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"Starting From Scratch"

An Exploration of the Narratives of the Pathways Leading up to the First Episode of Self-Wounding

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"Starting From Scratch"
An exploration of the narratives of the pathways leading up to the first episode of self-wounding

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NOTATION

. . . : (3 dots) indicates omitted text

(.) **:** indicates a pause by participant

↑denotes a rising tone, equivalent to ! or ? marks

! and ? are used in reported speech

<u>Underlined</u> indicates emphasis

A dash in between a few words is a device to indicate an emphasis on my part (as used in Textuality and Tectonics)

Fnfi: **F**ield **n**otes **f**ollow-up **i**nterviews: these interviews were not recorded. Only

verbatim notes were taken.

(*)= text belonging to a very short second recording file which was not transcribed.

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ABSTRACT

Self-wounding is part of the self-harm spectrum. As a practice, it is still difficult for most people, clinicians included, to understand and accept, often leading to negative attribution. While there is an abundance of studies investigating the nature and functions of self-harm, means of prevention and treatment options, links with specific diagnoses, association with suicide etc., there has been no research focusing specifically on the first episode. A first episode is by definition a unique event that cannot be reproduced, taking place in between a "before" and an "after" period; ignoring it and the pathway(s) to it, leads to crucial elements continuously being missed. *Starting from Scratch*, grounded in the user researcher's personal experience of self-wounding, is an attempt at addressing this issue.

The study used a qualitative, mix-narrative approach, using first person accounts, with a sample of six men and five women recruited from the community and the local NHS Mental Health Trust.

The research found that the first episode is indeed a unique learning event as participants were surprised by the effects of self-wounding (relief of tensions and release of emotions) to the extent that a strong memory was created and used at subsequent episodes. The research also found that narratives were important in furthering our understanding of self-wounding by producing a more accurate and experiential landscape of narrative journeys, where turning points (both positive and negative) could move the story in many directions. Implications for health practitioners include skilled training in self-wounding issues and severing the link with suicide ideation.

Key words: self-wounding, first episode, unique event, learning, memory, relief, release, narratives, meaning, journeys.

PROLOGUE

This research is a first person study of someone with the experience of self-wounding, of using mental health services and who is actively engaged in the psychiatric survivor movement.

The overall design of the thesis was influenced by Foucault's notion of theatre of discourse (1971) and, inspired by the performative qualities of the narratives and of the cast of the different voices that support this work: those of people who shared their experiences, my own (through the Prologue and Epilogue -which open and close the piece), and generally throughout the thesis including in places where it is not normally expected; and that of. The role of Interludes is to bring breathing spaces that sometimes illustrate or echo themes from the thesis. I therefore consider this thesis to be a form of 'theatre of discourse' where different voices and different narratives perform.

Anne-Laure's narrative

What is my identity narrative? My passport would tell a stranger that I am French; it gives details of my place and date of birth, of my physical appearance over and, above, the photograph where I managed to keep my eyes open for once. This though is only the administrative identity that defines me as a legal citizen of a recognised country of the European Union. It does not say anything about me as a person.

My identity is multiple. I am a woman, I am white, I come from a multi-cultural, mostly French/Russian background (with some Scottish, Austrian and Spanish thrown in), I am agnostic... and so forth. I am also, like anyone, a person constructed in many different ways: through my gender, the influence of the education I have received (formal and informal), but also of the events that have occurred in my life or the places I have lived in; the people I have met; those I have loved, fallen out of love with, or grieved for, etc.; and through my interactions with the social world.

I am also an exile, now living in the UK, having left another life behind, one where I was suffocating. This has had a bearing on language and meaning-making in my life. Taking inspiration from Eva Hoffman's book, I have often felt 'lost in translation'; thoughts

and experiences that were embedded in a social-cultural framework did not always translate in the way that I needed them to. Sometimes I learned or created new ways of conveying those thoughts and experiences for myself. One of them has been to become an activist in the mental health survivor movement which has allowed me to express myself using a very different identity. Another has been through creative writing. Perhaps more accurately than 'lost in translation', I feel that I have been in constant translation, where my narrative is constantly tentatively being built, forever marrying and divorcing both sets of culture at the same time, while building on both. Maybe I have felt like this all my life.

It is said that our identities are also defined through our activities (or lack of) and I guess one of my identities, in that sense, is that of a person with the experience of self-wounding and I shall now turn to and see how it fits into this narrative.
I started self-wounding (in the textbook sense) in my mid-thirties while an outpatient in a psychiatric unit. I had been drifting in mental health services for a number of years and still did not have a care plan. I felt ignored, even more 'lost in translation' in psychiatry (incapable of making myself heard, unable to make my cultural differences understood yet alone accepted) and reduced by arbitrary systemic operational protocols to statistical data.

My first episode? That night (O nights, hosts to endless ribbons of insomnia...), I just knew that I had to break the envelope of my self, that self that was not, I felt, allowed to be. I had recently experienced a humiliating encounter with a consultant psychiatrist who had written me off as a woman and refused to listen to my concerns. This shattered my sense of self greatly. It was a turn in my narrative as a psychiatric patient, to see part of my identity arbitrarily erased , yet again, by someone else and by someone in a position of authority. After about two weeks, something finally snapped and I cut myself. That was the next turn. Although I felt extremely wound up, the experience was remarkably tense and calm at the same time. I was surprised at the effect of what I was doing to myself. Maybe hours later, I realised that this was something that I could and did control, and that gave me an extraordinary sense of peace, and relief.

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I never considered what I did then as self-harming/wounding. I did not have the words. Psychiatry gave them to me later in the way that staff described my 'behaviour' back to me and recorded it in the notes. By breaking the envelope and letting the blood free, I was looking to give consistency and reality to my despairing self. Cutting, then and later, never quite brought relief but a never ceasing amazement, while disconnecting me. Although I never actively sought to reproduce this effect, I have always hoped for it.

It was personal and I never talked about it until one day some of my scars became visible, albeit only slightly. I had always been careful not to cut deeply; I did not want the scars. Scars meant the wrong kind of attention. Still, they were noticed and straight away dismissed by my key worker ("What are you doing this for? Aren't you ashamed?"). My self-harm was put away and ignored. The notes of this meeting in my medical records were very vocal though succinct: "A-L presented with self-made minor scratches. No infection". "Self-made", that sounded like a flat-pack experience, the ultimate in disposable experience. "No infection". Rather, did my self-wounding appear so emotionally infectious that this nurse could not engage with me about my reasons for self-wounding? This was odd. And yet, where were the questions, the real questions this professional should have asked? What had become of my experience, other than those few dismissive words amongst medical notes? As someone said to me, "if you don't ask, you cannot know". Maybe she did not want to know. Maybe she could not ask. Those will remain unanswered questions. Needless to say that this experience, together with the subsequent reading of my medical notes, put me off from opening up to anyone on the subject again for a very long time.

My self-wounding has always been (is still) considered by psychiatry as suicidal ideation ('notes' again!) and not what for it really is, a crisis of the self. Psychiatry has only ever been interested in my 'behaviour' and never in my 'self' and yet my 'self-skin' was there, just there, like the 'elephant in the room', framing the moving landscapes of my inner distress.

A turn in the narrative: Becoming a user/survivor researcher
From being a service user to becoming a user/survivor researcher represents a remarkable event in my life narrative, a turn of momentous proportion as it gave me a

new identity and a much more solid sense of purpose to my activism. This happened by chance (serendipity?) through a user-led project where I was first a volunteer and then became its paid coordinator.

User/survivor researchers have experience: of the condition, of using a health service, of navigating a (politically, economically) managed system of care known as mental health services, of taking medication or receiving specific treatments (or of not getting access to those), and so forth. Such is the epistemology of user/survivor research, totally grounded in experience. It forms part of what is sometimes known as "mad culture" and still has to knock hard at the door of academia where it is only really accepted if it agrees to conform to the local habitus (Webb, 2006). It has been reporting about people's experiences in a way that psychiatric research had never done (Sweeney et al, 2009; Wallcraft, Schrank & Amering, 2009). User-led researchers assert that research

> should be based in the subjective, lived experience of emotional distress. This raises the issue of ecological validity, or the way in which research findings reflect, or fail to reflect, what happens in the real world. Redefining outcomes according to a/priorities can help to make greater sense of clinical research, improving its ecological validity. (Faulkner & Thomas, 2002, p. 2)

As a survivor researcher, I consider myself politically engaged in creating experiential knowledge, in the context of evidence-based medicine where lived experience and first person accounts are often ignored because they are deemed anecdotal since unsupported by academic and clinical research (Wallcraft, 2007, p. 342).

I became involved in self-harm research also by chance and took part either as a participant or as a research partner. However, I was frustrated by the bio-medical perspective on self-harm. I could see its merit but I also became increasingly aware, precisely because of my experience and what I knew of others', that this type of research continually missed many elements. The first episode of self-wounding is a case in point. Just like Webb (2006), I could not recognise myself either in the clinical body or much of self-harm research that claims to talk about my experiences, about my self. Sometimes I saw glimpses of potentiality for something different which quickly vanished through reductionist and sometimes distorted assumptions made by

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'experts' who claimed to tell the truth about the experience of self-wounding from their academic positions. The decisive turn took place when I decided to act on my responsibility as an activist and partnered up with another survivor researcher with the aim of promoting the qualitative salience of the first person voice. This led first to an NHS project and then to the present study which has known many twists and turns until a methodological compromise was reached and a more narrative approach applied.

PART I: THE STUDY

LITERATURE REVIEW, THEORETICAL FRAMEWORK and METHODOLOGY

CHAPTER ONE : LITERATURE REVIEW

This chapter will present the self-harm research environment, different meanings of the phenomenon in the literature, looking at the medical, language and socio-cultural discourses. It will also will introduce the theoretical framework of the study and present the rationale for the study, followed by aims and objectives.

1.1 Historical context

Although self-harm has gained much wider public awareness in the last thirty years, it has been documented as far back as the Greek philosophers (Bataille, 1930/2009, p. 72). The famous case of Van Gogh's severed ear has been the focus of much debate. For Bataille, Van Gogh's act is the mark of sacrificial self-mutilation and a way of "spitting back in the face" (sending the ear to a brothel) of all those brought up to believe that life is sacred (1930/2009, p. 31). By contrast, French artist and writer Antonin Artaud, who had an affinity with the depressed artist, considered Van Gogh's act as a perfectly reasonable proposition in a world that was trying to silence the voice of true genius,

> One can talk about the good mental health of Van Gogh who, during all of his life, only cooked one of his hands and as far as the rest is concerned, only cut his left ear off once.[1] (Artaud, 1947, p. 9)

Self-harm has sustained a high level of interest from many fields: psychiatry, neurobiology, sociology, ethics, psychoanalysis etc., each with its own perspective on the subject. It has however been the focus of medical and psychological attention and research mostly since the 1910s and has been a major public health concern since the late 1960s, partly due to the increase of presentations in hospitals (Frost, 1995). This is reflected in the abundant literature on the subject. Historically, the psychiatric literature on self-harm goes back to the late 19th, early 20th century with papers published in France (Bourgeois, 2009) and the US (S. N. Shaw, 2002) exploring its psychopathology. The main areas include on the one hand, the clinical, epidemiological, public health and social medicine approach, mostly concerned with interventions and prevention and, on the other, the socio-cultural approaches, which have a more context and humanistic based approach.

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[1] "On peut parler de la bonne santé mentale de Van Gogh qui, dans toute sa vie, ne s'est fait cuire qu'une main et n'a pas fait plus, pour le reste que de se trancher une fois l'oreille gauche."

There is a lack of historical perspective which would allow a critical analysis. Naomi Shaw's (2002) meta-analysis, which focuses on episodic, repetitive (with no suicidal intent) self-injury, is a notable exception. She shows how the focus has predominantly been on women and young girls. She highlights how the thinking on the subject of self-harm has not evolved greatly through the decades and that the same debate and the same questioning are still taking place. She argues that the tensions apparent in the literature are the radical oppositions between two schools of thought. On the one hand, socio-cultural and psycho-analytic approaches which take into account "interpersonal relationships and social environments", acknowledging that self-injury is viewed as "adaptive, tension-relieving and self-soothing" (pp. 196-197) . On the other, a more medical model approach, "where the behaviour is seen as addictive, interpersonal relationships and social environments are de-emphasized and the pathology is located within individual women and their inability to resist self-destructive impulses" (p. 198) . This is a shift towards pathologising the condition, constructing "self-injury as a syndrome of impulse dysregulation"(p. 198). Shaw identifies cycles of activity in self-harm research since the 1950s with periods of inactivity at historical points, which she links to clinicians,

> [Pulling] back from the investigation of self-injury as they come closer to making meaning of the behaviour and potentially grasping its significance. They do so by failing to document and explore the phenomenon in the clinical literature, dismissing the behaviour as the wilful manipulation of deviant, pathological women, or alternatively by disengaging from women in treatment. (S. N. Shaw, 2002, p. 205)

Shaw (2002) and Sharkey (2003) provided the only two literature reviews specifically focussed on self-injury/self-wounding. Shaw offers the following explanation for the absence of publications on episodic or repetitive self-wounding for about 30 years until the mid 1960's,

> because it has been assumed that the study of self-injury was simply subsumed in the suicide literature . . . My examination of the suicide literature reveals that what is actually investigated in this scholarship in mainly self-poisoning, not self- injury. (2002, p. 196)

1.2   Self-wounding as a coping strategy

Self-wounding is a specific aspect of the self harm spectrum and refers to an act which consists in inflicting an injury to one's body without suicidal intent. It is described as a

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coping mechanism (McAllister, 2003; S. N. Shaw, 2002; Babiker & Arnold, 1997). The tensions that exist between different perspectives on self-harm (Reece, 2005; McAllister, 2003) possibly suggest very differing approaches in terms of clinical interventions. Examples of self-wounding include: cutting, burning, biting, scalding, punching, hitting, scratching, scraping, rubbing, pulling out hair, inserting or swallowing objects, etc. Self-wounding, unlike self-injury, does not include taking non-fatal overdoses (those can be ambiguous).

1.3   The pathologisation of self-harm/self-wounding

1.3.1   The medical discourse

The pathologisation of self-harm has steadily increased since the mid 1980s (S. N. Shaw, 2002). Already in the late 1960s, there is evidence of "insistence in official (DHSS, 1968) guidelines that all people who self-harm should be seen by psychiatrists"(Frost, 1995, p. 6) reflecting "the broad assumption that they are mentally ill" (ibid). The pathologisation is also seen in the type of research that has been conducted, most of it usually in the shape of random control trials, e.g. (Bennewith et al., 2002), using large samples. Becker (1973) argues that "almost all research on deviance [behaviours linked to mental illness being regarded as deviant from the norm] deals with the kind of question that arises from viewing it as pathological . . . using the tools of multivariate analysis" (p. 22).

