation is socially redeemable – she presents herself as the responsible and considerate daughter. These three reasons serve to normalise and rationalise Maggie's refusal to continue with therapy, which may have otherwise been seen as concerning or socially unacceptable in the context of her interview.

5.3.6.2 Extract 12: Dana

1	Interviewer:	Uhuh. Okay, let's go back to this thing ((gestures to interview schedule))
2		okay, have you ever trie::d um: therapy, [or]
3	Dana:	[Um] no:::. I've been to therapy but

4		not about that, I didn't tell
5	Interviewer:	Okay
6	Dana:	Tell them
7	Interviewer:	Okay
8	Dana:	Yeah um:: (.) my friend suggested that I should↑
9	Interviewer:	Mhm. Which friend was that, the one that=
10	Dana:	=No the other- there was another-

Extract 13: Dana

1	Dana:	[.hhh] So she suggested that I should talk about it when I went for therapy
2		but I:: (.) didn't heh heh yea::h
3	Interviewer:	Okay
4	Dana:	Yeah I, I didn't see the seriousness of bringing it up, I didn't know what it
5		would sort of (.) solve

Dana's friend, Tracy, is referred to in Extract 12 and 13. Tracy was present the last time Dana self-harmed, and is described as a positive role model. Tracy threatened to tell Dana's parents if she harmed again, and encouraged her to go for psychotherapy. Dana's expressed attitude towards therapy is different to Maggie's. Maggie justifies not going to therapy with a number of reasons, as described above, suggesting collusion with the medico-psychiatric discourse that therapy makes people better, and that 'normal' people *want* to get better when they are ill. Dana, on the other hand, is more dismissive about therapy. She states that she went to therapy but that she "didn't tell... them" about her self-harm, despite Tracy's encouragement to do so (line 8, Extract 12; line 1, Extract 13). Dana adds "but I:: (.) didn't heh heh yea::h" (line 2, Extract 13). The elongated "I", the pause, the laugh and the drawn out "yeah" suggest dismissiveness. However, on a limited response from the interviewer, Dana expands on her response by offering an explanation for not seeking help for her self-harm (line 4 – 5, Extract 13). She does two things with this statement: she minimises the importance or significance of her self-harming behaviour ("I didn't see the seriousness of bringing it up") and weakens the effect or validity of therapy ("I didn't know what it would... solve").

5.3.7   Summary

Maggie and Dana both do discursive work in the interview to establish their self-harm as meaningful and serving a purpose in their lives. Maggie described feeling "self-hatred", "worthlessness" and "oppressive depression" which she constructs as being outside of her ability to understand or control and thus relied on self-harm to moderate these feelings;

while Dana was more ambiguous, describing her feelings as "uncomfortable or heightened... emotions", and positions them as something she needed to escape from through the use of self-harm. By constructing emotions in this way, participants offered motivation for why they self-harmed. They positioned themselves as being controlled by these emotions and lacking the skills to deal with these emotions in a more 'normal', 'socially acceptable' manner. This explanation rationalises their self-harming behaviour, and shows participants' use of the 'victim' discourse (Morison, 2006). However while this discourse restricts the attribution of perceived blame, it also restricts any expression of power or autonomy over themselves.

Both participants have tried psychotherapy, and seemed to display a reluctance to engage in psychotherapy to assist them with resolving their self-harming behaviour. This could be seen as demonstrating treatment-resistance (see Section 2.2.10). However, to psychoanalyse the participants is beyond the ability and duty of this researcher: rather, one must focus on participants' use of language within the interview and the conversational effects they achieve thereby. By providing the interviewer with unasked for reasons for not going to psychotherapy, both participants are demonstrating acknowledgement of social pressure to seek healing when 'ill', whether psychologically or medically, in order to get better. By not seeking psychotherapy, the assumption could be made that Maggie and Dana *want* to remain ill – therefore both participants justify their choice not to engage in psychotherapy. Maggie explicitly justifies her decision to discontinue psychotherapy; while Dana minimises the effectiveness of psychotherapy and the seriousness of her self-harm, presenting it as unnecessary for her to seek counselling. These justifications are provided to preserve their self-presentation in the interview.

5.4 The construction of the first experience of self-harm

In describing their first experience with self-harm, participants position themselves as being both disempowered (without any other options to assist them in coping with difficult emotional experiences), and empowered (with the agency to choose a specific method of coping, namely self-harm). This sense of empowerment is diminished in their narratives however, through the simultaneous use of disempowering discourses, and also through

their description of self-harm as something which became addictive, removing any sense of control or agency they may have initially felt they had over it.

5.4.1 Extract 14: Maggie: One harm to fix another

1	Interviewer:	Okay (.) um I'd like to explore, like a little more, like the history of self-harm,
2		how, how long ago did you start, how old were you when you first started?
3	Maggie:	(.) I was (.) I was fifteen when I first started cutting myself
4	Interviewer:	Okay (.) and um you mentioned bulimia, did that also start round about the
5		same time?
6	Maggie:	Yes (.) [ya]
7	Interviewer:	[Ok] (.) um (.) what kind of led you to that point, where you first (.)
8	(.)	
9	Maggie:	hhhh It's difficult (.) I, I was about <u>thir</u>teen (.) twelve, thirteen, when
10		I first started restricting <my food intake>
11	Interviewer:	Okay
12	Maggie:	A:::nd (.) I used to exercise obsessively, I was very hard on myself (.) a::nd (.)
13		I was also (.) a:: an emotional eater
14	Interviewer:	Okay
15	Maggie:	Um:: (.) and then I think, with the onset of puberty (.) and the extra stress of
16		high school=
17	Interviewer:	=Mm:
18	Maggie:	And (.) I think also (.) puberty and stress (.) and you know (.) moving in
19		towards adulthood, um:: (.)
20	Interviewer:	It's a stressful time=
21	Maggie:	=Depression, ya, it, it just all exasperated everything
22	Interviewer:	Mhm
23	Maggie:	And I started um (.) binging (.) more (.) and um (.) the binging just (.) started
24		to really (.) aggravate me a lot
25	Interviewer:	Mhm=
26	Maggie:	=And I couldn't handle (.) the overeating, and then eventually I just (.) I don't
27		know why↓, I just one night I just (.) I just <u>purged</u>
28	Interviewer:	Okay
29	Maggie:	And then THAT I think, it was after (.) after I started purging that I started (.)
30		to cut myself because (.) I just <u>really</u>, really hated it
31	Interviewer:	Mhm (.) Hated the purging?
32	Maggie:	<u>Ya</u>
33	Interviewer:	Okay
34	Maggie:	I <u>really</u> did
35	Interviewer:	Was it something you could control or would it just be like a natural=
36	Maggie:	=No it was uncontrollable
37	Interviewer:	o-
38	Maggie:	Oh what the purg-=
39	Interviewer:	=the purging ya
40	Maggie:	I what do you mean, I'd <u>force</u> myself to purge
41	Interviewer:	Okay, okay, and then=
42	Maggie:	=And the:n (.) it was I reached the point where I was hhh (.) it's (.) BULIMIA's
43		a really <u>addictive</u> thing, I mean, I reached the point where I was, where I was
44		binging and purging up to like ten, fifteen times a day.
45	Interviewer:	Shjoe
46	Maggie:	AND (.) ya, this is the thing hhh um: (.) I was actually in quite a, quite a

47		dangerous situation
48	Interviewer:	Mm
49	Maggie:	And (.) and (.) I just I really was just <u>filled</u> with self-hatred and (.) I:: (.) ya (.) I,
50		I relieved that by, by the cutting.

Maggie provides justification for why she began to binge eat, which in turn led to purging, which led to the self-cutting because of how much she hated the binging (line 23 – 30). This description of the 'leading' of one form of self-harm to another is described as inexorable and inescapable, positioning it as something which she "hated" but which was out of her control (line 29 – 30). Maggie positions the binging and purging as being very "dangerous" (line 47), which contributed to an increasing sense of "self-hatred" (line 49) which she "relieved by... the cutting" (line 50). By positioning her self-harming behaviour in this way, it contributes to the image of herself, as constructed in the interview, as one who had no control or agency in the situation. This is seen by her positioning of her first experience with purging as something that "I just (.) I don't know why↓, I just one night I just (.) I just" did it (line 26 – 27). This way of positioning of her first experience is heightened by the repeated use of the word "just", suggesting a simplicity in the event – things 'just happened', and she is presented as having little choice over these events (lines 23, 26, 27, 30, 49). She evokes sympathy in the interviewer (as seen through the "shjoe", line 45), with the result that the interviewer takes a more passive role in this section of the interview. This is visible through an increase in the overlaps of speech, and also in the lines 35 – 41, where the interviewer tries to ask a question and Maggie re-assumes control of the conversation. Maggie describes this time emotively, negating any blame on her part – which is representative of the victim discourse (Morison, 2006).

5.4.2   Extract 15: Maggie: Claiming agency

1	Maggie:	Yeah so anyway the FIRST time I purged, I had, I had <u>emoti</u>onally eaten, I'd
2		<u>binged</u>
3	Interviewer:	yeah?
4	Maggie:	A:nd I'd (.) decided that I was going to try and purge (.) a::nd (.) because I
5		just wanted this out of me, I just couldn't stand the feeling, of feeling this
6		full=
7	Interviewer:	=Yeah
8	Maggie:	And feeling this dis<u>gust</u>ing
9	Interviewer:	Mhm?
10	Maggie:	And I just wanted to be empty
11	Interviewer:	Yeah?
12	Maggie:	A::nd (.) >it took a little while< and afterwards I was like (.) disgusted, but
13		like quite proud of myself