Most research on self-harm is thus still being done from a psychopathological perspective usually with an emphasis on clinical interventions, often driven by the desire of the UK government to reduce the incidence of suicide, mostly because of the perceived link between self-harm and suicide attempts (Pattison & Kahan, 1983). The last UK Government had set targets to reduce suicide and self-harm, exemplified by the National Service Framework for Mental Health (DH, 1999) which had made suicide prevention one of its key priorities. European research programmes, in particular, the 7th *Framework Programme for Research and Technological Development* (FP7, 2007-2013) feed into the work of the European Mental Health Pact which has the prevention of depression and suicide as one of its beacon themes (Wahlbeck & Mäkinen, 2008). Such programmes, under the auspices of the World Health Organisation (which has a very heavy biomedical perspective) influence greatly what health research is being carried out at national level. This goes quite some way

towards explaining why the medical perspective is dominant in the current body of literature on self-harm through policies, guidelines, reactions and writings, with an emphasis on A&E and in-patients settings (e.g. Evans, 2006); tensions between primary care and secondary care interventions, e.g. Appendix 16 of the *NICE Guidelines on Self-Harm* (NICE, 2004), etc.

1.3.2 Taxonomy of self harm: Hierarchies and value judgements

The pathologisation of self-harm has also been reinforced and set by "the need to categorize and label"(Johnstone, 1997, p. 422). Since the 18th century, there has been a growing interest in systematically classifying everything, from our environment to our cognitive and emotional selves, in an attempt to decipher the links between human experience and its environment. This need to classify nurtured the development of various methodologies (Foucault, 1966, 2003). In medicine, classification is linked to aetiology, as a basis for organisation.

Psychiatry has had a long-standing need to observe and describe symptoms, to classify illnesses according to their external and physical manifestations. Philippe Pinel, the father founder of French psychiatry, thought of classifying as a way of counteracting the excesses of the 18th century's methodical theorists (Brown, 1994). In the early 19th century, madness changed status from an "error of judgement" or "illusion" to a "force that needs to be controlled" (Foucault, 2003, p. 127) allowing the beginnings of an architecture for a new power dimension towards madness to appear in the shape of the psychiatric hospital, bringing with it its own classifications (Foucault, 2003). Classifying has also been used as a way of taming what is sometimes difficult to understand and explain (de Swaan, 1990). This approach has, unsurprisingly, been extended to self-harm. Karl Meninger is often cited (Favazza, 1996; S. N. Shaw, 2002; Strong, 1998) as one of the first clinicians to attempt (in 1938) to categorise self-injury in the psychiatric literature. He distinguished four categories of self-harming "behaviour": neurotic, psychotic, organic and religious. One of the best known names within the contemporary medical discourse is that of Armando Favazza, an American psychiatrist who too has proceeded to establish a new hierarchy of "self-mutilating behaviours" and "deviant-pathological self-mutilation" (1996, p. 233): major, stereotypic, compulsive, impulsive (Favazza, 1996, 2002). This hierarchy, from "high" to "low lethality" poses a number of problems.

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Bowker and Star (2000) argue that categories are mutually exclusive thus reinforcing the idea that classifications are rigid concepts which eliminate the possibility of fusion, overlap or slippage despite the fact that self-wounding may move between these different categories or incorporate different elements of these categories according to the episode. The biomedical stamp of Favazza's categories makes classification authoritative and indisputable, and therefore rigid. Scheff (1975) argues that classification, on top of abstraction, also includes "forgetting that the category is an abstraction; second, acting as if the abstraction were the thing itself"(p. 77) . In other words, this amounts to the reification of individuals, excluding their experiences and the context. Such classifications reflect a judgement supported by a hierarchical value on a person's practice. Ultimately, they also put the burden of norm-ality (or by extension/conversely of "deviance") onto the person who has the experience (Favazza, 1989).

Classifications are also contrary to notions of constructs (how individuals view and understand the world they live in) which acknowledge evolution over time and lived experience (Association des Psychologues Freudiens, 2011). Finally, although Favazza acknowledges that this classification is "simplistic", he also says that "it is comprehensive and useful clinically" (p. 234), these two contradictory arguments can, and do, lead to simplistic and erroneous value judgements, clinical appraisals and decisions about how best to approach an individual's experience of self-harm (Bristol Crisis Services for Women, 1995) perpetuating the idea that it is purely a pathological condition, even when Favazza himself recognises that self-harm may also serve as a coping mechanism (Favazza, 1989, 1996).

1.3.3.   Labelling and cultural issues: Word power of the language discourse
It also seems important to explore the issue of language since, historically, most of it is effectively a product of the medical discourse.

There are many labels attached to self-harm. The most common terms found in the literature were self-harm, deliberate self-harm, self-harming, self-wounding, self-injury, parasuicidal behaviour, burning and wrist-cutting or wrist-cutting syndrome. Less common terms found were: self-inflicted violence, self-mutilation, self-

excoriation, self-cutting, self-soothing and self-destructiveness, focal suicide[2], anti-suicide, non-fatal act, indirect self-destructive behaviour, and auto-aggression.

This range of terms is understood to refer to "self-poisoning or self-injury, irrespective of the apparent purpose of the act" (NICE, 2004). Each of these terms defines the experience in a different way which, in turn, reflects a different professional and/or cultural perspective, therefore different interpretations and approaches. The literature also shows that the terms "self-harm" and "self-injury" are often used interchangeably (S. N. Shaw, 2002); this blurring of the line poses a serious problem as it prevents considering self-wounding as a distinct coping mechanism.

From a first person perspective of someone using mental health services, what is striking is that self-harm (including self-wounding) is usually described and named first by professionals, something that the literature does not pick up on. Most of the time, the experience is not named directly, for instance during a therapy session, but it emerges in clinical records: someone else labels the experience as a technical term, making their own judgment on the experience in the process (Pembroke, 1994).

In research interviews or in clinical settings, individuals who self-harm may not use the term "self-harm" (and its variations) themselves. An example of this is a study I took part in as a user-researcher (Evans et al, 2006), in which participants talked about self-harm by describing the action itself: "I feel like cutting', 'I'm going to cut", "they can't prevent me from doing it", "If I started doing it ", "I feel like doing that", "I can't go out if I do this", " just used to do it quickly" (Evans, 2006). They did not actually name the act but use everyday talk ("it", "that", "this"). It was the researcher who named the action ("self-harm") therefore labelled the person as a self-harmer.
Labels do not happen by chance but because someone designates someone else by a certain (negative) name (H. S. Becker, 1973). This is further compounded by the fact that when an experience, here self-harm/-wounding, is defined and named by people other (clinicians and researchers, writers etc.) than the original person who performs the act, the experience is taken away from them and it raises the question its ownership. Mackinnon (1993) says that it is not what speech 'says' but what it 'does'

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[22] Meninger in Frost (1995, p21): focal suicide refers to "suicidal impulse concentrated on part of the body or as a substitute for the whole".

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that matters; Judith Butler's exploration of performative language provided similar evidence. She says, "Being called a name is also one of the conditions by which a subject is constituted in language"(Butler, 1997, p. 2). With regard to self-wounding, this constituting is performed through the naming of the experience by the medical or the research discourse which constructs and constitutes the self-hood of the person who self-harms. Johnstone (1997) argues that the psychiatric approach to self-harm, through labelling and categorising, effectively removes power and control from the person who self-harms.

The clinicians I dealt with always failed to address directly the issue of my self-harm practice other than in technical terms (where, how often, how deep); they did not address the story behind either, as with Pembroke "My doctor merely wanted to know how many times I had attended the accident and emergency department since my last appointment" (1991, p. 32). For Fairclough (1992) such encounters between patient and medics reveal a clash between the physician's need to control "the basic organisation of the interaction"(p. 140) and the patient's attempts to introduce their "'lifeworld' or ordinary experience" (p. 142) , thus reinforcing the impression that the doctor is working towards a pre-set agenda or routine" (p. 141) . This agenda will be pursued even at the expense of the patient's "turn" (p. 141). This reduces the patient's experience to a mechanistic phenomenon. Patients have no control over this practice which extends to medical records whereby some practitioners make a choice to record only what relates to the 'disorder' and little or nothing about the context or the experience from the person's perspective (Kleinman, 1988). I therefore argue that the act of naming an individual's self-harm experience without it being a negotiated process is most likely to result in a form of disempowerment,

> The label itself does not alleviate the pain . . . It stops the individual from <u>owning</u> the experience and finding his/her <u>own</u> language and interpretation. Disempowerment of this kind drives people crazy. It causes people to <u>be</u> and <u>stay</u> 'mentally ill'. (Pembroke, 1994, p. 36, empahasis in text)

The issue of power is further noticeable in the evidence of labelling in mental health. Trughill argues that "language as a social phenomenon is closely tied with the social structure and value systems of society" (1974, p. 19); values "can have an effect on language"(p. 20).

The English language is not immune to cultural differences within its variants. For instance, the adjective "deviant" is commonly used in American English with regard to self-harm. It is a striking example "of the common view" that identifies rule breaking "as something essentially pathological, revealing the presence of a disease"(H. S. Becker, 1973, p. 5). By contrast, for Becker "Deviance is not a quality that lies in the behaviour itself but in the interaction between the person who commits the act and those who respond to it" (p. 14). In UK English, such a term is problematic because it belongs to a pejorative and stigmatising répertoire. Scheff, in his body of work, has repeatedly pointed to the cultural differences in the interpretation and uses of certain words in relation to emotions, thus reflecting the societal differences that also influence those (Scheff, 2003). In UK English though it is the term "deliberate" which, when attached to "self-harm", is extremely problematic. The term "deliberate self-harm" (DSH) was first coined by psychiatrist Morgan Gethin (Cresswell, 2005c) in the 1970s to define the intentional, deliberate act to cause harm to one's self. Its US version is NSSI or non suicidal self-injury, also related "to maladaptive behaviours" (Klonskky & Glenn, 2009; Nock, 2008, 2009). The association of the adjective "deliberate" to "self-harm" only serves to add confusion to the debate in particular in the way that it is used. For instance, a cohort study describes DSH thus: "Deliberate self-harm (DSH, attempted suicide)"(Gunnell, Bennewith, Peters, Stocks, & Sharp, 2002, p. 599). Blunt and unequivocal, the description creates a crude automatic link between self-harm and suicide through an authoritative statement. Deliberate can also suggest a degree of responsibility and culpability which is further stigmatising and can be counter-productive. For instance, Rodham and colleagues (2004) associate deliberate self-harm and "premeditation"(pp. 80-81-84), a criminology term, which runs the danger of reinforcing the notions of guilt, attention seeking and manipulation. It is important to note that the group which worked on the National Institute for Clinical Excellence (NICE)[3] *Guidelines on Self-Harm* (2004) decided "not to use the words 'deliberate' or 'intentional' to prefix self-harm"(p. 18). The term DSH is however contested not only by persons with a self-harm experience but also by a growing number of health professionals who find it unhelpful and stigmatising (S. Allen, 2007; Woldorf, 2005). While "the issue of language when working with people who self-harm is critical" (S. Allen, 2007, p. 174), the continuous use of the term

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[3] NICE is part of Department of Health (DH) in the UK

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"deliberate" may be construed as a reflection of the meaning of self-harm in professional practice.

Looking briefly at at least one other language, I considered my mother tongue, French, and noticed cultural differences. In French, the most commonly used term is "automutilation", an umbrella word for all forms of self-harm, including self-wounding. It is followed, although far more rarely, by scarifications, or brûlures/saignées/blessures infligées à soi-même[4]. The term "deliberate" is rarely used.

1.3.4   Associations between self-harm and diagnosis mania

Labelling and categorising self-harm practices in psychiatry has resulted in regular attempts to align them with "existing psychiatric groupings" (Johnstone, 1997, p. 422). For instance, calls were made in the early 1980s to classify self-harm within DSM IV as a separate diagnostic syndrome (Pattison & Kahan, 1983). In the UK, such alignments go against the recommendations from the NICE *Guidelines* (2004) which clearly state that "Self-harm is not an illness, but is a more or less dangerous behaviour that should alert us to an underlying problem, difficulty or disorder" (p. 166). However, the use of terms such as "dangerous" and "disorder" are still effectively dangerous in themselves as they posit self-harm not only within the illness but also within the criminology discourse. Thus if NICE offers an alternative approach, it is nevertheless flawed as it leaves ample space for ambiguity about the nature of the experience. Johnstone (1997) denounces the association between self-harm and medical disorders as stigmatising and negative as it only serves to pathologise the practice while ignoring the psychosocial dimensions of the distress that often creates the practice in the first place.

There is also an over-representation in the medical literature of articles and papers which link self-harm with mental illness, in particular schizophrenia, psychosis and especially Borderline Personality Disorder (BPD) (Walsh & Rosen, 1988; Favazza, 1996). For Favazza, "each type of self-mutilation is usually more prevalent in certain mental disorders either as a central diagnostic feature or as an associated feature" (p. 234). BPD is a controversial diagnosis often attributed to women who self-harm (C. Allen,

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[4] Scarification, burns, bleedings, self-inflicted wounds

2004; APA, 2000; Johnstone, 1997; C. Shaw & Proctor, 2004). Throughout its existence, BPD has been criticised for a range of reasons including its lack of scientific reliability and validity (Pilgrim, 2005), its weighted construction, which pathologises the coping strategies and options of particular populations - such as women (D. Becker, 2000). It does so by ignoring the trauma, disempowerment, silencing, and exclusion that most of those women have have suffered from, or by focusing on "defective" individuals rather than a defective society (Shaw, Spandler & Warner, 2007; Tantam & Whittaker, 1992) with the use of terms such as "maladaptive styles of behaviour and thought" (DSM IV-TR, APA, 2000). However, despite the fact that some prominent voices have clearly stated that BPD is "an enduring pejorative judgement rather than a clinical diagnosis" (Lewis & Appleby, 1988), being "little more than a sophisticated insult" (p. 44) (Lewis Herman, 1992), BPD remains firmly attached to self-harm in the minds of many health practitioners with resulting discriminatory practice (Pembroke, 1994).

1.3.5   Self-wounding and the suicidology discourse

Another major longstanding attempt at aligning and enshrining self-harm practices, including self-wounding, firmly within the illness discourse, is its recurrent inclusion within the suicidology discourse. Cresswell & Karimova (2010) point to medicine's moral code to explain the quasi link between self-harm and suicide that has prevailed historically. This unwritten code has been portraying and treating individuals who successfully commit suicide or who are ill, as "genuine" and "sincere", and individuals who self-harm as "insincere", "manipulative" or "ungenuine" (Cresswell & Karimova, 2010, p. 164), weighing up conduct according to this positive/negative, good/bad code whereby individuals are responsible (not deserving of help) or not responsible (deserving) for their actions.

In order to understand this so-called 'link', it is necessary to briefly examine the policy context of the early 1990s which allowed this association to flourish. Cresswell argues that it is only after the publication in 1992 of the Department of Health's "*Health of the Nation"*, that Morgan claimed that "DSH becomes a sheer numerical fact figuring in a number of risk 'scenarios'. Chief among these is 'suicide'" (2005b, p. 270). Not content to be only a "numeral fact", "psyche is severed from any causal linkage with the bodily act- something Morgan insists on" (Cresswell, 2005b, p. 270). Thus the

reality and experience of the person are denied and therefore silenced in this objectification of the act.

However, even numerical facts are problematic. Statistics that would give a true picture of the self-harm (including self-wounding) experience are virtually impossible to find. The only figures available are for presentations at Accident and Emergency Departments (A&E) in England and Wales which rarely differentiate between single and multiple presentations, can only hint at actual numbers of people who self-harm and ignore the nature of self-harm or the story behind it. Figures which are available and readily offered are mostly about suicide. However, these do not tell the real story either and their value is uncertain, "unquestionable reliance on such statistics in an effort to inform service provision could be misleading" (S. Allen, 2007, p. 174).

In the suicidology discourse, self-harm becomes an "indicator of suicide", a "suicidal behaviour" and, in some quarters, it is considered "a cause of suicide" (Webb, 2006a, p. 39). It is this deliberate focus on a link between self-harm and suicide in research that shifts the discourse towards suicidology (e.g. Hawton, Zahl, & Weatherall, 2003). However this link is hardly new. From 1844 onwards the pre-printed forms used in the Royal Bethlem Hospital's medical recordkeeping included a question asking whether patients were "disposed to suicide or otherwise to self-injury"; but from 1854 onwards and well into the twentieth century, this printed query is shortened to "whether suicidal" (Gale, 2012). It seems that self-harm was not diagnostically distinguished from suicidal activities as early as the mid-nineteenth century.

Another factor is the way clinicians and researchers look for evidence to explain someone's death. Psychological autopsies are sometimes performed after a successful suicide attempt,

> One of the difficulties with statistical data such as that proposed in *Hawton et al 2004* is that information is gathered following a 'suicide' and, through this retrospective exploration of preceding events, a history of self-harm may be revealed. However, what cannot be clarified are the nature, meaning and intention of the person prior to his or her death. (S. Allen, 2007, p. 174)

Psychological autopsies are thus not very sophisticated, preventing a true depiction of what went on in the person's mind. Furthermore, statistics based on this data are biased towards a simplistic causal link between self-harm and suicide. Another, and

complementary explanation, is the claimed increased risk of suicide by "self-mutilators" (Favazza, 1996). However, what the statistics do not reveal are the reasons why someone who self-harms/self-wounds may attempt suicide. These may be unrelated; participants may not have got help for their self-harm or other issue; help may have come too late, etc. (Pembroke, 2002). Such autopsies however are blind to such aspects of the story. The quasi automatic and crude link between self-harm and suicide is thus a source of tension as it not only confuses a potential correlation with causation but also ignores the purpose of self-harm without suicidal intent (self-wounding), which is mostly attempt at self-preservation (Bristol Crisis Services for Women, 1995; Pembroke, 1994). It simply ignores self-harm, and self-wounding, as a human response to an often intolerable situation.

In Webb (2006a, 2006b), the proponents of the suicidology discourse consider suicide attempts and suicidal behaviours as symptoms of psychiatric disorders (rather than as a crisis of the self); this find echoes in the conflict that opposes self-harm as a form of suicide ideation and self-harm as a coping mechanism (NICE, 2004, p. 73). The inclusion of all forms of self-harm within suicidology leads to a discourse which treats the experience in an abstract, third person fashion that negates, if not denies, the person who has gone through the experience. Webb talks about the experience of suicide being described in the official literature and at conferences as "some sort of an exhibit in a glass jar to be pointed at" (2006a, p. 9). Similarly, we have already seen that it is usually health professionals and researchers who name the experience on behalf of the individual.

1.3.6   The pathologisation of self-harm/self-wounding

The pathologising process is achieved in different ways.

First through a dominant focus in the literature that considers self-harm/self-wounding as a disease. For Kleinman, disease "is what the practitioner creates in the recasting of illness in terms of theories of disorder . . . That is to say the practitioner reconfigures the patient's and family illness as narrow technical disease problems"(Kleinman, 1988, p. 5). This narrow approach clearly constructs and reduces self-harm/self-wounding to an alteration of a normal behaviour (hence the use of such terms as "deviant" in parts of the literature) and acceptable social norms, a disorder that needs controlling and correcting. The 'behaviours' described in these studies are virtually transformed into

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problem lists, leading to a problem-solving approach which can be found in numerous studies that focus on the function of self-harming and behavioural aspects of "self-harmers"(Klonsky, 2009: Klonsky & Glenn, 2009; Lloyd-Richardson, Perrine, Dierker & Kelley, 2007, Nock & Prinstein, 2004) and "other harmful behaviours" (Nock, 2008). The hypothesis seems to be that if clinical research can decode its function and associated 'behaviours', then interventions can be designed to reduce and stop self-harming. However this model mostly ignores the existence and importance of meaning of the experience, in particular from the perspective of those of engage in it; at best it is hinted at. The design of large scale studies may respond to health economics policy concerns but it cannot report on meaning, temporality, or experience. As Kleinman puts it,

> Symptoms scales and survey questionnaires and behavioural checklists quantify functional impairment and disability, rendering quality of life fungible. Yet about suffering they are silent . . . such research is scientifically replicable but ontologically invalid; it has statistical, not epistemological, significance; it is a dangerous distortion. (Kleinman, 1988, p. 28)

Not only this but "research that avoids the human side of disorder places the profession and its practitioners in iron chains of restricted knowledge"(Kleinman, 1988, p. 266). As the biomedical model of research focuses on symptoms and behaviours, the subject becomes decentred and its subjectivity (the meaning it constructs from experience) is ignored, denied. In the field of self-harm/self-wounding, this means ignoring the contextual world in which this is taking place and the meaning the person gives to the experience. As the expert (established) perspective on self-harm/self-wounding, the biomedical model of clinical research is very difficult to challenge because of the place it is speaking from, medicine, and the alliances it has made with other fields such as health economics.

For Gabriel (2004) modernity introduced the expert, "Nowhere is the authority of the expert more clear than in the field of medicine. . . One of the main casualty of the expert's unassailable authority was 'everyday experience'. Where the voice of experience was not entirely silenced, it was relegated to the standing of 'mere opinion'" (Gabriel, 2004, p. 176). Today still, the dominant hierarchy of knowledge in the field of research places random control trials as the gold standard and people's experiences, therefore their subjectivity, as the least valued type. Glasby and

Beresford (2006) have argued for a more knowledge-based approach to policy and practice. They have also raised important questions about methodologies used to find out about people's experiences such as, "What is more important – an academic commitment to a particular way of knowing and researching the world, or the alleged abuse, extreme boredom and poor quality care that some service users say they experience in mental health hospitals?"(Glasby & Beresford, 2006, p. 278). It is this "particular way of knowing", and constructing new knowledge, that supports the dominant methodologies in self-harm/self-wounding research, therefore frames (or restricts, to pick up on Kleinman) much of the thinking on the subject into a rigid biomedical perspective which is akin to Procrustes' symbolic bed.

Second, the pathologisation is achieved through the hierarchical taxonomy of self-harm/self-wounding which precludes all notions of context, experiential knowledge and social and personal constructs.

Third, taxonomy also encourages the creation of labels which, in turn, have the power to stigmatise. Link and Phelan define stigma as "the co-occurrence of its components–labelling, stereotyping, separation, status loss, and discrimination–and further indicate that for stigmatization to occur, power must be exercised"(Link & Phelan, 2001, p. 363). In psychiatry, power relations between patients and medical staff are highly significant in the sense that psychiatry is the only field of medicine where patients can be forced to receive treatment (in the UK, since the first Lunacy Act of 1840). They are therefore not free subjects in the Foucauldian sense. Labels, through the power of language, also concur to remove ownership of the experience and enhance the biomedical perspective on self-harm/self-wounding.

1.4 Clinicians' attitudes to self-harm

Although there has been a lot of research on self-harm looking at interventions and prevention, there has been very few systematic studies looking at how professionals think and feel about self-harm/self-wounding. Self-wounding is possibly even more difficult to grasp, "The typical clinician (myself included) treating a patient who self-mutilates is often left feeling a combination of helpless, horrified, guilty, furious, betrayed, disgusted and sad" (Frances, 1987 cited in Favazza, 1996, p. 289). It brings up new issues for clinicians faced with conditions which are perceived as difficult,

when the acts are made public, misunderstandings and lack of awareness in clinical practice, both in general medicine and psychiatry, can lead to service responses that are not only unhelpful, but may make matters worse for people who self-harm. This lack of understanding, and the fear thus engendered, can manifest itself in the attitudes, language and treatment of service users who self-harm. (NICE, 2004, p. 73)

Frost argues that the

attitudes of the medical profession are clearly informed by and reflect those of the society at large. Suicide and self-harm (generally held to be two sides of the same coin) are seen as sinful. So people who self-harm are regarded as 'bad' as well as 'mad' (Frost, 1995, p. 10)

The use of terms such as "attention seeking" or "time wasting" to describe the behaviour of someone who self-wounds " 'allows' the profession to ignore the behaviour by adhering to the behaviourist concept of positive and negative reinforcement . . . Thus . . . if you ignore the behaviour you prevent repetition" (Frost, 1995, p. 10). Whereas there is greater empathy for a person's depression, anxiety or experiences of psychosis, there is little for those who seek to find relief in self-wounding.

There has also been very little research on how health professionals actually make ethical decisions based on moral judgements when faced with (perceived) difficult situations or conditions. Hill says "The role of moral judgment is largely unrecognised in the literatures on healthcare communication, caring, empathy, trust, disparities, and education" (2010, p. 2). Hill however notes the presence of studies on areas which are difficult to clinicians, known as "dirty work",

The 'dirty work' literature further explores the contextual dynamics of moral judgment. Dirty work tends to be designated as such because it is inherently 'odious and onerous' and often ineffective, as described in a study of community psychiatric emergency intervention. This literature extends the earlier finding that patients who fail to legitimize clinicians' effectiveness acquire negative labels. Patients with mental illness, for instance, frequently represent dirty work to primary care physicians, whereas moral or social judgments may not matter when the same patients present with remediable problems. As one physician gleefully noted, 'I enjoy anything which involves bone-setting, plastering, stitching, draining pus' (2010, p. 4)

Notably, Hill shows that

> Blameworthy appraisals are more likely for conditions that appear
> controllable and that appear to be social as much as medical in origin. Self-
> injurious behavior, e.g., suicide attempts and cutting, tends to generate anger
> and frustration along with diminished optimism and effort, unless,
> notably, the clinician self-identifies as having expertise in assisting these
> patients (2010, p. 7)

Negative attribution towards individuals who self-wound sometimes translates into punishing practice whereby little clinical care is taken. Andy Smith and Louise Pembroke's experiences of A&E are illustrative examples, "The physical abuse was usually in the form of inadequate anaesthesia to no anaesthesia or analgesics"(Smith, 1994, p. 17), "I was insulted, condemned and even ridiculed. It would take days to recover from the trauma [of going to A&E]" (Pembroke, 1991, p. 32). Here, someone takes the view that the person who self-harms/wounds deserves less or no clinical empathy, "The staff just confirmed for me that I really was the lowest form of life and reinforced every negative feeling I ever had about myself" (Pembroke, 1991, p. 32). Here, professionals respond to self-harm/self-wounding with an attitude which is based on moral values. Cresswell and Karimova (2010) expose "medicine's moral code as a *discriminatory* code. Professionals' treatment of self-harm *discriminates* against self-harmers, creating adverse effects in their lives" [*italics*] (p. 159). The NICE *Guidelines* condemn such conduct,

> It is totally unacceptable to use scare tactics (e.g. refusal to use anaesthetic or
> threaten service users with sectioning) or to 'talk over' the service user to their
> friends/family members or advocate if the person is conscious and has capacity.
> (NICE, 2004, p. 83)

The training of the professionals does play a part and remains a crucial issue. Huband and Tantam (2000), while examining the attitudes of staff towards self-harm, came to the conclusion that qualifications in counselling and psychotherapy were helpful in diminishing defensive and negative attribution. Nurses, and professionals with a more psychodynamic approach tend to have a more holistic approach to self-harm (McAllister, 2003) and to not always restrict, in theory at least, self-wounding to a collection of symptoms and behaviours that need to be controlled. However, recent articles in *Nursing Times*, still highlight a lack of specific training regarding self-harm for nurses (October 2010).

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The issue of control of self-harm, on wards in particular, is contentious. Sometimes a person is admitted to a ward specifically for their self-harm, because it has become unmanageable or puts their life in danger; sometimes their self-harm is only one of the reasons for their admission. However being an in-patient drastically reduces a person's choice of treatment as this is often dependent on the availability of local resources, the ward 'culture', and possibly the legal status of the person. An example of control includes "contracts of good behaviour" (Sharkey, 2003; S. N. Shaw, 2002), sometimes called "safety contracts"(Walsh, 2007) with threats attached to them, such as sectioning or immediate discharge (Bristol Crisis Services for Women, 1995). Punishment, or threats of punishment, can have adverse effects, "Preventing the individual from self-harming by conditioning themselves only relieves the distress of observers. The individual is left with no outlet for explosive emotion" (Pembroke, 1991, p. 32); "Punishment may be an overt or a covert element in behavioural treatment but, irrespective of the ethical issues concerned, there is no evidence that it is of benefit"(Tantam & Whittaker, 1992, p. 458).