14	Interviewer:	Mhm?
15	Maggie:	Y'know? A:nd (.) I:: (.) >remember the first time I cut myself<
16	Interviewer:	Yeah?
17	Maggie:	I, I also (.) I like, I remember trying to cut myself (.) but not having pressed
18		hard enough
19	Interviewer:	Mm::
20	Maggie:	A:nd (.) um:: (.) similar to the purging, I didn't, like, kind of push my body
21		hard enough (.) same sort of thing (.) and then, kind of, just like going for it,
22		and then being like quite proud of myself also, going 'See? You can do it, you
23		can (.) do whatever you want to yourself'
24	Interviewer:	Yeah
25	Maggie:	Um:: (.)
26	Interviewer:	Was that again like a worry of failing, or?
27	Maggie:	YEAH, I think, I think that is probably what was working on, that kind of (.)
28		y'know (.) 'You can't just put, put the knife back, you can't turn around now,
29		it's' (.)
30	Interviewer:	Mhm?
31	Maggie:	'That's °la::me'°
32	(.)	
33	Interviewer:	Yeah=
34	Maggie:	=Y'know? (.) and then um:: and then being quite proud of myself, and then
35		just hhh (.) And then feeling (.) feeling a certain amount of relief because (.)
36		y'know seeing, seeing the blood
37	Interviewer:	Mhm?
38	Maggie:	Was quite (.) quite calming (.)
39	Interviewer:	Yeah
40	Maggie:	I think the adrenalin I'm sure (.) had, had a lot to do with it also
41	Interviewer:	The adrenalin, from the p- pain, or?
42	Maggie:	Yeah.
43	(.)	
44	Interviewer:	Okay
45	(.)	
46	Maggie:	A:nd (.) both times (.) set off a cycle
47	Interviewer:	Yeah
48	Maggie:	Of
49	(.)	
50	Interviewer:	Did it (.) like what, what would lead to the second time, and the third time,
51		was it (.) remembering that it felt good the first time, or (.) y'know what kind
52		of (.)
53	Maggie:	Ye::s (.) ya: (.) this is, this is the thing though (.) with both cutting and
54		purging is that (.) y'know (.) even though you know that it's not good for you
55		[and that]
56	Interviewer:	[mhm]
57	Maggie:	And that (.) purging is really bad, and it's quite disgusting↑ (.)
58	Interviewer:	Mhm
59	Maggie:	It feels really good (.) um:: (.) a::nd (.) it's this kind of, like with cutting (.)
60		especially (.) a↑nd with, yeah °purging, it's exactly the same°=
61	Interviewer:	=Mhm=
62	Maggie:	=You get like this build-up of negative feeling
63	Interviewer:	Yeah

Maggie, in her description of her first act of self-harm, describes having "binged" (line 2), leading to a feeling of being too full (line 5 – 6) and "disgusting" (line 8) and wanting "to be empty" (line 10). In another section of the interview, Maggie describes her self-harm as "an expression of, of just um:: (.) just too much going on and then it just helps me to (.) clear (.) clear the storm inside my head". Thus, she establishes the self-harm as providing a means of emptying herself, both physically and emotionally, when she is 'too full' (whether of food or difficult emotions). In both her first experience with purging and with self-cutting, Maggie describes making the decision to do it, and then persisting through the discomfort until she achieved it. She describes feeling "quite proud" (line 13, 22, 34) that she was able to "push [her] body hard enough" (line 20 – 21). She describes this pride as a feeling of "'you can do whatever you want to yourself'" (line 22 – 23). This invokes a sense of strength and of power – she has the strength and control over herself to make her body do anything – "even though you know that it's not good for you" (line 54) – which brings a sense of agency to her interview. This agency has been lacking in the discussion in her interview up until this point, with repeated references made to the 'victim' discourse (Morison, 2006). Additionally, by describing her pride as being grounded in a sense of "you can do whatever you want to yourself" (line 22 – 23), she conveys a freedom from social norms.

This conscious decision to harm herself, which actively goes against social norms, is reminiscent of the villain discourse (Morison, 2006). Grounded in the medico-psychiatric discourses, it allows self-harmers to claim agency over their self-harm while simultaneously rebelling against these social norms. This discourse does, however, expose the self-harmer to potential criticism for a behaviour they have apparent authority over. Maggie has positioned herself in most of her interview as being *without* agency until this point in the interview. Even here, this agency is limited: she describes knowing that self-cutting and bulimia is "not good for you" (line 54) and that it is "really bad, and it's quite disgusting" (line 57), but due to a "build-up of negative feeling" (line 62), Maggie feels she has no other resort than self-harm, which she positions as "quite calming" (line 38). Thus, while she describes feeling a sense of agency and empowerment in her first self-harming experience, this agency is limited, and is described as becoming more limited over time ("both times set off a cycle", line 46) as she became 'addicted' to it.

5.4.3 Extract 16: Dana: Self-harm as the 'path of least resistance'

1	Dana:	So:: (.) a replacement for talking about things, or a replacement for sort of (.)
2		getting upset or getting, sort of like crying, or getting physically emotional,
3		like a sort of °replacement for that°
4	Interviewer:	Okay
5	Dana:	Yeah
6	Interviewer:	And um: can you tell me <u>why</u> you sort of went with that over sort crying, or=
7	Dana:	=UM=
8	Interviewer:	=Or that sort of thing
9	Dana:	At the beginning I don't actually know. It just
10	Interviewer:	[Mhm]
11	Dana:	[Just] um:: just (.) yeah it just sort of happened (.) ah::: yeah I don't know it
12		just was like <u>at</u> that sort of moment I decided that's (.) the sort of way I
13		would deal and thereafter (.) um (.) it just seemed like the <easiest thing to
14		do>.
15	Interviewer:	Okay
16	Dana:	Yeah

Dana describes using self-harm as a "replacement" for expressing emotions physically (line 1 – 3). Self-harm is constructed as being the "easiest thing to do" (line 13) – rather than allow herself to cry or get upset (line 1 – 2), Dana would turn to self-harm to physically express difficult emotions in this way. Her description of her first act of self-harm is simultaneously disempowering *and* empowering. She describes it as something that "just sort of happened" (line 11) and she does not "actually know" why she chose self-harm over crying (line 9), which positions herself as being without agency in her first experience of self-harm. Additionally, Dana, like Maggie, repeats the word "just" in her description of her first self-harming experience (line 9, 11, 13), which adds to the sense that her agency was limited. However, Dana also describes her first act as a *conscious* decision – imbuing herself with the power to make that choice (line 11 – 12) to self-harm. Once the initial decision was made, however, self-harm became the "easiest thing to do" (line 13). This suggests that while she is constructed as having some agency initially, with the power to choose how she would deal with difficult emotions, this constructed agency is positioned as diminishing over time as she became more addicted to self-harm.

5.4.4 Extract 17: Dana: 'There was no other option'

1	Interviewer:	Okay (.) um::: (.) can you tell me the story of <u>how</u> you began to self-harm,
2		like what kind of led you:: (.) you said you didn't know but where there any=
3	Dana:	=Um:: yeah um:: at the beginning it was, I was sort of – I don't know if you
4		want the background story of=
5	Interviewer:	=That's up [to you]=
6	Dana:	[yea:h] um at the beginning it was actually (.) the same person
7		that I spoke of now (.) this guy had a girlfriend

8	Interviewer:	Mhm?
9	Dana:	And he really liked <u>me</u> though, so I was dealing with the, like <u>not</u> wanting to
10		for any, >and I also liked him as well<, so I was dealing with sort of not
11		wanting (.) the, the wrongness of the situation, the fact that he had a
12		girlfriend
13	Interviewer:	Yeah
14	Dana:	And then a <u>mutual</u> friend of ours (.) um:: (.) was sort of getting upset with
15		both of us, because she said what's happening is wrong, and I was trying to
16		explain that, y'know, <u>I wasn't doing</u> anything wrong and that sort of thing
17		and I just (.) I just <u>couldn't</u> handle it, I don't know why I just wa- we were
18		arguing about it, over SMS
19	Interviewer:	Mhm?
20	Dana:	And I just sort of (.) couldn't handle it and I (.)
21	Interviewer:	Yeah?
22	Dana:	And it just became (.) °the next sort of option↑°
23	Interviewer:	Okay
24	Dana:	Yeah
25	Interviewer:	Had you, had you ever heard of someone self-harming before you [started]?
26	Dana:	[yeah].

In this extract, Dana constructs the story of how she began to self-harm, drawing strongly on the 'victim' discourse (Morison, 2006). She positions herself as being in an inescapable, intolerable situation, and presents herself as powerless to change it (lines 7, 9, & 10). She describes feeling guilty – she was "dealing with sort of not wanting the wrongness of the situation" (line 10 – 11), and presents herself as lacking the agency to change the way they felt about one another or the fact that he had a girlfriend. Dana then describes having a fight with a mutual friend (Sarah), who blamed Dana for the situation, which further amplified the intolerableness of the situation and further lessened Dana's sense of agency, as constructed in the interview. She describes not being able to "handle it" (line 20) and self-harm "*just* became the next sort of option" (line 22, emphasis added). This construction of her first self-harming experience is lacking in agency, despite taking place moments after the conversation in extract 16. In extract 16, Dana states that "at that sort of moment I decided that's the sort of way I would deal", which implies she had some choice – there were other options available (line 12 – 13); although by stating that it "*just* sort of happened" (line 11, emphasis added, Extract 16), she limits the conscious awareness she may have had over this decision. In extract 17, she describes self-harm as "the next sort of option" (line 22), implying she had no other choice. This anomaly could be due to Dana wanting to present the best possible 'face' to the interviewer, by being understood but not blamed for her self-harm. By constructing the story of her first time in this way Dana

minimises any agency on her part, which removes any associated blame with making the decision to harm herself ('victim' discourse).