1.5   Where are the men?

Despite being absent or marginal in self-harm studies, and their self-harm experiences mostly ignored by the feminist praxis, many men do self-harm,

> Studies which look at all instances of self-harm, regardless of means or intent, usually find that rates are higher in females than males by a ratio of 1.4–2.1 to 1 (Williams 1997, p. 70), with the gap closing in recent years.
> (Taylor, 2003, p. 84)

For Woldorf "the actual gender distribution is unknown. Many theorists and clinicians alike consider SI [*self-injury*] a 'female problem', an assumption that may be self-perpetuating in that it might further discourage men from seeking mental health services"(2005, p. 197). It may possibly be responsible for keeping the research focus on women or mix-gender samples.

A search through the National Research Register, which keeps records of NHS funded research, shows instances of exploratory studies, which are not available (possibly not published). It seems Taylor (2003) remains to date the main study focusing particularly on men and self-harm.

Statistics specific to men are not available, again mostly because they are often lost amongst mixed-gender samples. The reality of the situation is difficult to ascertain, "Establishing an accurate picture of the number of men (or women) who self-harm is a near-impossible task" (Taylor, 2003, p. 84), although Rodham confirms that "recent work has indicated that just as many male as female self-cutters are seen in accident and emergency departments" (Rodham et al., 2004, p. 85) which would support the need for further exploration of self-wounding in men in particular since, according to Taylor, men may have a different way of dealing with strong emotions than women,

> They are also more likely to engage in public and violent self-harm, such as themselves or a wall, breaking bones, or in dangerous behaviour as a means of self-harm. Dangerous behaviour (such as joyriding, getting into fights and dangerous sexual behaviour) is particularly unlikely to be identified as self-harm, helping to keep male self-harm from the public consciousness. (Taylor, 2003, p. 86)

Although some practices by men may not be identified as self-harm by other parties, such as health services or relatives, or the general public, they may be by the individual themselves even if they do not say so openly. For instance, some may present with injuries at emergency departments using the excuse of DIY clumsiness; these injuries are then recorded as "accidents" (Frost, 1995, p. 6). This practice belongs to what Turp calls "low visibility" or "hidden" (p. 200) self-harm when the practice is occasional and not disclosed, "The self-harm in question does not fit prevailing stereotypes . . . and passes unnoticed, or is noticed but not recognised for what it is" (Turp, 2002, p. 200). Some individuals, in particular young men, choose not to conceal but "wear" their self-harm as a defiant badge of honour (Woldorf, 2005, p. 197) in the same way that some people, football fans for instance, wear tattoos as marks of allegiance to the team they support. In this instance, self-wounding is as much about validation as it is about provocation (my skin bears the mark of <u>my</u> experiences; a form of re-appropriation of life), a form of self-advocacy (Cresswell, 2005a).

Babiker and Arnold (1997) point to masculinity issues which have not yet been explored in depth. They stress the burden placed on men to perform as men in Western cultures,

> Men are expected to be successful in certain quite public spheres . . . and ownership of material things such as cars. If they fail in these spheres, for example due to illness or unemployment, men may feel they have no role or

power and may become more vulnerable to depression and emotional
difficulties, which of course may possibly lead to self-injury (1997, p. 42).

This may be because "there are few ways in which they are likely to feel comfortable in
expressing other emotions"(1997, p. 43). However, the speculative nature of what is
known about men and self-harm only calls for urgent research into this field.

1.6   Self-harm research in nonclinical populations

There has only been some research some involving non clinical populations. These
studies have usually been conducted using homogenous sample groups, such as
military recruits (Klonsky, Oltmanns, & Turkheimer, 2003) or university students (Gratz,
Dukes Conrad, & Roemer, 2002). They show that self-harm is also present in these
groups and that individuals self-harm for the same reasons as those in clinical
populations. Such findings are important as a confirmation that self-harm is to be
found across all sections of the population but the use of homogenous samples does
not actually produce any new knowledge about self-harm or self-wounding.

1.7   The socio-cultural discourse

In this section I examine aspects of the socio-cultural discourse on self-harm/self-
wounding: self-harm survivor activism and the socio-anthropological perspective.

1.7.1   Self-harm survivor activism

Self-harm survivor activism started in the late 1980s, in parallel to the revival of user
and survivor activism in the UK against a conservative psychiatric system in which
users felt totally disempowered (Campbell, 2005). In response to the top-down system,
activism has produced bottom-up forms of self-advocacy with a view to challenging
the status quo. Indeed, as Peter Campbell, himself a survivor and writer, and a founder
member of the Survivor History Group[5] states, this movement is not just about
"people speaking out and acting for themselves"(Campbell, 1999, cited in Cresswell
2005, p. 1669). It is also about "forms of speaking from the locus of the suffering 'I' and
constitutes a serious claim to truth and these people incorporate a knowledge forged
in the direct experience of 'surviving'" (Cresswell, 2005, p. 1670). These forms of self-
advocacy form what the self-harm activist movement calls "truth-claims" or
"testimonies" (ibid).

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[5] www.studymore.org

Self-harm activism itself "originated at the confluence of mental health and feminist movements" (Cresswell, 2005b, p. 260). In the mental health and self-harm literatures, survivors are experts of their own experiences, which is similar to the feminist stance where women are also portrayed as experts of their own experiences.

Some strands of feminism construed acts of self-harm as "culturally unacknowledged forms of self-knowledge and self-expression for girls . . . [where] what cannot be known or named in girls' experience find a new language – a knowledge written on their body" (Rogers, 1996, cited in Shaw, 2002, p. 202). This is reminiscent of some aspects of the self-harm survivor literature, which highlights self-harm as a way of using the body to interact with the world (McAndrew & Warne, 2005). The feminist praxis in particular has often focused on how women experience the world in which they live but also their relationship with their body in relation to their environment (Piran, 2001; Cresswell, 2005). It has also strongly insisted that self-harm and self-injurious behaviours belong firmly to the realm of women's experiences. In turn, most of the feminist self-harm research focuses on female self-harmers (Shaw, 2002; Kiselica & Zila, 2001). The ground-breaking work of the Bristol Crisis Services for Women has adopted a social constructionist position exploring women's experiences, using their testimonies as a political tool (M. Cresswell, 2005). In a survey conducted on self-injury, it was argued that,

> Consideration for the reasons for women's self-injury also points to the need to understand this in terms of sexual politics. Life experiences which underlie women's self-injury, such as sexual abuse and battering by partners, lack of and response to their needs. Lack of power and control and the imposition of caring roles, bear a direct relationship to women's social position and their socialisation towards this. (Bristol Crisis Services for Women, p. 25)

For its part, self-harm activism has brought a new dimension of self-advocacy and self-awareness (Cresswell, 2005b) to the self-harm literature. There has been a growing number of experiential writings published, particularly regarding the experience and meanings attached to self-harm (Harrison, 1995; Arnold, 1995). This literature is political in the sense that it uses direct experience to challenge the hegemony of the institutionalised discourse which pathologies and denies the experience as anecdotal, thus silencing it (Cresswell, 2005c). These accounts are akin to what Foucault referred to as "subjugated knowledges", "that have been disqualified as nonconceptual. . . that

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are below the required level of erudition of scientificity" (2003, cited in Cresswell, 2005b, p. 268). It is thus a way of virtually taking over the asylum and illustrates what Laing called "the politics of experience" (Laing, 1975) and attempts to offer a different definition and interpretation of the experience other than that of the medical discourse (Cresswell, 2005b). It could also be said that, in the way that this literature challenges how knowledge is constructed, it is reminiscent of resistance narratives (Ewick & Silbey, 2003) where the extent and limits of power are tested.

One recurrent theme, or metaphor, of the survivor self-harm literature is the "silent scream", referring to self-harm. It was first coined at the first 'Survivor Speak Out' conference in 1989 by the late Maggy Ross (Cresswell, 2005b; Pembroke, 1994),

> So what is it? It's a silent scream. It's about trying to create a sense of order out of chaos. It's a visual manifestation of extreme distress. Those of us who self-injure carry our emotional scars on our bodies. (Ross, cited in Pembroke, 1994, p. 15)

Since then, it has been "redeployed" as a "leitmotiv" by others in the movement and has "diffused to penetrate mainstream civil society" (Cresswell, 2005b, pp. 268-269) by being picked up in numerous publications. The strength and endurance of the metaphor is twofold: its power to encapsulate the experience of women in particular being silenced, having to conform, having to show appropriate behaviour and levels of emotions in a society where dominant codes are experienced as being shaped by men (Pembroke, 1994); as an illustration of "the political deployment of language . . . one of the means by which self-harm survivors 'struggled' with the hegemony of psychiatry" (Cresswell, 2005b, p. 281).

Although by no means the only one, the following example of experiential writing still stands the test of time: *Self-Harm. Perspectives from Personal Experience* was written by survivor and creative artist Louise Pembroke (1994). She was the first survivor to crack the wall of silence that surrounded self-harm for so long in the UK. *Perspectives* uses first person narrative accounts of self-harm, evidenced from the edge to describe what it is like to self-harm/self-wound, to seek and receive treatment in various health settings, in order to draw out critical issues, notably addressing the discriminatory aspects of psychiatry and medicine's moral code which weighs self-harm with highly negative values (Cresswell & Karimova, 2010).

Perpectives and the work of Pembroke have been seminal in the UK context. Pembroke organised the first conference on self-harm in 1989, run by survivors, and set up the National Self-Harm Network in 1995 "in order to campaign more effectively for 'rights for self-harmers'" (Cresswell, 2005a, p. 1670). By throwing the taboo of self-harm into the political and public limelight, Pembroke and the voices within *Perspectives* threw the gauntlet at psychiatric services and the sterile bio-medical approaches to self-harm,

> Self-harm is a painful but understandable response to distress, particularly in western culture. Self-harm thrives in an environment where people are stripped of freedom and control over their lives and yet are expected to behave in a controlled manner . . . Self-harm is a sane response when people are gagged in order to maintain the social order. Self-harm mirrors what we don't want to acknowledge . . . Self-harm is about self-worth, self-preservation, lack of choices, and coping with the uncopeable.
> (Pembroke, 1994, p. 5)

What this hints at is that self-harm activism is a human rights based approach, looking for "mental health services to shift from treatment-based, prohibitive responses to people who self-harm, to rights-based approaches"(Pembroke, 2002, p. 18). This is about the right to self-harm as a means of survival.

This collection of texts was closely followed by other seminal first person accounts, Diane Harrison's *Vicious Circles: an Exploration of Women and Self-Harm in Society* (1995); and Sharon LeFevre's *Killing Me Softly: Self-Harm, Survival Not Suicide* (1996) or her extraordinary play *On the Edge of a Dilemma* (1996) (Appendix 8).

The survivor self-harm activism literature also includes peer-reviewed papers and a number of publications focused on practical help and self-help (harm minimization) as well as on the political issue of the impact of the BPD diagnosis on women (who may self-harm or not). For this see in particular the work of Claire and Terri Shaw, Helen Spandler and Sam Warner. Close to the self-harm perspective is the socio-anthropological perspective.

1.7.2   Socio-anthropological perspective on self-harm

We all interact with our body, often following norms and aesthetic values which are deeply buried in our daily lives. We may have learnt some practices (from our parents, peers, media) or we may have created some ourselves (Haidt, 2001). For Liotard,

The history of individuals as social groups is mapped out with instructions indicating how to mark one's body in order to signify one's social or group membership. The respect of codes, rules and law regulating how we appear to others implies interacting with the body, aiming to modify its appearance according to social situations, the status of the actors, their gender, their age, etc.[6] (2003, p. 9)

The socio-anthropological perspective differs greatly from the dominant bio-medical perspective. Whereas the latter accepts that there are cultural forms of interventions that transform the body, it still calls them "forms of self-harm", "body mutilations" (Favazza, 1996; Jeffreys, 2000) or "CASHAs" (Culturally Accepted Self-Harming Acts) (Turp, 2002, p. 206) when associated with practices which "reflect a society's behaviour, traditional beliefs, cultures, and have symbolic meaning" (Favazza, 2002). The contraposition of cultural sanction and self-harm labelling sits oddly and yet is common.

For its part, socio-anthropology rejects the psychiatric language and approach which it says stigmatise and judge a priori, and "fail to define the person's intent correctly while enclosing them in a symptomatology which says nothing about their distress or motivation"[7] (Le Breton, 2003, p. 72). By focusing on the body, and more precisely the skin, socio-anthropology moves away from "behaviour" to focus on the 'inside of the box', the self. "The body provides the first locus of amazement of realisation of the Self"[8] (Le Breton, p. 16). The body, the skin become a vehicle, a framework where events are written and re-written. "In life, our human condition translates into a physical condition. The Self becomes diluted through the skin"[9] (ibid, p. 48). Skin can then be as much a friend as a foe, theatre of the events and traumas of life,

Skin encloses the body, the limits of the self, it establishes the borders between the inside and the outside in a lively, porous manner because it is also an opening to the world, its live memory. It envelops and incarnates the person while distinguishing it from others . . . The surface that others see is supported

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[6] "L'histoire des individus comme des groupes sociaux est balisée d'instructions indiquant de quelle manière marquer le corps pour attester de son appartenance sociale ou groupale. Le respect des codes, des règles et des lois concernant les manières de paraître implique en effet un travail sur le corps, visant à le modifier dans son apparence, en fonction des situations sociales, du statut des acteurs, de leur sexe, de leur âge, etc.»

[7] « Les termes échouent à nommer l'intention de la personne qui en use et l'enferment d'emblée dans une symptomatologie qui ne dit rien du désarroi ressenti ou de la quête poursuivie »

[8] « Le corps est pour l'homme le premier de l'étonnement d'être soi»

[9] « Dans l'existence nous sommes notre corps ; notre humaine condition se déploie en une condition corporelle. Le Moi est dilué dans le corps »

backstage by hidden life events, wounds or strong identity shields.[10] (ibid, p. 24)

The strands of socio-anthropology which have taken an interest in self-harm, have often built upon the psycho-analytical work of Didier Anzieu (1985) for whom "Skin provides the psychological apparatus with constitutive representations of the Self and of its main functions"[11] (Anzieu, 1985, p. 95). Our relationship to the world becomes a "matter of skin, and of strength of the containing function"[12] (ibid). Le Breton also considers 'skin' as a concept-metaphor for the psychic envelope, pointing to containment and internal space. In turn, this containing function can be understood as a barrier between the tensions and pressures coming as much from the outside as from the inside. If the skin is the surface, it nevertheless incarnates the interiority of our intimate selves (Le Breton, 2003). This containing function fails when the self is in crisis and the individual may self-wound. In socio-anthropology, self-wounding is therefore understood as a crisis of the self rather than as a psychiatric condition.

And yet, the rasping element produced by self-wounding is in stark contrast with intellectually and culturally sanctioned practices, codes and norms. The norm is about self-preservation, and keeping the body safe; it can be traced back to Descartes and more recently to Lavoisier, when it becomes formalised in humans (Canguilhem, 2009). Today this message is often firmly enshrined in our psyche and in many 'official' health type 'messages',

> Maintaining normality is hard work: a body must be rested, cleaned, groomed, and clothed every day; it must be fed properly and decorously at the correct time and it must be made to walk the right tracks and talk the right things. Such normality presupposes that everyone else behaves more or less as expected, and that the entire society pursues its appointed course, so that for any one person the preconditions of achieving his or her individual normality are fulfilled. (de Swaan, 1990, p. 1)

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[10] « La peau enclot le corps, les limites de soi, elle établit la frontière entre le dedans et le dehors de manière vivante, poreuse, car elle est aussi ouverture au monde, mémoire vive. Elle enveloppe et incarne la personne en la distinguant des autres. La surface présentée aux autres est étayée en coulisse par des événements de vie, des blessures ou des remparts identitaires »

[11] « La peau fournit à l'appareil psychique des représentations constitutives du Moi et de ses principales fonctions »

[12] « est ainsi une question de peau et de solidité de la fonction contenante »

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How 'rasping' it is indeed for our comfortable norms when someone defies them by attacking themselves, by attacking the sacralised body. Such practice does not fit the idealised messages that constantly promote sanctioned and normative interactions.

1.8   Summary of the literature on self-harm /self-wounding

Self-wounding is a fairly new topic, not often present on its own in the literature, despite the fact that it is recognised as a coping mechanism. Most self-harm research focuses on clinical populations, on women and adolescents while men are still routinely largely left out. In these studies the medical and psychiatric institutionalised discourses dominate, presenting self-harm (all aspects of the spectrum) as the result of psychopathology which needs to be prevented, controlled, treated and suppressed, and is still often measured against suicidal intention.

The survivor self-harm activist movement, which uses first person narrative accounts, challenges the dominant discourse and its discriminatory code, by stressing the human rights need to be allowed to speak the unspeakable and to talk about self-harm as a survival, rather than a death wish. It creates new knowledge by presenting a different kind of evidence, that of life-change and transition. By moving away from behaviour and focusing on the Self, the socio-anthropological discourse offers a completely different and dynamic perspective on self-wounding.

CHAPTER TWO : THEORETICAL FRAMEWORK OF THE STUDY

In this chapter I examine the main concepts which underpin the approach to and the analysis of the study: narratives, narratives and autobiographical memories, the first episode of self-wounding and pathways to self-wounding.

2.1   Narratives: Definitions and traditions

In this section, I examine definitions of narratives in the literature and give a brief context to narratology, present the narrative traditions this study has drawn from and discuss why a narrative approach is important for this study.

A review of the literature about what constitutes a narrative shows that there is not a single or precise definition (Riessman, 1993). This serves to show the rich and diverse dimensions of the concept: verbal, non verbal, virtual, symbolic and so forth. In fact,

the idea of a single definition does not really make sense. Whilst there is no one definition, there is however a broad consensus that narratives are a means of telling the story of lived experience. They are about meaning-making and about a construction of the self (Kohler Riessman, 1993). For Sarbin too,

> *Narrative* is coterminous with *story* as used by ordinary speakers of English. . . The story is held together by recognisable patterns of events called plots. Central to the plot structure are human predicaments and attempted resolutions" (*italics*, 1986, p3).

This description points to a journey inside a story and its basic framework is made up of elements (events in time, in places, of different qualities...) that constitute a moving plot.

There are very many different narrative traditions which link to virtually all areas of human activity. Barthes produced a very helpful list: "Narrative is present in myth, legend, fable, tale, novella, epic, history, tragedy, drama, comedy, mime, painting . . . stained glass window, cinema, comics, news items, conversation." (Barthes, 1966, p. 1), stating that narratives can be "supported in many different ways using structured language, written or oral language, fixed or moving images, movement and a combination of all these elements" (ibid) .

The background of the researcher or theorist/writer, whether a linguist or philosopher or a psychotherapist etc., also has a significant bearing on the definitions of, approaches to and construction of narratives and meaning, as well as on their analysis (Hammersley & Atkinson, 1983; Okely, 2004). This has produced an extensive range of narrative traditions: socio-linguistic, historical, cognitive, psychoanalytical, socio-cultural, literary, organisational, industrial to name but a few.

Let us not forget that films and literature have also contributed to a long tradition of reflecting on the construction of narratives and meaning, and have accustomed us to unconventional ways of creating them[13]. Dziga Vertov's Kino Vérité in the 1920s, or Chris Marker, are but two examples. La Jetée (Marker, 1962) is a film deliberately treated as a "horizontal" unravelling story, where characters and events are entangled in a web of flashbacks, and twists of time and plots. It is constructed mostly with static

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[13] I first graduated from the Film Studies department at Paris III- Sorbonne Nouvelle.

slides to tell the story, with only two filmed sequences. The sound track is the tool which is used to move the story in different directions, sequencing parts of the narrative; here the music track has a textual "wall paper"/decorative function. Such 'dysnarrative' narratives challenge the conventional use of image, sound and text while constructing other types of narratives.

This study has drawn on specific traditions: health/illness narratives, socio-linguistics, philosophy, cognitive sciences, psychotherapy, social constructionism and socio-culturalism.

2.2   Health/Illness narratives

One of the main theoretical frameworks for the study comes from illness narratives which have grown as a genre in the last couple of decades (Kohler Riessman, 2004) . In contrast to social-constructive approaches to narratives which emphasize form, illness narratives are more focused on content and on the teller. They illustrate a journey, they frame a story to be told from the perspective of the person with the experience. Two main traditions are presented here.

2.2.1   Psychoanalytical perspectives

Spence (1982) offers a perspective based on his work as a psychoanalyst with a focus on human dynamics and interactions of actions and thoughts (rather on patterns of behaviour). Spence highlights the tensions, in the therapeutic space specifically, between narrative truth and historical truth by which he means the possibilities and difficulties of reconciliation between the different layers of meaning that exists in narrative accounts into a coherent whole: context and content, account and "what really happened", construction and reconstruction of the story and so forth. The narrative comes into being in the psychotherapy sessions where individuals participate in a 'conversation'. In that space, he says, "[the person] to be understood and appreciated tends to bias his utterance towards what is sayable and away from what really happened" (p. 28). This is reminiscent of socially desirable or acquiescent responses in social sciences research when participants feel they should meet the perceived expectations of the researcher. This means that historical truth (what happened) may be influenced by the context in which the narrative truth exists, here the therapeutic session.

For Spence, the role of narratives is to render coherent a story that possibly was not to start with, "There is no doubt that a well constructed story possesses a kind of narrative truth that is real and immediate and carries an important significance for the process of therapeutic change" (p. 21), "conviction emerges because the fit is good, not necessarily because we have made contact with the past" (p. 32) .

This echoes the idea of a well constructed story following the distinctive pattern of the beginning-middle-end structure which the literature says renders accounts coherent and manageable (see section 1.2), in particular for analysis purposes. Coherent refers to validation and veracity and leaves no space for chaos and contradictions, which sits oddly with the notion of patient-centred work or with the notion of psychic reality for the person. The emphasis on truth is also a feature of the psychiatric discourse which prefers well-fitting to ill-fitting stories.

By contrast, Epston and White (1990) start from their work as psychotherapists to propose a different perspective, focused on narratives as texts (where individuals "reauthor" their voice (p. 13) and texts as embodiment(s) of expression of troubled lived experienced. The term "reauthor" is important here as it places emphasis on the teller as an enabled agent in a process, rather than as a passive individual. Their focus is more on the dynamism of narrative accounts and less on truth. Particularly, they have drawn on Foucault's perspective on truth, power and knowledge in relation to their psychotherapy practice. The originality of their work lies in their will to draw out the "broader socio-political context of the person's experience" (p. 18) from the text analogy in order to liberate the true nature of an individual's accounts. This is particularly important for self-wounding since the dominant narrative or ideology that still prevails in mental/health services is suicidology.

2.2.2   Illness narratives

Whilst the psychoanalytic approach to stories placed emphasis on truth, this is a lesser feature of these narratives which are not used primarily with a therapeutic aim but as a way of creating meaning and adding to the body of knowledge. In research, there may also be a healing element for the participant as they take part in the research process. This is where first person accounts can find and create a natural space of expression.

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One of the more interesting approaches comes from Frank (1995) and is the model which was used for this study. Frank claims that illness can be construed as a "call for stories", meaning that there are "selves and stories" (1995, p. 53) to be told from the perspective of experience. In *The Wounded Storyteller* (1995), he proposes the following types to help frame an individual's narrative accounts of their experiences:

a)   The Restitution narrative: As the name implies, it is about recovering one's health but also about the social construction of getting better,

> Anyone who is sick wants to be healthy again. Moreover contemporary culture treats health as the normal condition that people ought to have restored. Thus the ill person's own desire for restitution is compounded by the expectation that other people want to hear restitution stories. (p. 77)

And so the story goes: "I was healthy, I am sick today, but tomorrow I'll be healthy again" . In this model, medicine is in control of what happens, the person's story is considered from the perspective of diagnosis, treatments, interventions, what can and what cannot be done, preferably in the hope of a positive ending in sight. Transposed to psychiatry, an example from White and Epston can be used to illustrate how such restitution narratives function in that context,

> If a person experiencing some form of acute crisis presents to a 'clinic', and if work of this clinic is oriented by analogies drawn from the tradition of positivistic science [*which mental health services are*] then it is likely that the crisis will be interpreted as some sort of breakdown or regression. Attempts will be made to convert the person's experience into a precise diagnosis according to some system of classification, and questions will be introduced that attempt to indentify a cause of the 'breakdown' that is consistent with the model. Then procedures will be performed by experts – procedures that . . . revise the past according to the tenets of the model. The goal would be to retrieve and reconstruct the person, thereby returning him or her to a 'good enough' functioning. (p. 7)

Self-wounding in particular jars within such restitution narratives, since the person actively, by definition, withdraws from the model by "attacking" their own body.

b)   The Chaos narrative: By contrast, Frank describes the chaos narrative as a "non-plot",

> Chaos is the opposite of restitution: its plot imagines life never getting better. are chaotic in their absence of narrative order. . . The lack of any coherent sequence is an initial reason why chaos stories are hard to hear; the teller is not

understood as telling a proper story. But more significantly, the teller of the chaos story is not heard to be living a 'proper' life, since in life as in story, one event is expected to lead to another. Chaos negates that expectation. (p. 97)

Thus, "chaos stories are as anxiety-provoking as restitution stories are preferred" p. 97). I would suggest that the chaos of self-wounding narratives is not so much about "non-plots" as about crashing plots, unresolved plots, which leave the person on hold in time; contradictory plots, fed by narrative wreckage (see below), creating the feeling of chaos that individuals have. Most self-wounding narratives find a space within chaos narratives as their many layered journeys are an expression of chaos and, notably, this chaos pitches them to silence, leading to self-wounding.

In common with both restitution and chaos narratives is Frank's "narrative wreckage". This is the destructive effect of events (including illness, social isolation etc.) on people's individual life stories, maps, sense of purpose and destination in life (pp. 53-54).

c)   The Quest narrative: in Frank's model, these transcend both restitution and chaos narratives by "meeting suffering head on; they accept illness and use it" (p. 115)

> The quest narrative affords the ill person a voice as teller of her own story, because only in quest stories does the teller have a story to tell . . . the quest speaks from the ill person's perspective and holds chaos at bay. (p. 115)

Louise Pembroke's accounts (1994) are a good illustration of such 'quest' narratives. Pembroke has also chosen not only to bear witness but also to campaign, through her writings, dance performances and research work, with the aim to improve how self-harm is considered and approached by professionals and the general public. In her work on self-harm and on "eating distress", she always promotes experience as evidence, as a form of self and group advocacy.

From this tradition I have taken the importance of giving prime place to the teller's story; the importance of a well constructed story enabling coherence and significance and so proceeded to reconstruct the narratives from the relative chaos of the interviews. I have also considered narratives as texts, which included sub texts (e.g. self-wounding scars) focussing more on what was going on within the narratives and less on truth - which is also primordial from a first person perspective. Finally I have taken Frank's narrative model in order to describe the reconstructed narratives as it

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seemed to acknowledge best the twists and turns of their feelings and emotions, the impact of events and the need for flexibility in the re-telling exercise.

2.3   Socio-linguistic tradition

This tradition places great emphasis on the construction of identity and of meaning through language, independently from psychological make-up. Linguists like Labov and Saussure belong to this school. Others chose a different path, such as Levy-Strauss, who "drew on principles of structural linguistics to describe a structural system that lies below the consciousness and that organizes human action into meaningful piece units" (Ricoeur, 1976, p. 4). Such logical structures could be found in the person as a psychological given (Polkinghorne, 1988, p. 140).

Labov is perhaps best known as a socio-linguist in the field of narrative/ analysis. He defines narratives as "one way of recapitulating past experience" (1972). In the socio-linguistic context, each clause can be considered a "narrative clause" (Labov, p. 361) and narratives are complete "when they have a beginning, a middle and an end" (p. 362). This strong emphasis on temporality as a means of bringing order to what is often regarded as a degree of human chaos, is strongly reflected in the literature as a given feature of narratives while referring to the concept of emplotment,

> Labov, in particular, assumes all narratives are stories about a specific past event, and they have common properties . . . Most scholars treat narratives as discrete units, with clear beginnings and endings, as detachable from the surrounding discourse rather than as situated events. (Kohler Riessman, 1993, p. 17)

However, there have been discussions as to whether a good representation of the world through narratives should necessarily follow the "beginning, middle, end" convention that prevails in the narrative literature (Gergen, 2001; Kohler Riessman, 1993; Labov, 1972; Sarbin, 1986) . Hyvärinen (2006) in particular, contrasts "well-made stories" and "mere sequences". He quotes White who asks,

> Does the world really represent itself to perception in the form of well- made stories, with central subjects, proper beginnings, middles and ends and a coherence that permits us to see 'the end' in every beginning? Or does it present itself . . . as sequences of beginnings that only terminate and never conclude? (H. White (1987) cited in Hyvärinen, 2006, p. 24)

The presentation of narratives as layers of events, has a very interesting potential for exploring self-wounding narratives which are often extremely chaotic.