5.4.5 Extract 18: Dana: Worked up

1	Dana:	Um:: (.) <u>yeah</u> (.) <u>no::</u> (.) the (.) I mean, I don't mind details and stuff. The first
2		time it was just with a safety pin. So it was small, heh
3	Interviewer:	Yeah
4	Dana:	Um:: a:nd I mean not any less important, but it was <u>small</u>. And so (.) um:
5		yeah (.) that, I did that twice like sort of (.) in the first da:y and then (.)
6		thereafter it just escala(h)ted heh
7	Interviewer:	Okay
8	Dana:	Yeah
9	Interviewer:	Okay. And how did you:: like what kind of thoughts did you have before,
10		during [that time?]
11	Dana:	[um: I was] frustrated
12	Interviewer:	Yeah?
13	Dana:	And <u>irritated</u> (.) And I felt almost at a <u>loss</u>, like I didn't kno::w what else to, to
14		do↑
15	Interviewer:	Mhm?
16	Dana:	Um::: (.)
17	Interviewer:	Like helpless?
18	Dana:	Yeah. YEAH like helpless and almost- yeah just at a loss of like, like f- like I
19		say frustrated, like tired of (.) having to deal with it
20	Interviewer:	Mm. Yeah.
21	Dana:	Um:: and then afterwards though guilty heh.
22	Interviewer:	Okay
23	Dana:	Yeah
24	Interviewer:	Okay
25	Dana:	Yeah, like rea::lly guilty (.) and sort of (.) <u>disappointed</u>
26	Interviewer:	Okay (.) and then the next time it happened did you have similar kind of
27		feelings?
28	Dana:	Um:: The next time same well same sort of thing frustrated it was a friend of
29		mine, another friend of mine kept sort of, telling me that "I had changed so
30		much" and
31	Interviewer:	Mhm?
32	Dana:	"She didn't know me" and all of this stuff and I just got so worked up about
33		it=
34	Interviewer:	=Mhm=
35	Dana:	=That yeah the same thing, the frustration, the irritation, <u>worked</u> <u>up</u> is
36		mainly ((clears throat)) um:: and then (.) yeah guilty thereafter y(h)eah(h)
37		the same sort of pattern
38	Interviewer:	Okay (.) Yeah
39	Dana:	((clears throat))

Dana describes her first experience with self-harm as scratching herself with a safety pin (line 1 – 2). Dana positions this action as "small" (line 2), and then clarifies "I mean not any less important, but it was <u>small</u>" (line 4). She adds this caveat to reassure the interviewer that she is not diminishing the act's *significance*, but rather is trying to describe the amount

of damage, which was small. The conversational effect is the same however – being "small", it is positioned as 'not serious'. Belief that her self-harm is 'not that serious' enabled Dana to justify, as described in extract 3, that she was not like other self-harmers and hence undeserving of the stigma of attention-seeking. However, Dana describes self-harming twice on that first occasion (line 5), after which the behaviour increased in frequency and severity, indicating that it may have been more critical than she presents in the interview. Dana laughs as she says the word 'escalated', which diminishes its seriousness. This is a discursive technique she uses throughout the interview, whenever she presents something that could be taken as very serious or significant, for example: "the last time I did it (.) it was (.) like really ba(h)d a(h)nd s(h)o (.) it like bled for like a few days"; "I've also (.) burnt myself... um:: we can ge(h)t onto tha(h)t if you want"; "just sort of sh(h)ock(h)ed me into, like seriousness"; and so forth. The laughter within Dana's speech at these moments controls how the interviewer hears and responds to her, as it lessens the gravity of what she is saying.

Dana describes feeling "frustrated" (line 11), "irritated" (line 13), "at a loss" (line 13), "helpless" (line 18), and "tired of having to deal with it" (line 19) when she self-harmed for the first time, emotions which she summarises throughout the interview as "worked up". The use of "tired of having to deal with it" reaffirms what Dana said in extract 16: that self-harm was an easier option and could 'replace' coping with these emotions.

Dana also describes her second self-harming experience, similarly to her first experience. She describes a social situation where a friend was criticising her, which she found unbearable at the time. She describes feelings of "frustration", "irritation" and being "worked-up" (line 35 – 37). Both constructions of her first and second self-harming experiences position the source of the 'problem' as external, and thus beyond her power to change. This construction positions her as un-blameworthy, as she is presented without agency. Dana's narrative is conflicting, however, as she also presents herself as choosing to respond in this way, which does imbue her with a certain amount of agency. This confusion in her presentation may mean that she feels she had power over the behaviour initially, which she lost as she became addicted to the self-harm (which she discloses in another section of the interview). Or, it may mean that her strategies of presentation are in conflict

with each other: she may not want to be blamed for her behaviour, so she presents it as out of her control; but may still want to claim some sense of agency in her narrative which leads to inconsistency in her account. Whichever the case, it is interesting to note that this inconsistency occurs in both Dana's and Maggie's accounts.

5.4.6 Summary

Both participants use empowering and disempowering discourses in presenting their first experience with self-harm. Maggie's construction of how she began to self-harm focuses on intra-psychic reasons for her self-harm; whereas Dana refers to being in intolerable social situations which she feels disempowered to change. In other words, for Maggie the source of the problem is within herself, for Dana the source of the problem is outside of herself; but for both participants the problem is beyond their control. They presented themselves as initially having the agency to choose how they would respond to difficult situations in their lives, but simultaneously that they felt they had no other choice and described the self-harm as something that 'just' happened. This sense of disempowerment is increased as they describe becoming 'addicted' to self-harm, which further limits any initial descriptions of agency. This conflicting positioning of being empowered and disempowered may be motivated by a desire to present themselves as socially conforming (without blame for 'abnormal behaviour'), while still empowered to a certain degree (with a certain amount of agency in their lives).

5.5 Other self-harmers and their discursive positioning in relation to participants

Both participants described knowing a self-harmer before they started self-harming. For both participants, these individuals were close friends they had known in high school. Both participants also described an individual in whom they confided about their self-harm, who subsequently began self-harming themselves. Participants' discussion of these other individuals will be examined in the sections below, as well as their discursive positioning of these individuals in relationship to the participants themselves.

5.5.1 Knowing someone else before I start

5.5.1.1 Extract 19: Maggie: Best friend in high school

Extract 19 is a continuous extract, which will be analysed in segments.

1	Interviewer:	Um:: (.) okay (.) when um (.) you began to self-harm, back when you were a
2		teenager still, did you know anyone else who was doing it, was (.) were you
3		the only one that you knew (.) of?
4	Maggie:	No I did know people who were doing it
5	Interviewer:	Okay. The bulimia? Or the cutting as well?
6	Maggie:	No, <u>cut</u>ting
7	Interviewer:	Okay
8	Maggie:	Um:: I had a friend who (.) she was quite open about it though
9	Interviewer:	Mm::
10	Maggie:	And (.) hhhhhh she had this obsession (.) with a band
11	Interviewer:	OH
12	Maggie:	And (.) she (.) she cut the name of the band (.) into her arm (.)
13	Interviewer:	Okay
14	Maggie:	And (.) it was (.) .pt (.) >ya, so anyway< [heh heh]
15	Interviewer:	[heh heh]
16	Maggie:	We, we um:: but we're very close um:: (.) she was having problems with her
17		mo:m (.) she also had problems with her self-esteem and (.) also quite a high
18		achiever and a hard worker and (.) um:: she ended up going and speaking to
19		the, the school psychologist and (.)
20	Interviewer:	Mhm?
21	Maggie:	I don't (.) Yeah.

Maggie describes a self-harming act by Kate, a high school friend. She describes the act quite neutrally in line 10 and 12. Then Maggie says "and (.) it was (.) .pt (.) >ya, so anyway< [heh heh]" (line 14). She smacked her lips instead of completing her description of what "it" was like, avoiding an explicit value-judgement. This value judgement is still communicated, however, by the smacking of Maggie's lips, and the dismissive "ya, so anyway" and laugh. In line 16 – 19 Maggie continues, but qualifies the statement made in line 14, by saying "we, we um:: but we're very close um::" (line 16), which may be seen as an attempt to manage how the interviewer heard her previous statement, to ensure the interviewer does not think Maggie is being critical of Kate. Maggie continues by describing the issues Kate was facing at the time (line 16 – 18). These explanations psychologise Kate's motivations for self-harming, and try to justify to the interviewer why Kate should not be thought badly of for doing something like carving the name of a band into her arm. The factors that she describes, such as "problems with her mom", "problems with her self-esteem", and "high achiever", overlap with the motivations Maggie described in the interview to rationalise her own self-harming behaviours.

Extract 19 (continued)

21	Maggie:	I don't (.) Yeah.
22	Interviewer:	Okay (.) So was she doing it before you started, or (.)
23	Maggie:	YA actually she did do it before I started (.)

24	Interviewer:	Okay
25	Maggie:	I thought it was quite stupid at the time (.)
26	Interviewer:	Yeah?
27	Maggie:	And then (.) ac(h)tua(h)lly I've never thought of this before (.) I did, I thought
28		she was really silly (.) and then (.) and then like (.) a year later I did it (.)
29	Interviewer:	°Yeah°
30	Maggie:	°It's quite funny°

In this segment, Maggie conveys a 'sudden' awareness of the fact that she had thought Kate's behaviour was "stupid" (line 25) and "really silly" (line 28) at that time, and then says "and then like a year later I did it" (line 28). In the context of the interview, Maggie had been describing what self-harm was like for her, justifying and rationalising it. She is now confronted with the fact that her friend Kate's behaviour, conducted for similar motivations as her own (as described above), which she had thought was silly at the time, could be seen as similar to her own. Her phrasing suggests that even though she thought that kind of behaviour was silly, she herself went and did it a year later anyway, which opens up the possibility that others could think her own behaviour was "stupid" and "really silly" too. Maggie quietly states that "it's quite funny" (line 30). This seems like a pensive contemplation of the irony of her juxtaposition between Kate's and her own self-harm. Hence in order to save face in the next segment, Maggie begins to do the work of denying that Kate's and Maggie's self-harm are related:

Extract 19 (continued)

30	Maggie:	°It's quite funny°
31	Interviewer:	Do you think (.) 'inspires' is the wrong word to use, but (.) do you know
32		what I mean?
33	Maggie:	No:: I don't think they're related
34	Interviewer:	Okay
35	Maggie:	I think that (.) I, I don't think I even thought about (.) 'cause they, they were
36		VERY different, y'know=
37	Interviewer:	=Different reasons?
38	Maggie:	Different reasons and different circumstances
39	Interviewer:	Okay
40	Maggie:	And, and hers was <u>more</u> (.) meticulous (.) and kind of, HERS was definitely
41		more of an attention, kind of seeking
42	(.)	
43	Interviewer:	Okay (.) Um::
44	(.)	
45	Maggie:	°You know what I mean°
46	Interviewer:	Yeah

Maggie denies that her and Kate's behaviour are related in any way: she states "no, I don't think they're related" (line 33) and begins to explain why she denies it, in line 35 (without an

explanation this may seem rude in polite conversation - Potter and Wetherell, 1987). She
has two false starts: "I think that"; and "I, I don't think I even thought about" in line 35 – the
second of which denies any conscious decision on her part to 'copy' Kate. She settles on an
explanation which creates as much distance between Kate and Maggie's behaviours as
possible (line 35 – 41). By emphasising the fact that they were completely different types of
behaviours, Maggie denies any causal link between them. She describes Kate's self-cutting
as "more meticulous" (line 40), which is set up against her own self-harm, which provides a
vehicle for her to lose control (as described in extracts 6 and 7). Thus according to Maggie,
her own behaviour serves a purpose by being *less* meticulous; which serves to identify her
own behaviour as more rational and acceptable in contrast to Kate's. She also distances
herself from Kate's self-harm by referring to Kate's as "more of an attention, kind of
seeking" (line 40 – 41). The moderators "more of" and "kind of" lessen the strength of what
she is saying, making this criticism of her friend sound more socially acceptable. Maggie
identifies Kate with the discourse of attention-seeking self-harmer (which she argued
against the injustice of in extract 1), and through this distances *herself* from this discourse.
After two pauses (line 42 and 44), where a limited response is all that is forthcoming from
the interviewer (line 43), Maggie appeals for a show of understanding and agreement in line
45: that she is different from Kate and not an attention seeker (even though her behaviour,
such as smashing glasses against the wall, could be seen as more theatrical, difficult to
conceal and 'attention-seeking'). The interviewer's response is a single complicit "yeah"
(line 46), which leads to Maggie's response as below:

Extract 19 (continued)

46	Interviewer:	Yeah (.)
47	Maggie:	But (.) not that I'm criticising her or anything
48	Interviewer:	No:: (.) yeah
49	Maggie:	But
50		(.)
51	Interviewer:	People always assume that when you say attention seeking, it's, I don't
52		know, people tend to assume that it's meant in a bad way=
53	Maggie:	=YES=
54	Interviewer:	=Sometimes it's just a needing to express something, and not being able to=
55	Maggie:	= Exactly
56	Interviewer:	Yeah
57	Maggie:	Exactly

In the light of a limited response from the interviewer after calling her friend Kate "attention-seeking", Maggie goes a step further and explicitly says "but not that I'm criticising her or anything" (line 47) in order to try to manage how she has been understood and ensure the interviewer does not think badly of her. The interviewer eventually complies with Maggie, by expressing agreement in line 48, and then in line 51 – 52 and line 54 offering a different way of understanding the term 'attention seeking' – that it could be behaviour drawing attention to a person who cannot express themselves – a non-verbal call for help, as considered in the literature review (Section 2.3.1.1). This more positive understanding of 'attention-seeking' elicits a strong positive response from Maggie: she answers "YES" (line 53), and "exactly" (line 55 and 57), as this enables her statement about Kate being an attention seeker to no longer be interpreted as critical.

Extract 19 (continued)

57	Maggie:	<u>Exactly</u>
58	Interviewer:	Okay (.) .hh So yours wasn't a needing to [ ]
59	Maggie:	[NO, no I] was always very
60		embarrassed about (.) everything I did (.) and (.) feeling the way I felt
61	Interviewer:	Okay
62	Maggie:	And it took me a long time (.) to be able to talk about this sort of thing
63	Interviewer:	Oka::y (.) I really appreciate you being able to [talk about it, thank you]
64	Maggie:	[HEH HEH heh heh]
65	Interviewer:	So thank you=
66	Maggie:	=I appreciate it too, it, it feels good to be able to reflect and to be able to
67		think things through and to be able to get other people's input=
68	Interviewer:	=Mhm=
69	Maggie:	=On this sort of thing.

Despite this re-interpretation of 'attention-seeking' as an unspoken desire for help, Maggie still rejects this as an interpretation of her own behaviour. Her speech overlaps the interviewer's in her haste to deny this and she raises her voice as well. Even though this understanding of 'attention-seeking' reflects what Maggie was saying in earlier extracts about not being able to cope with and express her difficult emotions, she still will not permit her behaviour to be viewed by the interviewer as attention-seeking, even if seen as an unspoken request for help. Maggie claims deep embarrassment meant she did not *want* to draw attention to herself at all.

To summarise, the stigma of being seen as attention-seeking is so strongly instilled in Maggie that she does a lot of contradictory work in Extract 19 to deny being seen as

attention-seeking. She attempts to achieve a balance between being viewed as a good friend to Kate, and setting Kate up as the 'typical' self-harmer who is an attention-seeker, in order to distance herself as much as possible from this discourse.

5.5.1.2 Extract 20: Dana: Two good friends from high school

1	Interviewer:	Had you, had you ever heard of someone self-harming before you [started]?
2	Dana:	[yeah].
3		Ya, a good, one of my really good friends from school
4	Interviewer:	Mhm?
5	Dana:	<u>Two</u> (.) actually, two of my really good friends from school
6	Interviewer:	Yeah? Okay (.) and had they been (.) were, were they cutting, or
7	Dana:	Oh yeah
8	Interviewer:	Cutting
9	Dana:	Yeah, the ONE would sort of tell me about it, like and if I noticed I would
10		speak to her about it and
11	Interviewer:	Mhm?
12	Dana:	Um uh I won't say I didn't ap<u>prove</u>, but I was really concerned about it and
13		so that's why I think I was a little bit surprised at myself when it sort of came
14		to that point
15	Interviewer:	Okay
16	Dana:	As well, yeah.
17	Interviewer:	Okay (.) So was it just a:: sort of (.) almost like a not thinking about what was
18		happening=
19	Dana:	=YEAH literally like a (.) just a reflex (.) action almost.
20	Interviewer:	Okay
21	Dana:	That's it, yeah
22	Interviewer:	Okay and did you, did you cut yourself, or?
23	Dana:	Mhm
24	Interviewer:	Okay (.) um (.) did you find yourself sort of doing the same kind of thing that
25		<u>they</u> did? That they'd told you about?
26	Dana:	Um:: (.) <u>Yeah</u> (.) <u>No::</u> (.) The (.) I mean, I don't mind details and stuff. The first
27		time it was just with a safety pin. So it was small, heh

Dana describes two high school friends that were self-harming before she began to self-harm. Dana says "I won't say I didn't approve, but I was really concerned about it" (line 12). This contrast between disapproval and concern comes up in relation to her friends' reactions to her own self-harming behaviour. The friend who shows disapproval is described as a bad friend who causes her more emotional issues (Sarah). The friend who shows concern is described as more accepting and supportive and assisted Dana to stop self-harming (Tracy). So in referring to herself as "I won't say I didn't approve, but I was really concerned about it" (line 12), Dana sets herself up as a good, supportive friend. She describes herself as "concerned", which shows her collusion with the social norm that self-harm is maladaptive or "abnormal" (to refer to her definition, as described in Extract 4) and

she confirms this by following her statement with "so that's why I think I was a little bit surprised at myself when it sort of came to that point" (line 13 – 14). By constructing her statement in this way, Dana creates the appearance that there was nothing she could do to control her actions, that they were beyond her power and hence she cannot be 'blamed' or held accountable for them. The interviewer seeks confirmation for how she is hearing Dana's statement: "okay, so was it just a sort of almost like a not thinking about what was happening" (line 17 – 18); which Dana confirms "Yeah literally like a, just a reflex action almost" (line 19). By terming it a "reflex action" Dana makes her 'non-culpability' clear: it was a process she had no control over. Hence, according to this construction, she cannot be held responsible for her actions, as they were beyond her control. By utilising this explanation, Dana again makes use of the victim discourse (Morison, 2006).

When asked if she engaged in the same kind of behaviour as her friend, Dana replies "um:: (.) yeah (.) no:: (.) the (.) I mean, I don't mind details and stuff. The first time it was just with a safety pin. So it was small, heh" (line 26 – 27). Her confusion is explained by stating that because her self-harm was only with a safety pin, it was a different *kind* of behaviour to her friend's, rather than a difference in degree of severity. Thus she also minimises the influence of her friend, similarly to Maggie. However, in Extract 21 one can demonstrate just how far her understanding and experience of self-harm has been shaped by her friends:

5.5.1.3 Extract 21: Dana: Friends' influence on self-harming behaviour

1	Interviewer:	Um:: okay so um::: hhh how did it, kind of, become more of a pattern, like
2		would you sort of begin to rely on it more?
3	Dana:	Um:: YEAH and it became (.) I don't know my friends said at the beginning
4		that they y'know when I said "No it was just a safety pin or whatever" and
5		they said "Yeah but it gets worse" and I said "No well it's not gonna get
6		worse" y'know
7	Interviewer:	Yeah
8	Dana:	Um: (.) But it did
9	...	
10	Dana:	Each time, yeah (.) um:: (.) And then yeah admittedly it did get worse as (.)
11	Interviewer:	Mhm
12	Dana:	Time progressed (.) um: just 'cause I was also told something about how like
13		(.) you never sort of reach that same (.) the way you feel the first time you
14		never reach there so each time you sort of=
15	Interviewer:	=Try and [get] back to that
16	Dana:	[Try]
17	Dana:	get back to that.
18	Interviewer:	O↑kay

In this extract Dana describes how she became addicted to self-harm. Her narrative, however, refers heavily to her self-harming friends: for example, "*they said* 'Yeah but it <u>gets</u> worse'" (line 5, emphasis added), and "I was also told something" about what the self-harming experience would be like (line 12). In other words, the way that Dana constructs the narrative of her experiences is shaped by how her friends have described self-harm to be. In this way, Dana sets up her self-harming friends as *mentors,* whose description of what self-harm would be like for Dana shapes Dana's narrative in the interview setting. As described in extract 20, however, Dana does differentiate her first experience with self-harm from her friends' self-harm, positioning it as less severe, although not to the same degree as Maggie. This serves to create a certain amount of discursive distance between Dana and her friends, which contributes to her projection of herself as 'other' to the self-harming population (as discussed in extract 3).

5.5.1.4 Summary

Both participants knew someone who self-harmed before they began. Both expressed disapproval about their friends' self-harm – participants positioned friends' behaviour as 'silly' and 'stupid' (Maggie) or as something worthy of concern (Dana) – while moderating their disapproval in both cases so as to still present themselves as a 'good' friend. They minimised (Dana) or denied (Maggie) causal links between their friends' behaviours and their own, and in so doing, distanced themselves from their friends' behaviours. This may be because self-harm is not socially acceptable, so participants 'needed' to show disapproval of their friends in order to demonstrate social competency, defining their own behaviour as 'different' to their friends', as somehow better and more acceptable. This suggests that the social unacceptability of self-harm may be deeply ingrained in the participants, particularly Maggie – while doing work to make her own behaviour seem rational her friend's behaviour was constructed as a 'scapegoat', in opposition to her own. In the next section, participants' description and discursive positioning of self-harmers starting after them will be analysed.

5.5.2 People that start after me

5.5.2.1 Extract 22: Maggie: Mother self-harmed

1	Interviewer:	One of the worries though, y'know that I've come across in the readings is
2		that um:: with (.) y'know (.) it's that whole (.) and this was kinda what (.)
3	Maggie:	It'll encourage people

4	Interviewer:	Exactly. That um: <u>most</u> people that you talk to that used to self-harm knew
5		someone who self-harmed before they sta↑rted (.) sort of thing=
6	Maggie:	=YOU know what?
7	Interviewer:	Yeah?
8	Maggie:	YOU know what? Hhhhh (.) My <u>mom</u> (.)
9	Interviewer:	Mhm?
10	Maggie:	Self-harmed (.) <u>after</u> (.) she found out (.) that I self-harmed
11	Interviewer:	Oh okay?
12	Maggie:	Y'know what, I only thought of that now↑
13	Interviewer:	Yeah?
14	Maggie:	<u><That is fucked up></u>
15	Interviewer:	Because they see it as "oh that's a coping mechanism that they're using", it
16		might be from different reasons, it might be from different experiences=
17	Maggie:	=She wouldn't have DONE it, if she didn't know about me doing it
18	Interviewer:	Don't blame yourself now though!
19	Maggie:	No, NO I don't, because
20	Interviewer:	Yeah?
21	Maggie:	Because I couldn't have, y'know there's (.)

The interviewer and Maggie were discussing the dangers of educating people about self-harm, that it might "encourage people" (line 3). The interviewer had hoped to discuss further her relationship to Kate (and was introducing the topic in lines 4 – 5) when Maggie interrupts the interviewer. Maggie repeats "YOU know what?" in line 6 and 8, with emphasis on the "you" to gain the interviewer's attention. Maggie then states that "my <u>mom</u>... self-harmed (.) <u>after</u> (.) she found out that I self-harmed" (line 8 and 10) and then repeats "Y'know what, I only thought of that now↑" (line 12). While Maggie was obviously in possession of these facts already, Maggie positions this knowledge as something that she has just 'put two and two together' about. Her shock seems very genuine ("<u><that is fucked up></u>", line 14), and, speaking as the interviewer, the situation was not handled particularly elegantly due to dismay and concern at Maggie's reaction. Unfortunately, Maggie did not complete her sentence in line 21, and the interviewer changed the subject to a less sensitive one (to preserve the continuity of the interview without upsetting Maggie too deeply), which is regrettable on reflection, as this topic could have been more deeply probed. Maggie herself is convinced, however, that "she wouldn't have DONE it, if she didn't know about me doing it" (line 17), which positions her mother's self-harm as causally linked to her own self-harming behaviour, occurring as a direct consequence of 'knowing' about Maggie's self-harm.

5.5.2.2 Extract 23: Dana: Close friend self-harmed

1	Interviewer:	Okay. UM D- did your relationship – you know the, the first friend that you,
2		you told – did your relationship change (.) after that? Did she
3	Dana:	Um:
4	Interviewer:	Did she get like more watchful::l
5	Dana:	She got – the scary part of the whole thing, is she got more watchful but
6		then she started herself.
7	Interviewer:	O::kay↓
8	Dana:	Um:: (.) she – the first time she did it (.) <she said because> (.) she was also
9		worked up or whatever and she had seen – she knew – y'know she
10		remembered the fact that I had done it whatever
11	Interviewer:	Okay
12	Dana:	Um:: (.)
13	Interviewer:	How did that make <u>you</u> feel?
14	Dana:	I felt <u>guilty</u>
15	Interviewer:	Yeah?
16	Dana:	Firstly. But then also really frustrated that she had resorted to it, it was
17		almost like a – I was being almost hypo- hypocritical
18	Interviewer:	Okay
19	Dana:	Like (.) '<u>Why</u> do you do that? <u>Why</u> do you deal with it like that?' when in
20		actual fact
21	Interviewer:	Yeah
22	Dana:	I was the same, so (.) THROUGH out our sort of friendship up until the last
23		time (.) It's been almost a:: (.) I'll shout at her, she shouts at me
24	Interviewer:	Okay
25	Dana:	We don't really get anywhere with it because we're both in the same boat
26		as such
27	Interviewer:	Okay
28	Dana:	Um:: (.) Yeah (.) So – but she did still get more watchful, if I got worked up
29		she would say "please don't do anything stupid"
30	Interviewer:	Okay

Dana describes a similar phenomenon to Maggie: one of the chief people she confided in about her self-harming behaviours subsequently began to self-harm. Unlike Maggie, Dana was more emphatic in her construal of a causal link, perhaps because Sarah is presented as having directly said that "she remembered the fact that I had done it whatever" (line 9 – 10). Dana seemed more emotionally detached in the interview, with the result that more time was spent talking about this issue than with Maggie.

Dana describes her first self-harming experience as taking place due to a fight she was having with Sarah (Extract 17). Dana describes in another part of the interview how she told Sarah about it after it happened:

Interviewer:	Um:: (.) Okay, did anyone know about what you'd, what you'd done?
Dana:	Yeah um: the first time [[clears throat]] I told (.) <my one friend>
Interviewer:	Mhm [the one]

Dana:	[actually] the one who, who had um:: sort of y'know frustrated me in the first place
Interviewer:	[Oka::y↓]
Dana:	[I told her about it]
Interviewer:	Yeah
Dana:	She was really upset about it

Dana presents the fact that Sarah started self-harming as "scary" (line 5). Dana's chief motivation for self-harming is described throughout the interview as feeling "worked up", normally by emotions such as tension or anger. Dana states that Sarah told her she was "also worked up" (line 8 – 9) and "she had seen – she knew – y'know she *remembered* the fact that I had done it" (line 9 – 10, emphasis added). By using the verbs "seeing", "knowing" and "remembering", Dana enforces a causal connection between her own self-harm and Sarah's, one which she says made her feel "guilty" (line 14). Dana emphasises this was her first response and that her second response was frustration (line 16), which she acknowledges was "almost hypo- hypocritical" (line 17). This acknowledgement of hypocrisy might have been made in order to stave off any perceived or potential accusations by the interviewer.

5.5.2.3   Summary

Both participants shared that someone that they had confided in about their self-harming behaviour subsequently began to self-harm as well. Interestingly, both participants volunteered this information in the course of talking about other topics. Both participants portray these individuals as starting as a direct consequence of knowing about Maggie and Dana's self-harm, and they expressed shock (Maggie) and guilt (Dana) while talking about it. It is noteworthy that this causal link is strongly expressed when talking about individuals who started after them, but is denied or minimised in relation to the start of their own self-harm in relation to self-harming friends.

5.5.3   Summary

In the previous section, both participants described self-harmers that they knew of, prior to the start of their own self-harm. Generally speaking, this influence was minimised by the participants and described as not having a strong effect on their subsequent behaviour. Additionally, both participants stated that someone they had confided in about their self-

harming behaviour had subsequently begun self-harming, which was positioned as occurring in direct consequence of knowing about their own behaviour and was described as shocking (Maggie) or "scary" (Dana).

Thus, participants positioned friends who self-harmed before them differently to how they positioned friends/family who began self-harming after them. Causal links were minimised (Dana) or denied (Maggie) between individuals self-harming before them; and, in Maggie's case, this individual was identified with medico-psychiatric discourses of being attention-seeking, which further increased the discursive distance between Kate and Maggie. On the other hand, individuals starting after participants were positioned as being *caused to* by knowing about participants' own self-harm. Causality is denied on the one hand, and endorsed on the other.

This could be because there is more at stake for participants to deny causal links to previous self-harmers in the establishment of their own self-harm as a meaningful and legitimate coping mechanism. This may be because when these friends were self-harming, participants themselves were on the "outside" (Dana, extract 4) or in a different "paradigm" (Maggie, extract 1), and so understood self-harm in a different way; and this different understanding still influences their current views on these friends. Whereas, with individuals who began self-harming after participants, participants have since 'changed paradigms' and so have 'insider knowledge' and are hence more understanding and less rejecting of potential links. On the other hand, this conflict in the presentation of other self-harmers in relation to themselves may also be due to a need to 'maintain face' in the interview. In the course of presenting themselves as engaging in rational behaviour for which they should not be judged or punished, participants position themselves as victims, engaging in meaningful behaviour which is more than 'mere' attention-seeking. They do discursive work so as not to be identified as part of the self-harming population (which Maggie does implicitly, and Dana does explicitly), and present their self-harm as different to their friends' (particularly Maggie). By doing this, the maintenance of their presentation as rational victim is validated, because they are 'not like' these friends who self-harmed before them. This does not, however, explain why individuals starting after the participants were presented differently. It may be because there is less at stake for participants – admitting a causal link with these

individuals will not affect the interviewer's perception of the acceptability of their own self-harm, and so it was more acceptable for causal links to be made between participants and subsequent self-harmers. Or perhaps an underlying sense of guilt promoted this described causality. This has become, however, an attempt at mindreading. Suffice it to say, different strategies were at play in both participants' accounts regarding the positioning of individuals who began to self-harm either before or after participants.

5.6 Chapter summary

In this chapter, it was shown that participants relied on a 'victim' discourse to establish their self-harm as meaningful in a way which limited any blame or stigma attributable to them, but which subsequently limited a sense of agency in their narratives. The discourse of attention-seeking heavily influenced participants' narratives, and was acknowledged as the dominant discourse self-harmers must contend with in presenting their behaviour as meaningful and rational. Participants used various discursive techniques to deny the legitimacy of the attention-seeking discourse and minimise its applicability to themselves, thus avoiding the stigma associated with being seen as an 'attention-seeking self-harmer'. Upon examining participants' construction of their first self-harming experience, it was found that while participants described choosing to self-harm, they simultaneously limited any sense of agency by positioning the source of their 'problem' as beyond their control ('victim' discourse, Morison, 2006), and by describing a subsequent 'addiction' to self-harm. It was also found that participants referred to two types of self-harmers personally known to them, namely individuals who were self-harming before the participants began to self-harm, and individuals who were confided in by the participants, and who subsequently began to self-harm as well. Participants treated these two categories of individuals in different ways. Participants set themselves up as different to the friends who self-harmed before participants, minimising or denying links between them and thus distancing themselves from the stigma of being a self-harmer. Participants did not use these strategies in discussing individuals who began self-harming after them; rather, they identified them as doing so in direct consequence of knowing about participants' self-harm. In the following chapter, these findings will be discussed in terms of the literature review and the research questions.