From this tradition I have taken the notion of beginning, middle and end while bearing in mind the counter arguments which strongly suggest that events are rarely as boundaried as this.

2.4 A view from the philosophical tradition

Ricoeur's philosophical standpoint had a great influence on the field of narratology, in particular with regard to interpretation of meaning. Ricoeur's standpoint was a philosophical enquiry into interpretation theory, specifically the "hermeneutic task" (p. 23).

In *Interpretation Theory* (1976), Ricoeur tells us that something is happening in discourse (here dialectic, between event and meaning) - which he calls "*the* event of language" [*italics*] (p. 9) - which has the potential to create movement and change. The source is temporality. He also stressed the importance of the connexion between narrative and the human experience of time, "Time becomes human only when it is articulated as a narrative" [14] (Ricoeur, 1983, p. 17) . Narratives create a synthesis of time; from a succession of sequences a coherent story emerges.

From this tradition I have considered the significance of time and temporality which stresses the importance of language (therefore narratives) as events in their own right linked to events lived by individuals.

2.5 The social-constructive approach to narratives

For Gergen, narratives are important for the construction of self-conception as an expression of relational discourses. This means that we do not merely construct meaning of our experiences through our cognitive processes but also through "the performance of languages available in the public sphere" (Gergen, 2001, p. 247). In this model, the emphasis is on the beginning-middle-end structure as a necessity to render an account intelligible, otherwise "the telling becomes nonsensical" (ibid). There are evaluating shifts over time, leading to different types of narratives which Gergen (2001) describes as:

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[14] « Le temps devient humain dans la mesure seulement où il est articulé de manière narrative »

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- The stability narrative: where nothing much happens "life simply goes on, neither better nor worse"
- The progressive narrative: After a down period life shows a marked improvement
- The regressive narrative: This is marked by continuous "catastrophes' or narrative wreckages where the person is constantly 'battling the odds' and not 'winning'

To these basic forms, Gergen (2001) adds three more, which mix aspects of these. The "tragic narrative": progressive followed by regressive; the "comedy romance": regressive followed by progressive; the "happily-ever-after myth": progressive followed by stability and the "heroic saga": series of progressive-regressive phases. These latter forms of narratives exemplify the need to reflect the fact that lived experience rarely follows a smooth path and is often met by unexpected challenge, sometimes positive or negative.

From this tradition I have taken the performative and flexible quality of narratives. To some extent, this model echoes Frank's although it feels more literary and generalist.

2.6   The cognitive approach to narratives

Bruner (1990) brings a cognitive perspective and for him, "narratives are composed of a unique sequence of events, mental states, happenings involving human beings as characters or actors" (1990, p. 43). None of these elements is static and each produces movement, "[A] story as a model has a remarkable dual aspect - it is both linear and instantaneous"(Bruner (1996) cited in M. White & Epston, 1990, p. 3). He also refers to "story indifference"(ibid) in narratives which for him is an indifference to truth or falsity, which is possible due to a much greater emphasis to its relationship to the order of internal sequences. Thus, order creates the story's significance, not the fact that a narrative may be "imaginary" (ibid, p. 44). Lastly he argues that narrative is about linking the extraordinary ("the exception to the ordinary) to the ordinary ("what people take for granted in the behaviour around them") (ibid, p. 48). While stressing the need for order within narratives, Bruner recognises the idea of movement and linkages between sequences, reflecting the fact that human experience is not fixed even if there may be some predisposition to tell our stories in narrative forms.

From this tradition, I retained the importance of reconstructing the stories into coherent narratives with a beginning (journey/pathways leading to the first episode), middle (first episode) and end (here subsequent episodes) that would also make them the vehicles of the expression of experience rather than the tools of a 'truth' that is verifiable and replicable.

2.7   Reflections and epistemological assumptions for the study

Throughout the narrative traditions presented above, there are common features. The strongest, by far, is language. Different traditions highlight tensions with regard to the consideration of language in meaning-making and identity. Whereas socio-linguistics place emphasis on language (the 'outside' of the psychological box) to create meaning and identity, others such as psychology, psychotherapy/psychoanalysis and cognitive sciences place emphasis on the interaction between language, story, context and the teller and, overall, are more interested in the 'inside of the box'. Even then, there are further tensions which support different levels of emphasis on each of these aspects, depending on individual theoretical standpoints. These also highlight the complexity of these interactions, sometimes as a positive source of meaning-making and sometimes as a source of difficulty if the narratives fall out of the beginning-middle-end model. However, if socio-linguistics place emphasis on coherence of the narratives through this model, for Fairclough, "coherence is not a property of text but a property which interpreters impose on texts (including the producer of text) possibly generating different coherent readings of the same texts" (1992, p. 134). This highlights the subjectivity of those who comment on the validity of someone's narrative and its coherence. It also points to the possibility for individuals to construct meaning and subjective truths in ways other than the strict observance of the beginning-middle-end model.

Narrative inquiry introduces the idea of language as the central vehicle for bringing the narrative into existence by putting it 'out there', in the interview space. It creates a space where interaction between researcher and participant is possible, and where interviews become forms of conversation (Kohler Riessman, 1993). Language also refers to the notion of text as a synonym for narratives although Bakhtin possibly goes further,

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> if the word "text" is understood in the broad sense - as any coherent complex of signs - then even the study of art . . . deals with texts. Thoughts about thoughts, experiences of experiences, words about words, and texts about texts. (Bakhtin, 1986, p. 103)

This suggests that language as 'text' at the very least a form of narrative landscape, suggesting cartographies of thoughts and ideas, therefore of journeys and transitions. This idea is also picked up in parts of the literary tradition where concept of geo-poetics and nomadic spirit are long-standing (K. White, 1987, 2009).

The different narrative traditions presented here serve to show the limits of representation of an individual's (or group/community's) lived experience as each imposes its own model of construction, and representation, of the world. Bruner acknowledged that there was a limit to the power of narratives, "lived experience is richer than discourse. Narrative structures organize and give meaning to experience, but there are always feelings and lived experience not fully encompassed by the dominant story." (Bruner, 1986, cited in M. White & Epston, 1990, p. 11).

Narratives are however important for our appreciation of how individuals (or groups, communities etc.) understand particular aspects of their life , which is pertinent to this study. White and Epston tell us that "persons give meaning to their lives and relationships by storying their experiences"(1990, p. 13), therefore exposing a subjective truth. As Riessman says, "A personal narrative is not meant to be read as an exact record of what happened nor is it a mirror of a world 'out there'" (1993, p. 64). Thus, subjective truths narratives, help individuals construct their reality, the meaning they attach to it, and their sense of agency and identity (Sarbin, 1986). This evokes movement and evolution. Polkinghorne also points to movement when he says that the "Narrative form captures the notion that human lives are 'becomings' or journeys in which actions and happenings occur before, after and at the same time as other actions and happenings."(2004, p. 58). In narrative research, a particular self is constituted through the process,

> In the research interview, as in the rest of social life, language is the major cultural resource that participants draw on to jointly create reality, a process that qualitative studies are ideally suited to uncovering. Narrative retelling in interviews is a vivid instance of this . . . Typically, the moral character of the protagonist is sustained. (Kohler Riessman, 1990, 1990, p. 1195)

This highlights different important aspects of narratives. It shows that they are important as a tool for highlighting the dynamism of human experiences by drawing attention to changes and transition moments, that they are the expression of movement. Thus they are a means of describing the cartographies of experiences, that is to say the links between different types and levels of experiences as well as highlighting shared experiences.

Subjective truths may include contradictory workings of the human mind which find themselves in opposition to predictable and replicable behaviours or practice (Clandinin, 2007; Hollway, 2001) . These truths reject the reductionist treatment of experience in positivist research as a static state of being which consists in "lumping people together, generalizing about them and ignoring their reality" (Ragin & Driscoll, 1994, p. 158), hoping to create a universal, replicable truth. In particular, White and Epson argue that in the "logico-scientific" [positivist] mode, the particulars of personal experience are eliminated in favour of reified constructs, classes of events, systems of classification and diagnoses"(1990, p. 80), as exemplified by the medical and psychiatric discourses. In contrast, they argue that "the narrative mode of thought privileges the particular of lived experience"(ibid) , which is seen to be of " 'vital' consideration, and the links between aspects of lived experience are the generators of meaning" (ibid). Riessman echoes this argument,

> Traditional approaches to qualitative analysis often fracture these texts in the service of interpretation and generalization by taking bits and pieces, snippets of a response edited out of context, They eliminate the sequential and structural features that characterize narrative accounts. (1993, p. 3)

In this respect, Riessman echoes Bruner (who echoes White and Epson) who highlights "the restriction and the sanitization of subjective states not so much as the *data* [*italics*] of psychology . . . but as explanatory concepts" (Bruner, 1990, p. 15). Such an approach to subjective data renders it meaningless in a narrative context.

Narratives can only be interpretations rather than an explanation of events (Bruner, 1995) and narrative research can only be a humble and tentative attempt at interpretation of meaning. This perspective also finds support in narrative (psycho)therapy which accepts the validity of the narrative as the basis (effectively the equivalent of data) of the therapeutic work (Polkinghorne, 1988). First person

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narratives of direct experience, as expressions of political individual or group advocacy, present narrative traditions with a new challenge. For Webb, "The first person voice is a vitally missing ingredient to help unravel the mystery" (2006a, p. 27). First person accounts produce valid data precisely because this data is grounded in experience, and is not replicable; defiant testimonies of experience as alternatives to the dominant discourses. They are the data of 'subjective truths' of how a person constructs meaning out of their experiences. Survivor research supports these 'truths' over 'exact records' or 'historical truths' which the psychiatric discourse favours as proof of a person's truth/moral worthiness.

What also comes out of these narrative traditions is the idea of narrative landscapes as a means of mapping the many different threads and dynamics of the story. One could argue that these take us away from a rigid focus on the path of the story (beginning, middle, end) and encourage us to explore the different elements that make up its intrinsic qualities, "Each path is chiefly a route through a particular terrain" (Hughes, 1997, p. 7). If the path is the narrative, it is a story without a foundation when it is considered in isolation from the environment within which it is embedded. Whereas in positivist research constitutive elements of the landscape would be fixed or generalisable/replicable, in narrative inquiry this assumption cannot be made, as each story will have its unique elements. The landscape changes as the story progresses following narrative shifts, developments and turns, calling for a responsive and sensitive approach, "there is an interpretative pathway between action and meaning mapped out in terms of narrative histories (Clandinin & Connelly (2000) cited in Clandinin, 2007, p. 45). The landscape of narratives is thus made up of the many contexts surrounding and supporting a path: spatial, cultural, social, place, people, institutional (Clandinin, 2007) , to which I would add emotions and language-as-text, and geo-poetics[15]. They give the path meaning and provide the individual with a rich "locus" or "topology"[16] of being (K. White, 1987, p. 73) for their experience/narrative. Raggat speaks of "normal multiplicity" (Raggatt, 2002, p. 293) to talk about the tensions/oppositions between the different aspects of our narrative lives and selves, and the force that shape them. These ontological approaches fit well with a user/survivor ethics of experience as it acknowledges its variety and uniqueness, and

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[15] More about geo-poetics @http://www.kennethwhite.org/textes/index.php?id=7002
[16] Localité/topologie de l'être

aspects of unpredictability and contradiction which constitute authentic life experience.

As we have seen, the approach to self-harm is still largely embedded in the bio-medical model, resulting in many large scale, quantitative studies which focus mostly on symptoms and behaviours, treatments and prevention, with the stated aim to investigate the function of the phenomenon, sometimes in order to help/prevent it, or focusing on the decrease of "the self-harming behaviour as a priority" (Warm, Murray, & Fox, 2003, p. 128). The very few studies that explore self-wounding seem preoccupied with similar concerns (Tantam & Whittaker, 1992). Even when it uses a mix or more qualitative approach with a part thematic methodology, the stance remains positivist whereby people's experiences are compartmentalised, quantified and/or morally evaluated - for instance in terms of inconsistencies, something that positivist social sciences reject: "We are suspicious of complexities, distrustful of contradictions, fearful of enigmas" (King, cited in Clandinin, 2007, p. 60) despite the fact that they are a normal part of an illness narrative model (Frank, 1995; Kleinman, 1988). In this landscape, narrative inquiry per say of self-harm/self-wounding is rare if nonexistent. McAllister (2001) was possibly one of the first to highlight the potential of narrative accounts in self-harm therapeutic work and research. There is a number of qualitative studies that include a narrative approach in their methodology, and the treatment of the data suggests an understanding of temporality and change/movement (Lindgren, Wilstrand, Gilje, & Olofsson, 2004; Sinclair & Green, 2005). There are other studies that use the term "narrative accounts" when in fact regular excepts are treated through the lens of quantitative social sciences, with percentages and numbers (Heslop & Macaulay, 2009) or use "narrative" to mean 'theme' (Fortune, Sinclair, & Hawton, 2008). A recent literature search revealed nothing for self-wounding research. One has to turn to the flourishing literature from personal accounts to find instances of self-harm narratives in books, Internet fora or magazine articles (e.g. Pembroke, 1994; Stoehr, 2003; Strong, 1998). However, as this methodology becomes increasingly popular (fashionable?) more researchers may realise its potential to engage with the meaning of individual experiences and subjectivity and with meanings beyond symptoms, behaviours, contradictions etc.

Narratives are therefore the ideal tool for conveying the richness and subtleties of direct lived experience and subjective truths, without the fear of being submitted to the reductionist and sanitising treatment of positivist research. They enable qualitative salience over quantitative certainty or, following Levinas "Western philosophy implies reducing the otherness to the same" (Freshwater, 2007, p. 112).

2.8   Other important concepts for the study

2.8.1   First episode of self-wounding

As a concept, the first episode refers to a cognitive process by which a person acts on a decision; to wound themselves (Favazza, 1996). A 'first time' is by definition situated in between a 'before' and an 'after' period and has thus the potential to be of significant importance, in particular in terms of learning. Repeated literature searches for studies and accounts specifically looking at the first episode of self-harm/self-wounding have revealed a gap.