Chapter 6: Conclusion

In this chapter, the results found in Chapter 5 will be discussed in comparison to the literature review (Section 6.1) and the research questions (Section 6.2). In addition, the contributions (Section 6.3) and limitations (Section 6.4) of this study will be discussed, and recommendations for further research will be made (Section 6.5).

6.1 Themes linked to the literature review

Several themes discussed in the literature review were represented in the interview data. As self-harm is a stigmatised behaviour, the participants used various conversational techniques in order to render their behaviour as rational as they could, thus avoiding stigma. These techniques included the acknowledgement of negative discourses about self-harmers, including the discourse of being an attention-seeker; and doing discursive work to distance themselves as much as possible from these negative discourses.

Both participants engaged in self-cutting, which mirrors Klonsky *et al.*'s (2003) finding that self-cutting is the most common method of self-harm (Refer to Section 2.2.3). Dana also described engaging in self-burning behaviour. Maggie's description of anxiety, depression, and bulimia, coupled with subsequent self-harm, is in line with Wildman *et al.*'s (2004) findings (Refer to Section 2.2.9.1). Both participants described self-harm as addictive (Refer to Section 2.2.8).

Both participants frequently referred to the victim discourse (Morison, 2006). Participants presented themselves as lacking the agency to resolve situations/emotions in any way other than self-harm. By positioning themselves as 'helpless', participants were able to eliminate any blame which could be attributed to them, as they are rendered unaccountable for their actions (Morison, 2006). In the description of their first experience of self-harm, participants positioned themselves as *choosing* to self-harm, which implies some sense of agency. However, this agency was limited, as participants described 'not knowing' why they first resorted to it, and also described a subsequent addiction to self-harm, thus removing any sense of agency they may have initially experienced. Very little evidence was found of the villain discourse in participants' accounts.

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Both participants referred to the medico-psychiatric discourse of self-harmers as attention seekers (Refer to Section 2.3.1.1). Participants felt that non-self-harmers consider self-harmers to be attention-seeking; but while Maggie argued the legitimacy of this discourse, Dana expressed awareness of it and used this awareness as motivation for keeping her self-harm a secret, to avoid being seen as attention-seeking. Maggie later, however, used the discourse of being an attention-seeker when describing how she felt about herself as a self-harming teenager, and also identified her friend as being an attention-seeker. This demonstrates that despite arguing its legitimacy, the discourse of attention seeking is deeply instilled in Maggie (as well as in Dana).

Both participants discussed a close friend who self-harmed prior to the onset of their own self-harming behaviour, which suggests that contagion may have occurred (Section 2.5). Parallels were found for both the modelling mechanism (where individuals emulate others exhibiting these behaviours and copy them to demonstrate membership to peer or cultural groups) and the selection mechanism (individuals predisposed to these behaviours are attracted to each other, forming social groups, and thus behaviour is more likely to spread) in participants' accounts (Joiner, 1999; Young *et al.*, 2006). In Maggie's account, Maggie described similar rationalisations for engaging in self-harm (conflict with mother, high achiever at school, low self-esteem), which could suggest that selective mechanisms were at work. Dana's description of her self-harming friends suggests that modelling mechanisms may be at work, as her narrative demonstrated an influence from these friends over how they 'said self-harm would be'.

Alternatively, the simple act of knowing a self-harmer may have been sufficient to trigger later self-harming behaviour, via a 'disinhibiting' mechanism – see Section 4.1 for a discussion of the philosophy of human action, which offers a means of understanding how stigmatised behaviour comes to be replicated in others. To summarise the argument made therein, self-harm appears shocking to non-self-harmers ('outsiders' from another 'paradigm'), because it does not "make sense to you as something that might be done" (Doyal & Harris, 1986, p. 80). However, one may postulate, it may be likely that having a close friend or family member who self-harms may introduce you to this paradigm, so that self-harm begins to "make sense to you". This may provide a 'disinhibiting' mechanism,

which could overcome the social stigma of self-harm. The self-harming behaviour – despite being stigmatised– will form part of an individual's available lexicon of behaviours. Then, when faced with a difficult emotion or situation at a later stage, an individual may be more likely to draw on that as a coping behaviour, albeit a stigmatised one. Therefore, it could be suggested that having a self-harming friend may introduce self-harm to one's lexicon of available behaviours, becoming available to be drawn on thereafter, much to participants' expressed surprise and constructed passivity.

These hypotheses may offer a means of understanding how and why an individual begins to self-harm, which could be used to limit the proliferation of self-harming behaviours; however, more research is needed to investigate this more fully (See Section 6.5).

6.2 Research questions

The first research question was concerned with revealing the discourses drawn on by participants in the discussion of self-harmers in general. It was found that participants referred to the discourse of attention-seeking, expressing the belief that non-self-harmers, who were positioned as being "outsiders" or from a different "paradigm", believed self-harmers to be attention-seeking. Both participants also referred to a victim discourse. Participants presented self-harmers as 'othered' by society, and, surprisingly, also 'othered' self-harmers in comparison to themselves, setting themselves up as different and more rational, and hence undeserving of the stigma attributable to self-harmers in general.

The second research question dealt with how participants talked about their own self-harm, and whether they drew from the discourses as discussed in the first research question. In analysing Maggie and Dana's description of their own self-harm, it was found that both did discursive work in the interview to establish their self-harm as meaningful, and serving a purpose. Both participants presented self-harm as a coping mechanism, to deal with intense emotions which they were unable to cope with in a more 'socially acceptable' way. In this way, both participants relied on a 'victim' discourse, presenting themselves as disempowered yet blameless (Morison, 2006). Both participants acknowledged social pressure to seek healing when 'ill', by supplying reasons to justify their choice not to engage in psychotherapy.

The third research question sought to understand how participants constructed their first self-harming experience. It was found that both participants positioned themselves as initially having the agency to choose how they would respond to uncomfortable situations (Dana) or distressing emotions (Maggie), but that this sense of agency diminished over time as they described becoming 'addicted' to self-harm. Maggie's construction of how she began self-harming focuses on intra-psychic reasons for her self-harm; whereas Dana refers to being in intolerable social situations which she felt disempowered to change: both of which position the problem as beyond their control. Therefore, both participants present their first self-harming experience as one that they had the power to choose, and, simultaneously, that no other option existed.

The fourth research question asked if there were other self-harmers in participants' lives, and how they positioned these others in relation to themselves. In the course of presenting themselves as engaging in rational behaviour, participants positioned themselves as 'victims', engaging in meaningful behaviour which is more than 'mere' attention-seeking, but which they should not be held accountable for. In discussing how participants positioned other self-harmers in comparison to themselves, it was found that they related differently to individuals who started self-harming before them, compared to those who started self-harming after them. Maggie identified the friend who started self-harming before her with the attention-seeking discourse and then distancing herself from her friend's behaviour (and in turn from these discourses). Dana minimised perceivable connections between her self-harm and that of her friends', by positioning her own initial self-harm as 'small' and 'less serious'. Through minimisation and distanciation participants set themselves up as different to their friends and distanced themselves from the stigma of being a self-harmer. Participants did not use these strategies in discussing individuals who began self-harming after them; rather, it was positioned as occurring in direct consequence of knowing about participants' behaviour, and was described as inducing guilt, shame, and/or shock.

6.3 Contributions

It was found that the discourse of self-harmers as attention-seekers heavily influenced both participants' accounts. This discourse denies any meaning or rationality that self-harm may

carry for the self-harmer, trivialising their motives as manipulative and a "childish call for attention" (Marshall & Yazdani, 1999, p. 422; refer to Section 2.3.1). The fact that both participants' accounts were heavily influenced by this stigmatising discourse demonstrates that despite research (such as Machain, 2001 as cited in Ayerst, 2004; Marshall & Yazdani, 1999; McAllister, 2003; Morison, 2006), educational books (such as Strong, 1998), and an increased representation in the media (as described in Morison, 2006), self-harm is still stigmatised and disparaged through the discourse of attention-seeking. As a result, both participants, particularly Dana, described self-harmers as being misunderstood and expressed fear of being publically revealed as a self-harmer. It was found that participants presented self-harmers as 'othered' by society, but also 'othered' self-harmers in comparison to themselves. This discursive technique was used in order to distance themselves from the stigma of being seen as a self-harmer.

It was also found that both participants used the victim discourse extensively in their interviews. This discourse enabled them to attribute meaning to their self-harm without being blamed for it; however, it did limit their sense of agency and power over their own behaviour. In describing their first act of self-harm, both participants positioned themselves as empowered to choose to self-harm, yet this sense of agency was limited by a described lack of alternative available coping skills, and further diminished through the description of becoming addicted to self-harm over time. This concern with being blamed for their behaviour could also be attributed to the stigma of being a self-harmer – participants limit agency (positioning self as powerless) rather than face being blamed for their behaviour.

It was also found that both participants knew someone who self-harmed before they began self-harming. Evidence was found for both peer modelling and selection mechanisms (in Dana and Maggie's accounts respectively), which were described in the literature (See Section 2.5) as offering a potential mechanism for the 'contagiousness' of self-harm (Joiner, 1999; Young *et al*., 2006). However it may also be that simply "knowing others who self-harm" is a disinhibiting mechanism sufficient to result in the spread of self-harm (Hawton & James, 2005, p. 892). It was also found that both participants knew someone who began to self-harm after them, which participants both described as occurring in direct consequence of these individuals' knowledge of participants' self-harm.

6.4 Limitations

As discussed above in Section 4.6, the requirements of validity, reliability and generalisibility are re-interpreted in qualitative research as credibility, consistency and transferability (Silverman, 2005). By dealing with as much detail as possible in the analysis and by being transparent in the use of analytical techniques, it is hoped that a credible and consistent account, offering insight into the discourses surrounding self-harm, was achieved. Despite this attempt, however, credibility, consistency and transferability would have been considerably increased had there been more participants in this study.

Additionally, as discussed already, participants were not recruited according to the primary recruitment method as set out in the protocol (although contingency plans were set out in the protocol in case of this event). The primary recruitment method was the most ethical means devisable, so recruitment under other means, while not *un*ethical (as recruitment still followed the protocol), was less ethical than desirable. However, with the other ethical contingencies in place, such as working with the Student Counselling Centre to provide professional debriefing if required by participants; offering a takeaway form with emergency contact details (see Appendix 4); and ensuring participants knew that participation was completely voluntary, it could be argued that participants did not suffer as a result.

6.5 Recommendations for further research

The 'contagiousness' of self-harm was discussed in the literature review in Section 2.5 as an area that has been under-explained and under-researched. Upon finding that both participants knew someone intimately who self-harmed before they started, and that both participants knew people who had started self-harming after finding out about their own self-harm, it is strongly recommended that more research be conducted on this topic. It is important to ascertain whether this was mere coincidence in this study; a common trend in some self-harmers; or *the means by which* an individual becomes a self-harmer. It is recommended that a survey be conducted on self-harmers to ascertain if this is the case, and to better explore and validate/invalidate the selection, modelling, and disinhibiting mechanisms.

It was found that participants mostly referred to the attention-seeking discourse and the victim discourse in their interviews, suggesting that the stigma of being a self-harmer is deeply entrenched. It is recommended that further qualitative studies be conducted with larger samples in order to ascertain whether these results can be reproduced. In terms of this stigma, it may be useful to consider using research to develop educational programs to better educate non-self-harmers, which may assist in lessening the stigma of being a self-harmer. It would be advisable, however, to develop any programs in conjunction with further research on determining how individuals become self-harmers. If it can be established that simply 'knowing' about self-harm (the 'disinhibiting mechanism') leads certain individuals to experiment with self-harm, it may be possible that an increase in incident rates could occur, should information about self-harm be made more publically available. While not directly inferable from this study's results, this researcher feels that an educational program which is developed to be sensitive and de-stigmatising, while also recognising the dangerously addictive nature of self-harm and promoting healthier methods of coping behaviours, could perhaps go a long way to reducing incident rates and invalidating the attention-seeking discourse.

6.6 Conclusion

Self-harm is a stigmatised and misunderstood behaviour, and yet incidence rates are increasing (Craigen & Foster, 2009; Klonsky *et al.*, 2003; Whitlock *et al.*, 2006). It was demonstrated in the literature review (Section 2.5) that little research has focussed on discovering how and why an individual becomes a self-harmer, although some authors have suggested that knowing a self-harmer may play a role (Hawton & James, 2005; Laloë, 2004; Young *et al.*, 2006). It was found that not only were participants close friends with a self-harmer before beginning to self-harm themselves, but that they also knew someone who began to self-harm after learning about participants' self-harm. It seems relevant, therefore, for more research to be conducted to investigate whether knowing a self-harmer plays a role in becoming a self-harmer, whether by modelling, selective or disinhibiting mechanisms.

 In an interview situation, it was anticipated that participants as competent members of society would feel a need to account for their self-harm (an act generally perceived as

maladaptive and irrational), thus establishing themselves as rational and their self-harm as meaningful (Refer to Section 4.1). It was found that this was the case. Participants relied on the victim discourse (Morison, 2006) to establish their self-harm as meaningful in a way which would limit any blame or stigma attributable to them, but which subsequently limited their agency. The discourse of attention-seeking heavily influenced participants' narratives, and was acknowledged as the dominant discourse self-harmers must contend with in presenting themselves as rational to the interviewer.

This study has tried to provide a deeper insight into some of the discourses self-harmers use in constructing the narratives of their first self-harming experience. However, it has also highlighted the fact that, as a research community, we are far from understanding this complex and multi-faceted behaviour. In looking at the narrative of becoming a self-harmer, it was found that the discourses used by participants reflected the stigma and disempowerment of being a self-harmer and the fear of being trivialised as an attention-seeker, which resulted in both participants keeping their self-harm a secret. This author believes that this exploratory study offers direction for future research, and recommends focussing on the mechanisms at play in becoming a self-harmer. If these mechanisms can be better understood, it is hoped that the stigma of being a self-harmer can be lessened and the self-harm incidence rate decreased.

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Appendix 1: Letter to the Dean of Students

UNIVERSITY OF
KWAZULU-NATAL

Ms Sonti Masipa   School of Psychology
Dean of Students   P/Bag X01 Scottsville
UKZN   PIETERMARITZBURG, 3209
                                                                 South Africa
                                                                 Phone: +27 33 2605853
                                                                 Fax: +27 33 2605809

                                                                 6 April 2010

Dear Ms Masipa

RE: Application for Permission to Conduct Research through the UKZN Student Counselling Centres

I am currently registered as a Research Psychology Masters student at UKZN, Pietermaritzburg. As part of my degree I am conducting a research project looking at the experiences of student who self-harm. I am looking to recruit between two to six participants with experience of self-harm, for a single interview session. While much research has been done into the phenomenon of self-harm, it is still increasing in frequency and carries a lot of stigma. I believe that a qualitative study looking in particular at the experiences of self-harmers will benefit this area of research and will hopefully contribute towards a new perspective on aiding or improving treatment options.

I would like to request your permission, in addition to that of the Directors of the various UKZN SCCs, to advertise on the premises of the Student Counselling Centres in order to recruit participants for my study. Recruiting students specifically from the Counselling Centre will aid in lowering the associated risk in participating in a study concerning self-harm, and developing a relationship with the Centre will also offer participants not yet receiving any help the chance to enter counselling or therapy after the study is complete. My intention is to cause as little distress as possible to the participants, treating them with the utmost of respect and dignity. My supervisor, Prof DR Wassenaar, is a registered clinical psychologist and will assist me in my ethical management of this study. In addition, this study will undergo UKZN Ethics review before commencement of data collection.

I would sincerely appreciate your permission to approach the SCC heads for permission to recruit participants for the study.

Yours faithfully

Nicola Jacobs   Supervisor: **Prof DR Wassenaar**
                                                                 Regd Clinical Psychologist

07 April 2010   07 April 2010
079 714 0867   033 260 5853
ng_jacobs@yahoo.com   Wassenaar@ukzn.co.za

Appendix 2: Letter to the SCC Director

School of Psychology
P/Bag X01 Scottsville
PIETERMARITZBURG, 3209
South Africa
Phone: +27 33 2605853
Fax: +27 33 2605809

2 June 2010

Dear Mr Munroe

RE: Application for Permission to Conduct Research through the Student Counselling Centre

I am currently registered as a Research Psychology Masters student at UKZN, Pietermaritzburg. As part of my degree I am conducting a research project looking at the experiences of students who self-harm. I am looking to recruit between six to eight participants with experience of self-harm, for a single interview session.

While much research has been done into the phenomenon of self-harm, it is still increasing in frequency and carries a lot of stigma. Research has traditionally been done on self-harmers presenting to hospitals, prisons and mental institutions. However, new research suggests that the population of self-harmers are not homogenous, and self-harmers in a community setting may be qualitatively different to those in institutional settings. Additionally, the studies generally concentrate on *why* participants self-harm, and the efficacy of treatments helping them *stop*. My research interest rather lies on *why* individuals begin harming initially, and what *meaning* self-harm has to them. I believe that a qualitative study looking at the experiences of self-harmers in a community setting and focusing particularly on the initial experience of self-harm, will benefit this area of research and will hopefully contribute towards a new perspective in aiding or improving treatment options.

Participating in this study does carry a certain amount of ethical risk which, with the help of my supervisor, I have aimed to reduce. We would like to propose a co-operative study conducted in partnership with the Student Counselling Centre. What we would like to do is to advertise on your premises for prospective participants, and arrange for students to have access to a counselling session (at my expense) after the interview for professional debriefing. In this way we hope to reduce the risk associated with participation in a study of this nature. Additionally, in developing a relationship with the Student Counselling Centre it is also aimed to offer participants not yet receiving any help the chance to enter into counselling after the study is complete.

My intention is to cause as little distress as possible to participants, treating them with the utmost of respect, dignity and confidentiality. My supervisor, Prof D Wassenaar, is a registered clinical

psychologist and will assist me in my ethical management of this study. In addition, the study has already undergone and been granted ethical approval by the UKZN Ethics review.

I have already contacted the Dean of Students, Ms Masipa, for permission to contact you in this regard. She has advised me that for ethical reasons she would prefer to rely on your professional opinion before granting permission.

The study has been ethically approved by the Faculty Higher Degrees Committee and a letter from the HSSREC is pending.

If there is any additional information you need to assist you with your decision, my supervisor or myself would be more than happy to oblige. Please feel free to contact me with any questions.

I sincerely appreciate your time and attention in this matter.

Kindest regards

NJacobs

Nicola Jacobs
Research Psychology M1 Student
Contact details:
079 714 0867 033 260 5853
210535112@ukzn.co.za

Supervised by: Prof D R Wassenaar

Clinical Psychologist
Contact details:
Wassenaar@ukzn.co.za
033-2605853

Appendix 3: Informed consent form

CONFIDENTIAL

The following has been explained to me, and I both understand and agree to participate in this study, on the basis of these factors. Firstly, I agree to discuss my own experience with self-harm, in particular looking at the first time that I self-harmed. I understand that I will be taking part in an interview that will be tape recorded, and that the results will be used for a research project for the completion of the researcher's Masters degree.

I understand that the researcher recognises the sensitive nature of the material, and will do all that she reasonably can to protect my identity, through the use of pseudonyms and by keeping all preliminary documentation private. It has been explained to me that access to the audio-data of my interview will be restricted, and that it will afterwards be destroyed. However, I understand that should it become apparent to the researcher that I am planning on injuring myself grievously or otherwise am displaying suicidal intent, she will be obliged, in my best interests, to break this confidentiality and get help for me as outlined in the Suicide Intervention Contract.

I agree that I have consented to take part in one interview of approximately one hour long, but will make myself available for a possible second one if needed. I acknowledge that I have been offered a debriefing session, if I would like, to discuss my reactions to the study. I also confirm that I have been encouraged to see one of the counsellors at my local Student Counselling Centre in order to be professionally debriefed. I understand that my participation in this study is wholly consensual. I recognise my right to withdraw from the project at any stage during the research process.

Participant agreement to the study   Participant agreement for use of tape recorder

_____   _____
SIGNATURE OF PARTICIPANT   SIGNATURE OF PARTICIPANT

_____   _____
DATE   DATE

Researcher

_____
SIGNATURE OF RESEARCHER

_____
DATE

Appendix 4: Take-away information form

Dear Participant

Thank you for your interest in this study. The aim of this letter is to tell you more about the research project, so that you can decide with full knowledge whether you would like to take part in this study.

This research aims to look in detail at the experiences of self-harming students at UKZN, and in particular, at the first time that a student hurt him or herself. It is hoped that by looking at this aspect of self-harm this research will help to shed a fresh view on self-harm in general, and contribute to a better understanding of self-harm. The kinds of areas covered in the interview would include gaining a good understanding of how you see self-harm, the meaning it plays in your life, and thoughts and feelings you have about self-harm. The research process would involve meeting privately with the researcher for an interview lasting no longer than an hour. The researcher kindly asks for permission to audiotape the interview for transcription purposes.