Searching the literature for 'first time experiences' (and variants) and how they might influence someone's later actions, narrative, decision making process etc., proved to be an extremely frustrating process. Other fields were explored, such as criminology/forensic psychology and drug abuse. Although there seemed to be similarities to self-wounding (e.g. social background of the person), overall these experiences were very different in essence and motivation, especially regarding perpetrators of homicides (Christoffersen, Soothill, & Francis, 2004; Delisi & Scherer, 2006; Gresswell & Hollin, 1994). Differences were too irreconcilable (focus of the studies, context and circumstances that surround these first episodes, gender breakdown, motivation, decision-making process, etc.) for a parallel to be reliably contemplated. There were similarities to the field of drug abuse but only regarding people who use highly addictive drugs such as cocaine where the first hit is always the best and can never be recaptured, then lots of other learning processes take over (Keel, 2010).

Social learning theories show that many learning processes are created and nurtured not on one's own but in the company of other people (H. S. Becker, 1973); drug taking is one of those practices whereby users may physically give a syringe to another person (Keel, 2010). The literature on self-harm does not point to such active

interaction between individuals as part of the learning process. It does however mention imitation instances between individuals, to the (rare) extent of epidemics, on wards or in residential care (Crouch & Wright, 2004).

Exploring the first episode of self-wounding should help us further our knowledge of what happens at that potentially crucial moment/period and appreciate the participants' experience of what self-wounding offers them that other things do not (the meaning the participants attach to the experience through the narratives).

2.8.2   Narratives and autobiographical memories

This study attempts to place the memories of the pathways leading up to the first episode within a context, that of the relationship between memory (of the event), temporality (what was going on in their lives before, during and after) and meaning (attached to the experience). The context is potentially a very rich source of data as an attempt at understanding whether, and how, narratives of experiences are formed, as well as their potential impact on subsequent episodes of self-wounding. "Typically, autobiographical memories are of particular events, comprise a narrative (who, what, when and where) and include vivid associated imagery" (Kuyken, 2006, p. 278).

There has been much research on autobiographical memories (Conway & Pleydell-Pearce, 2000; Berntsen & Rubin 2002; Rubin & Siegler, 2004; Ross & Wilson, 2003). Conway and Pleydell-Pearce in particular have described different levels, "lifetime periods" (e.g. 'when I was at school'); "general events" (e.g. 'my trip to Paris') and "event-specific knowledge", often associated with post-traumatic stress disorder (PTSD) (Conway & Pleydell-Pearce, 2000, pp. 262-264). The latter potentially presents most interest for the study as it is linked to the experience of trauma and powerful emotions.

In parallel, the works of Bruner (1990), Schank & Abelson (1995) and McAdams (2003) on how we construct stories and meaning through the self, as well as how we construct knowledge, show that memories and narratives are closely interlinked. Indeed, autobiographical memories in particular, are built into identities via narratives (Berntsen & Rubin, 2002). In *Time and Narrative*, Ricoeur (1983) emphasises the importance of memory on the construction of future narratives.

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There is also evidence from the field of memory work that there is a strong theoretical basis for thinking that autobiographical memories may impact on future behaviour, because of a link between how we remember things, events, people and later events in life. Nelson tells us that,

> Most forms of memory are present and future oriented . . . The future oriented function of memory is basic to all organisms that have memory . . . Thus the past provides the experience that evokes reaction in the present action in the future to avoid dangerous encounters or to achieve desired ends. (Nelson, 2003, p. 14)

Also, for Arntz and colleagues "The idea that emotional events are better memorized than neutral events is widespread" (2005, p. 20). Memory only exists through its retrieval though and there is a distinction to be made between what and how we remember events. This highlights the importance of the role and type of retrieval of memories (Conway & Pleydell-Pearce, 2000). Individuals who have experienced trauma are often the subject of "repeated and intrusive recollection of the traumatic event"(Conway & Pleydell-Pearce, 2000, p. 280) through involuntary memories which are cued by external elements (Kuyken, 2006) and are "manifest in intrusions, nightmares and reliving experiences" (Arntz et al., 2005, p. 19; Conway & Pleydell-Pearce, 2000). There is also another aspect to memory and recall, namely 'truth'. Spence, pointing to Freud, reminds us that "valuable information is contained in distortions" (1982, p. 79), therefore how we remember is more important than accuracy of memory.

There is thus a strong theoretical basis for thinking that memories of trauma may impact on future behaviour, and dealing with self-harm often means dealing with emotionally charged accounts and events; therefore with emotionally charged memories across a period or a life span. This is potentially important when looking at how memories are formed at the first episode of self-wounding and the development of narratives at subsequent episodes.

2.8.3   Huband and Tantam's pathways

The chance finding of a paper written by psychotherapists and lecturers Nick Huband and Digby Tantam, "Repeated self-wounding: Women's recollection of pathways to cutting and of the value of different interventions" (Huband & Tantam, 2004) was

influential in proceeding with this study. They conceptualised the self-wounding experiences of the women they talked to from the key emerging themes of their study into two distinct pathways, which they called the "Spring" and the "Switch":

The "Spring" is linked to 'tension':

> Associated with a feeling of becoming increasingly 'wound up'. It is about a process by which the person is aware of using self-wounding to relieve tension and fights this off until they can no longer do so.
> (Huband & Tantam, 2004, p. 419)

The "Switch" is linked to 'impulsivity':

> Associated with a sudden and often overwhelming desire to cut, as if a switch has been thrown.
> (Huband & Tantam, 2004, p. 419)

Notions of tension and impulsivity in relation to self-wounding were not novel and yet this paper was intriguing for different reasons. It was not focusing on the usual themes of diagnosis and 'maladaptive' behaviours. The overall approach to the participants' recollection emphasised the importance of subjectivity and of their experience of self-wounding, therefore using words rather than numbers as data (Clandinin, 2007) while not looking for proof or veracity. The paper also focused on emotions which form part of the pathways' mechanism and landscape.

There were also interesting aspects which suggested the presence of narratives. The use of metaphors ("Spring" and "Switch") to conceptualise notions of tension and impulsivity have the potential to embody the pathways to self-wounding within a narrative framework, since metaphors are "a tool for opening and deepening our understanding"(Clandinin, 2007, p. 19). The pathways themselves emphasise and support the idea of a journey which could be transferred and applied to the first episode of self-wounding; pathways indicate movement and the possibility of transformation which are narrative concepts (Connelly & Clandinin, 1990). As pathways are understood as an organisational concept that supports transition and transformation (Clandinin, 2007; Clark, 2003), it was felt that the Spring and the Switch could be used to clarify the data and support its analysis as one of the analytical tools.

Put together, these aspects opened up the discussion about self-wounding rather than close it in the way that linear, causal modelling of self-harm/self-wounding, had done

so far resulting in a fragmentation of the experience of the phenomenon. It is quite possible that the professional background of the authors, both psychotherapists, was influential. Psychotherapy encourages illness narratives rather than purely biomedical ('syndrome-and-behaviour') narratives (M. White & Epston, 1990). Finally the paper resonated with our respective (opposite) experiences of self-wounding, which most of the peer-reviewed literature on self-harm did not, and still does not, do. Overall, despite its limitations (women-only sample, different focus) it was felt that the paper offered something different to build on and confirmed the need to explore the subject as a journey, using a narrative approach to the stories as data. The intention was not however to test this model.

2.9   Rationale for the study

This is a first person study. The first person is me, the user researcher. It is also each of the participants of the study, who are given as much space as possible to express their accounts of self-wounding within the constraints of the thesis. There is an unwritten principle in survivor research that their voice should be granted this space contra clinical research where it is often fractured into decontextualised excerpts in order to produce a generalisable and replicable 'truth'. Here narratives are about the promotion of individual, subjective truths of direct experience. The focus is on the stories and the affect.

Self harm, in particular self-wounding, are practices which most people, clinicians included, find particularly difficult to understand and accept. While there is an abundance of studies focussing on subsequent episodes when the practice is often established, investigating the functions of self-harm and its relationship to childhood abuse and dissociation, studying means of prevention, treatment options, links with specific diagnoses, association with suicide etc., nothing was found in the literature focusing on the first episode of self-wounding. This gap has left space for such speculative and ambiguous statements as "For whatever reason, they felt the need to hurt themselves" (Hodgson, 2004, p. 171). A first episode (of any kind) is by definition a unique experience that cannot be reproduced and will always be different from subsequent events. Indeed, it is a moment when decisions are made which may or may not make a difference to the development of that particular story.

There is therefore a need to explore whether ignoring the first episode of self-wounding and the pathway(s) to it, leads to crucial elements continually being missed. This study, grounded in experience, is therefore an attempt at addressing this issue, using a narrative approach to the data.

2.9.1 Aims and Objectives of the study:

The aims and objectives of the study focus on how individuals describe their first episode of self-wounding and the importance of narratives in furthering our understanding of self-wounding, in particular of the first episode.

CHAPTER THREE: METHODOLOGY

In this chapter, I set out the assumptions and I outline the methodologies on which I based my research methods and research analysis. I then describe how the topic guide and the sampling strategy were developed, and talk about dealing with sensitive issues and technical aspects. I then describe the two stage approach to the data analysis (for the NHS and the University).

3.1   Epistemology of the study design

This thesis is a development from an NHS pilot study, "A qualitative study exploring people's memories of the pathways leading up to the first episode of self-wounding" (Ref: 06/Q2001/11), (Appendix 1). I was the Principal Investigator and Ms Rosemarie Stevens, also a survivor-researcher, was my co-applicant. The study followed a semi-structured topic guide with a sample of 11 participants, five women and six men, with three follow-up interviews.

The study design was informed by different factors. It is a user-led research project (see Prologue). It was influenced by my experience of taking part as a participant or as a research partner in medical model oriented studies on self-harm which brought up many questions about the limits of such studies and about potentially continually unanswered (unasked) questions. My own experience of self-wounding, past and current, also played a part in defining the research question and the methodology.

3.2   Study design and developing the topic guide

The first stage of the project followed a thematic approach which had been imposed by the funders (NHS) as being adequate to draw out a few broad themes from the data. An initial topic guide was prepared with reference to the literature, in particular Huband and Tantam's paper on pathways to self-wounding (Huband & Tantam, 2004), to the (NHS) research questions (How do individuals describe their first episode of self-wounding? Do these descriptions reflect the "Switch" and the "Swing" pathways suggested by Huband and Tantam? Do the memories of the first episode have an impact on subsequent episodes?) and initially with the idea of doing thematic analysis. There is very little reference in the literature, if any, to time in relation to pathways to self-harm. An exploration of time as sequences at different stages, generated a

particular overall narrative structure: 'before' (background), immediately before (context, awareness of tension building up), 'during' (reaction to experience, emotions involved, response and methods used), 'after' (effects of self-wounding) and "after-after" (subsequent, if any, episodes of self-wounding) of this process. The aim was to explore the context in which the pathways to self-wounding developed, covering the broadest possible experiences relevant to the research question, in a logical way, until saturation (in its common sense) was reached. The final topic guide (Appendix 2) was a semi-structured schedule, inviting the participants to focus on the pathways leading up to and on the first episode of self-wounding, and its context. The topic guide sought to elicit the participants' memories and experiences of their first episode and was thus broken up to reflect the different periods. Feedback on the time sequences in the topic guide was sought from Dr Simon Farrell, Senior Lecturer in the Department of Experimental Psychology at the University of Bristol (memory work specialist) in order to check that our intuition was correct and that the topic guide would enable the narratives linked to the research question to be expressed.

The interviews started by asking the participants the two following questions: "How old were you the first time you self-wounded" (in order to confirm that they did fall within the criteria) and "Could you tell us what happened?" to get them into focus and start the narrative process. This offered a consistent approach in the way that the guide was used. The method was to allow participants to express themselves as freely as possible in order to keep the flow of their thoughts as unrestricted as possible, with the aim of getting fuller accounts and only to gently direct them towards particular areas if needed.

The limitations that we foresaw were about people's memory. We did not however intend to 'verify' the accuracy of their memory; instead we chose to place emphasis on how they remembered events, and the meaning they attached to them. Another limitation was about the impact of trauma on memory which might prevent a participant expressing themselves.

3.3 Data collection and methods

3.3.1 Sampling strategy

Inclusion criteria

The sample was made up of mostly service users of Avon and Wiltshire Mental Health in Partnership NHS Trust (AWP), Bristol North sector, who had experienced at least one episode of self-wounding, with non-suicidal intent. The project did not seek to replicate the perceived dominance of women in the population of self-harmers but attempted to offer a more balanced exploration of the research question by including men in the sample, since it was felt they are too often overlooked in this field of research. Taylor's (2003) rare study of men who self-harm illustrates the importance of exploring whether men have similar experiences.

Exclusion criteria

The study was limited to self-wounding since this is known not to be associated with suicidal intent (Pembroke, 1994; Taylor, 2003) unlike overdosing where motivations are sometimes unclear. Self-wounding is also known to be used as a coping strategy by individuals in distress (NICE, 2004; User-Focused-Monitoring, 2004). Another exclusion criteria was anyone who had self-wounded for the first time longer than two years before the interview. This time scale was imposed on the project by the funders for reasons of "accuracy of memory". A screening questionnaire was used to ensure that this criterion was met (Appendix 3).

3.3.2 Sample size and characteristics of the participants

The sample was originally going to consist of ten participants, five men and five women, although eleven interviews were eventually completed. Ten interviews had been deemed to be sufficient to indicate if the themes emerging fitted Huband and Tantam's two-pathway model (J. Cresswell, 1998; Smith & Osborn, 2003).

Of the eleven people interviewed, five were female and six were male. They were all 'White British'. The age of the participants at the time of the interviews ranged from 19 to 50, with one aged 19, four in their twenties, two in their thirties, three in their forties and one aged 50.

3.3.3 Recruitment difficulties

The project encountered some notable recruitment difficulties. Some of them were due to the nature of recruitment through the NHS. Even so, the recruitment drive conducted by clinicians on the project's behalf initially only yielded two participants in over six months, despite regular email contact with the team managers. It seemed that virtually no one self-harmed or self-wounded in North Bristol! It was therefore decided to change two of the recruitment criteria.

The original time bracket for the first episode of self-wounding, imposed by the funders, had the effect of excluding too many people by placing too great an emphasis on recall. Permission was obtained from the NHS funders and NHS Ethics, to open the sample to people who had started self-wounding from their teenage years (about 13 years of age). One participant (Jamie) was left in the sample despite his even younger age at the first episode. This was because his memory of the event was so vivid (Brewin, 1992).