Participation in this study is voluntary. If you do decide you would like to take part, you can still choose not to answer a particular question, or you can decide to withdraw from the study at any stage of the research process. **Your identity will be kept confidential whether you participate or not. Your name will not be associated** with the interview data and pseudonyms will be used to protect your identity so no one will know who was speaking. Any information containing your identity will be destroyed once the study is completed, or will be stored in a secure location by the researcher's supervisor and destroyed after a maximum of five years. The interviews will be held in a private location or in the Student Counselling Centre depending on your personal choice.

Due to the sensitive nature of the research project, the researcher kindly asks that you sign a Suicide Intervention Contract with her. This is an agreement between you and the researcher for your own safety, so that if you are faced with unbearable suicidal feelings, or develop a plan to kill yourself or injure yourself in a *life-threatening* way, action can be taken to help you to cope with this situation until these feelings have passed. This is the only situation where your anonymity may be contravened and *only in life-threatening situations*. Please see below for the contact details of your local Student Counselling Centre, as well as other emergency help-lines.

Some useful contact information:

Contact Person	Phone Number	Email Address or Website
Nicola Jacobs (the researcher)	0797140867	210535112@ukzn.ac.za
Professor Doug Wassenaar (The research supervisor)	033 260 5853	Wassenaar@ukzn.co.za
Local Student Counselling Centre	033 260 5233	munron@ukzn.ac.za
Lifeline	0861 322 322	http://www.lifeline.org.za
South African Depression and Anxiety Group: Suicide Crisis Line	0800 567 567 or SMS 31393 (SMS the problem to them and they will respond immediately)	http://www.sadag.co.za/

Appendix 5: Anti-suicide contract

CONFIDENTIAL

I agree that the researcher and I have discussed appropriate intervention procedures in the face of a potential suicide/life-threatening self-injury crisis situation. This is defined as a situation in which I have unbearable suicidal feelings or thoughts, and/or have developed an intention or plan to kill or injure myself in a life-threatening way, as indicated below:

1. If I become suicidal during the research interview, I will explicitly let the researcher know. If I have an intention to kill myself or injure myself in a life-threatening way, the researcher and I have decided that a professional counsellor at the Student Counselling Centre will be contacted to secure an appointment for me.

2. I acknowledge that I have been offered an optional debriefing session, to discuss how I experienced the interview process. I agree to inform the researcher of any psychological trauma I am facing as a result of the research process. If I do not inform the researcher, but the researcher nonetheless perceives that I have developed a potentially serious suicidal intent, I agree to submit to her judgement and allow her to contact the Student Counselling Centre for assistance until the crises has passed.

3. If I feel suicidal outside of the interview, and need some form of intervention, I can do one/more of the following:

    a. I can contact my local UKZN Student Counselling Centre on 033 260 5233.

    b. I can contact Lifeline on 0861 322 322, or the Suicide Crisis Line on 0800 567 567 or SMS 31393 for an immediate response, at any time daily.

    c. I can contact the researcher on 079 714 0867, and she will assist me in accordance with point 1. above.

I hereby agree to this contract in the event of a suicide/life-threatening self-injury crisis situation, recognising it is in the best interests of my health and safety. I agree to be honest and open with the researcher in the face of a suicide crisis so steps may be taken to help me to cope with this situation.

_____   _____

PARTICIPANT'S NAME or INITIALS   PARTICIPANT'S SIGNATURE

_____   _____

DATE   RESEARCHER'S SIGNATURE

Appendix 6: Interview schedule

1. Definition of Self-Harm
   o When I say the words "self-harm", what do you think about?
   o What kinds of images or words come to mind when you think of the term "self-harm"?
   o In terms of your experiences, how would you define self-harm?

2. Role and Meaning of Self-Harm
   o What does self-harm mean to you?
   o What role does/did self-harm play in your life?

3. History with Self-Harm
   o When did you start self-harming?
      ▪ Are you still self-harming?
      ▪ What things do you do when you self-harm?
   o Could you tell me the story of how you began to self-harm?
      ▪ Did you know anyone else who self-harmed before you began? What thoughts did you have about this person?
      ▪ What happened during that first time - what actions did you take?
      ▪ What feelings did you have (before, during and afterwards)?
      ▪ What happened afterwards?
      ▪ Did anyone know about what you'd done?
   o Did you ever harm yourself again?
      ▪ If so: what do you do, what kinds of situations lead/led you to harm, what feelings or thoughts do you experience? Have these changed since the first time?
      ▪ Did your thoughts or attitude to self-harm change over time? Did you begin to see it differently? How so? (habit or cycle? Addictive?)
      ▪ If in therapy, has this helped? What has been helpful? What hasn't been helpful?
   o When you have a difficult emotion, what do you do?
   o Does anyone know you self-harm? If so, please tell me more about their reactions, your relationship with them, whether this has changed because of the self-harm, how you think they perceive you, and so on?

4. Image of self-harmers in society
   o Generally speaking, how do you think self-harmers are seen by non-harming people? Do you think this image is fair?
   o If you could do anything to change this image, what would you say?

5. Is there anything else you'd like add?

Appendix 7: Transcription conventions

[ ]	Square brackets indicate overlapping speech.
(word)	Round brackets indicate a possible transcription.
( )	Empty round brackets show complete inability to distinguish the word.
((description))	Double round brackets indicate a description, rather than a transcription.
(.3)	Indicates the timed amount of seconds elapsed between speech.
(.)	Indicates a short pause, or an untimed pause.
=	Indicates there was no time lapse between speakers.
_____	Indicates that the word or syllable was stressed.
CAPS	Words in capital letters indicate an increase in volume.
::::	Shows that a syllable was elongated. The number of colons indicate how long the sound was held for.
.hhhh	Indicates an audible in-breath.
hhhh	Indicates an audible out-breath or sigh.
.pt	Indicates smacking of the lips.
↑	Indicates a rising intonation, where a question was not asked.
↓	Indicates a lowered intonation.
< >	Indicates speech slowed down.
> <	Indicates speech was speeded up.
°word°	Shows that the word was spoken more quietly than surrounding speech.
(h)	Indicates laughter within speech.
....	Indicates a portion of the transcription has been removed.

Appendix 8: Ethical clearance

**UNIVERSITY OF
KWAZULU-NATAL**

University of KwaZulu-Natal
Research Office
Govan Mbeki Centre
Westville Campus
University Road
Chiltern Hills
Westville
3629
South Africa
Tel No: +27 31 260 3587
Fax No: +27 31 260 2384
E-mail : naidoos4@ukzn.ac.za

19 May 2010

Miss N Jacobs
6 Campbridge Place
PINETOWN
3610

Dear Miss Jacobs

**PROTOCOL: A phenomenological exploration of the first act of self-harm
ETHICAL APPROVAL NUMBER: HSS/0262/2010 M: Faculty of Humanities,
Development and Social Science**

In response to your application dated 13 May 2010, Student Number: **210535112** the
Humanities & Social Sciences Ethics Committee has considered the abovementioned
application and the protocol has been given **FULL APPROVAL.**

**PLEASE NOTE: Research data should be securely stored in the school/department for a
period of 5 years.**

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

**Professor Steve Collings (Chair)
HUMANITIES & SOCIAL SCIENCES ETHICS COMMITTEE**

SC/sn

cc: M van der Riet
cc: Prof. D Wassenaar

Founding Campuses: ■ Edgewood ■ Howard College ∷ Medical School ■ Pietermaritzburg ■ Westville

Appendix 9: Request for protocol amendment

Prof S Collings
Humanities RSC
Research Office
Westville

Ms Beluah Jacobsen
Higher Degrees Office
Pietermaritzburg

30 August 2010

Dear Prof Collings and Ms Jacobsen

RE: **Nicola Jacobs, 210535112, Research Psychology Masters, Pietermaritzburg**

Request for amendment to protocol: A phenomenological exploration of the first act of self-harm. **Ethical Approval Number:** HSS/0262/2010 M: Faculty of Humanities, Development and Social Sciences

I would like to request permission to amend the protocol set out in my application for ethical clearance for my Master's thesis. I had originally decided to analyse my data using Phenomenology. However, I completed a course in Discourse Analysis in the first semester of 2010, and now feel I would be more confident in using the latter methodology, and I think I will obtain a far richer understanding of my research topic if I do so. My supervisor Prof D R Wassenaar supports this amendment request.

I will also need to change the title of my thesis, if permission is granted to change my methodology. The previous title, as approved by the Humanities and Social Sciences Ethics Committee, was 'A Phenomenological Exploration of the First Act of Self-Harm'. I would like to request permission to change the title of my thesis to 'Becoming a self-harmer: A discourse analysis'.

Thank you so much for your time and consideration.

Kindest regards

NJacobs

Nicola Jacobs
Research Psychology M1 Student
Contact details:
079 714 0867; 033-2605853
210535112@ukzn.ac.za

Supported by supervisor: Prof D R Wassenaar

Clinical Psychologist
Contact details:
033-2605853
Wassenaar@ukzn.ac.za

Appendix 10: Approval for protocol amendment

RESEARCH OFFICE (GOVAN MBEKI CENTRE)
WESTVILLE CAMPUS
TELEPHONE NO.: 031 – 2603587
EMAIL : sshrec@ukzn.ac.za

**UNIVERSITY OF
KWAZULU-NATAL**

10 SEPTEMBER 2010

Ms. N Jacobs (210535112)
School of Psychology

Dear Ms. Jacobs

PROTOCOL REFERENCE NUMBER: HSS/0262/2010M
PROJECT TITLE: 'Becoming a self-harmer: A discourse analysis'.

FULL APPROVAL NOTIFICATION– AMENDMENT
This letter serves to notify you that your application for an amendment has been granted full approval.

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study must be reviewed and approved through an amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number. PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years

Best wishes for the successful completion of your research protocol.

Yours faithfully

PROFESSOR STEVEN COLLINGS (CHAIR)
HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS COMIMITTEE

cc. Supervisor – Prof. D R Wassenaar
cc. Mrs. B Jacobsen

Founding Campuses: ■ Edgewood ■ Howard College ▨ Medical School ■ Pietermaritzburg ■ Westville