The second change concerned the geographical area for the recruitment. It was decided it should include all three Bristol Community Mental Health Teams (CMHTs), as well as to the community. Further NHS Research & Development and LREC[1] approval were sought, gained, and new recruitment packs were disseminated through the teams, adverts placed in Venue, The Big Issue, flyers fed through the Central Library dissemination system and placed in a variety of community places. Within a couple of weeks all participants were recruited. In fact the project quickly became inundated with requests to take part in the study, some from as far afield as Cornwall, Devon, Gloucestershire and Worcestershire.

An invitation to talk about the project on local radio (BBC Radio Bristol) with a particular focus on trying to recruit male self-harmers yielded one participant straight away. Ironically, the last participant to contact the project was a man who had been given a recruitment pack by one of the teams. As a result eleven participants were recruited into the project.

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[1] LREC: Local Research Ethics Committee

Events showed that six out of the seven participants who were recruited through advertising and flyers, had had contact with AWP for their self-wounding issues although they were not given a recruitment pack by AWP.

3.4   Researcher's assumptions and awareness

My awareness of what it is like to be a service user, of being a service user with experience of self-harm and of working in user-led research, influenced my assumptions. Those were: It is difficult to talk when you're unsure whether you will be heard at all or correctly; it is possibly even more difficult to talk when it comes to such sensitive issues as self-wounding; potential participants might find it difficult to talk to me as a complete stranger, a researcher and a user researcher about their self-wounding.

However, it was also possible that potential participants might find it a relief to be able to talk about their self-wounding to someone who also has the experience of self-wounding and that they might be more willing to take part in a study that is grounded in experience.

Originally a choice of male or female interviewer, or a combination of both, had been arranged. It was thought that the choice of gender was further justified for male participants for three reasons. First because they are rarely approached in self-harm studies, in order to offer the best possible interview conditions. Second as an issue of equality: men should have the same right to choose as women. Finally, it is known that some men, as children, have been victims of sexual abuse at the hands of women. Since there is also a known link for some people between the memory of sexual abuse and self-harm, it was assumed that being able to offer a choice of interviewers would be helpful. As it happened, all the men interviewed preferred to be interviewed by women rather than by men.

3.5   The interviews

The interviews were carried out with eleven participants during the course of 2007. The three follow-up interviews took place in early 2008. The interviews were conducted together by the two user researchers for reasons of safety, mutual support and basic inter-rater reliability.

A choice of settings was offered, at Bristol Mind (non-statutory), at a day hospital or in the participant's home. Three interviews took place in the participant's home (appropriate Health and Safety measures were observed). All the others took place at Bristol Mind on a Saturday when the office is closed, thus avoiding any noise or disruptions while preserving privacy. Most interviews took about an hour. The information sheet (Appendix 4) sent to the participants prior to the interviews clearly stated that both interviewers had personal experience of self-wounding.

The purpose of the research was explained as well as what had brought us to want to study the first episode of self-wounding, how we intended to carry out the interviews and what would happen to the findings. We explained that we would be following a topic guide to ask questions that would cover areas we were interested in. Participants were also told that we would then let them answer as much or as little as they wished, that they were free not to answer anything they did not feel comfortable with and that they could stop the interview at any time without having to give a reason. They were also told of our legal responsibilities as researchers with regards to disclosure or threat of harm towards a third party, or to self. Of course, these terms of engagement were put to them with sensitivity. A final opportunity to confirm or withdraw consent was then offered and the participants were then asked to read and sign the consent form, and were given a copy. (Appendix 5).

For consistency of approach it was decided that it would always be the same person asking the questions while the other, taking a more discreet position in the process (thus making the two-to-one power dynamics less strong), would keep an eye on the topic guide, ensuring that all areas were covered, take notes (which participants were welcome to read) and look after the recording equipment.

The interviews were digitally recorded. The participants were however given the choice of being audio-recorded or of notes being taken instead. No one refused to be recorded. Clear explanations about what was going to happen to the recordings were given. The participants were also told that the transcripts from the interviews and any quotations used for the NHS report, the University study or any subsequent publications and means of dissemination, would be anonymised.

Before we took our leave the participants were given a leaflet produced by Bristol Mind about sources of help and support in Bristol and offered a payment for their contribution. This modest amount, of £10, is in line with the recommendations from the Royal College of Psychiatrists for such interviews. Finally, it was important to close the whole interview process down by having an informal chat, as a way of bringing the participants back to the "here and now" in a safe and friendly way. A summary of the main findings for the NHS was sent to all the participants in March 2008, as well as to those who were not recruited but had expressed an interest in being kept informed.

The follow-up interviews were conducted for the purpose of validation of the process (See section 3.12). They were selected according to which pathway the participant followed, and gender: one woman and one man (to reflect the gender balance) "Spring" (tension reduction) and the only "Switch" (impulsivity) participant, a woman. They were given their detailed case-study to read on their own and were then told they were free to comment, challenge, ask anything they wished. In these follow-up interviews, the three participants were always keen to bring us "up to date" and report changes. These second interviews were resolutely kept shorter (about 30-40 minutes) as a matter of ethical consideration.

3.6 Ethical considerations

3.6.1 Dealing with sensitive issues

We were aware from the off-set that the interviews might raise some painful memories or issues for the participants. This was addressed in our application to NRES[2] with the following plan:

- Access to the Crisis Team: This is something that we had organised successfully on another project
- Should the participants become distressed to the point when we felt they may be at immediate risk, we would:
    - Offer to terminate the interview at that point
    - Tell them that, should they wish to, we could contact a health professional or any other person of their choice, or the Bristol Crisis Team
    - Offer to resume the interview should they wish too at a later date

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[2] National Research Ethics Services

There were also potential issues for us, the researchers, and we addressed by working together for mutual help and support and by ensuring that external supervision had been budgeted for and could be sought should the need arise.

3.6.2   Transcription and confidentiality issues

The recordings were transcribed by a professional transcriber who was asked to anonymise the transcripts using an identity number. They were also asked to keep pauses, sighs, hums, false starts and other signs of hesitation or emotional expressions in, in order to give a reasonable level of representation of what took place in the interviews when reading the transcripts at a later date. These indications were left in but not analysed.

Research Ethics (NRES) guidelines were followed for the management of raw data material. The digital recordings previously stored on computer were password-protected, transferred onto CD-ROMs, and will be kept in a locked cabinet in a secure office for a period of five years at Bristol Mind.

3.7   Data analysis methods

In this section, I describe the methods used to analyse the data during the two stages of analysis for the NHS and the university, using two different approaches, thematic and mixed case-study-narrative analysis.

3.8   First stage analysis (NHS)

The digital recordings were transcribed and fully analysed using the support of MAXqda2, a qualitative software package created by social researchers for Windows and Linux. It was used to manage the raw data and to create codes and sub-codes.

A simple thematic analysis was undertaken, inspired by Attride-Sterling (2001), in order to draw out the main themes. Her approach to thematic analysis was chosen over others as she engages more with the idea of movement, "Thematic networks are presented graphically as web-like nets to remove any notion of hierarchy, giving fluidity to the themes and emphasizing the interconnectivity throughout the network"(Attride-Sterling, 2001, p. 389). Being able to retain the idea of movement in the analysis was important when dealing with accounts embedded, among other things, in temporality.

An extensive list of themes (codes) was produced which were then regrouped under broad concepts, including: Emotions, Pain, Attitudes towards self-wounding, Families, Effects of self-wounding, Communication, Blood, Control, Switch, Spring, Suicide etc. Codes became signals for different kinds of meaning that would stand alone or which possibly had links with other codes. The data from the follow-up interviews only consisted of hand-notes but were taken into account during the analysis.

Then, further repetitive listening to the recordings, note taking and re-coding of the transcripts was undertaken. It was felt necessary to make sense of the stories that had been offered, with a particular emphasis on Huband and Tantam's Spring and Switch pathways and chronology. The outcome were two frameworks. The first consisted in the descriptive reproduction of all eleven participants' journeys in table form (Appendix 6) which broadly echoed the time sequences of the topic guide. This approach was further refined as the immersion process progressed and became stable after several stages of clarification. The focus was an attempt to bring clarity to the chronology of the narratives of the pathways. At first episode, a number of coding categories emerged : Spring or Switch; age at first episode, detailed background and context when available; feelings /expressing feelings; awareness of tension building up, suicidal thoughts/attempt, response/method, and effect of self-wounding (pain, release, control). After further listening to the interview recordings and reading of the transcripts, a second framework emerged. It was more interpretative, more flexible, allowed slight variations to come to light and explored the more detailed aspects between narratives (Appendix 7). The process was repeated over again for consistency of approach.

At subsequent episodes, the coding categories that came to light were the same as for the first framework, with the addition of: Lack of awareness of events (Kate only); Ritual; Frequency/addiction/craving; Telling/showing; Role played by scars; Continuing or stopping. For first and subsequent episodes, some of these appeared for most participants while others were unique to some only.

3.9   The need for a second stage: re- analysis

It had become increasingly clear that the thematic approach was not working. Although it is a "flexible and useful research tool, which can potentially provide a rich and detailed, yet complex, account of data"(Braun & Clarke, 2006, p. 78), in this case thematic analysis was not powerful enough to fully reflect what was happening in the data, nor bring out the narrative landscapes. It slotted ideas and concepts into a highly boundaried hierarchy of themes and sub-themes, which led to over simplification. The restricted use of excerpts that come with thematic analysis did not allow the political essence of first person accounts of direct experience (a core element of user research) to function. It only served a reductionist and positivist approach which I could not follow any longer. Finally, it obscured the dynamics and complexity of the first episode as an event.

The various stages of immersion, reading, coding and drawing out themes, had been pointing to something extremely dynamic and fluid. The stories the participants had talked about were not 'just' stories but had all the elements of narrative accounts, indicating plots, turns, development. In fact, in this study, the idea of narratives is already in the research question. While asking participants to talk about the journey that brought them to self-wound for the first time, it quickly became obvious that I was being presented with a story made up of a number of stories and ingredients which fitted the descriptions found in narrative inquiry, in particular the idea of temporality, of sequentiality, of attempting to create meaning-making etc. They narrate a journey where triggers and other elements (for instance the impact of autobiographical memories), could be considered as parts of a plot structure. Their accounts would, or not, come out as a story or stories by virtue of the interview process being an exchange of "questions and answers, arguments and other forms of discourse" (Riessman, 1994, p. 3). Especially, I was not interested in verifying facts or producing generalisable and replicable data but in adding texture, through the medium of the narrative, to the interpretation of meanings. I was looking for a different approach to experience as a sometimes intangible phenomenon, which Dewey described as "engrossing and matter of course" (Dewey, 1976, p. 235, cited in Clandinin, 2007, p. 38).

As a user researcher, i.e. with someone with experience of self-wounding I was also influenced by my own ontological assumptions which I had not been able to implement for the NHS part of the project. As someone engaged in creating experiential knowledge, I seek methods that place emphasis on the teller and on direct first person experiential knowledge, and reject methods that aggregate experiences into rigid patterns of behaviour and negate conflicting experiences. By contrast the use of narratives had the potential to develop into what Levinas calls an "alternative ethic to the other" (Freshwater, 2007, p. 112), here the other being the user/survivor and their experience of the phenomenon of self-wounding. Narrative accounts would enable me to capture a description of experience, and meaning, along different dimensions: temporal (before, at, after), emotional, sentient, dialogic, journey. Narrative inquiry , as "study of experience as a story" (Clandinin, 2007, p. 38) and as a methodology that adopts a particular view of experience as a phenomenon was appealing. The original thematic analysis approach was then abandoned in favour of one more sensitive to the narrative accounts.

3.10   Designing a methodology for the second stage analysis:

It was not possible to use a full narrative method of analysis since the research had not originally been designed in that way. Therefore it was necessary to use a pragmatic approach. The literature shows a great diversity and complexity of narrative analysis methods, and that many narrative researchers have often favoured a 'cannibalistic' approach whereby they have combined different elements from different methods (Catherine Kohler Riessman, 1993; Catherine Kohler Riessman, 2008). As narratology becomes increasingly popular, it is now used in a variety of ways. Riessman (1993) is a social scientist who comes to narratives with a mixed and 'pragmatic' approach (2008, p. vii) clearly influenced by the work of others and her own practice. Hall (2010) has been looking at narrative methods to highlight how flexible they can be around the data being explored. This is very different from clinical and generally positivist research which use often prescriptive methodologies. Here the method adapts to the different stages of the investigation. My main source of inspiration to create a pragmatic methodology that would suit this re-analysis was Riessman (1993; Catherine Kohler Riessman, 2008). I

therefore decided to build on the outcomes of the first stage analysis and to incorporate the more useful elements into the narrative analysis.

The resulting approach is a mix case study-narrative. There was however a danger that it would take the analysis into what Clandinin calls the "borderlands of narrative inquiry" (Clandinin, 2007, Chapter 2) where tensions can lead to the severing of the study from the "personal history of the one living it and is treated as fixed data" (Clandinin, 2007, p. 61). However, by choosing to keep the participant's voice in as fully as possible (long rather than short excerpts) and making it the prime drive for the analysis, by enhancing the notion of temporality through the use of chronology and by using specifically designed tools to highlight events in the narrative (form and content), it was hoped that the tensions, created by exploring and highlighting common experiences across narratives (the more thematic part of the approach), would at least be somewhat absorbed to achieve a richer account of the phenomenon.

3.10.1   Designing specific tools

Bearing in mind the need for a pragmatic approach at this stage of reanalysis, I developed a number of tools. Their purpose was to at least attempt to capture some of the narrative inquiry stance, and get a sense of what was happening in the stories, listening to (at the risk of mixing metaphors!) the landscape of emotions, thoughts, reactions to events, ideas as well as the contradictions and ambivalences (Brown & Gilligan, 1992) that might arise etc. The role of the tools was therefore to highlight, describe and/or analyse events in the narrative, actual events pertaining to the participant's story or to the narrative itself (its quality and dynamics). There are descriptive and analytical tools: case studies; use of chronology (before, at, after first episode); use of longer excerpts; post-scriptum/codas, identifying shared elements across narratives; identifying narrative structures, turning points, developments/shifts; identifying the presence of the Spring and Switch pathways; presence/absence of angel-type person, identifying the quality of narratives.

3.10.2 Descriptive tools

a. Case studies

The stories particularly lent themselves to a narrative case-study approach. Riessman states that "case studies focus attention on narrative detail (the "little things"). Important insights can unfold from 'the many sided, complex, and sometimes conflicting stories of actors in the field'"(Catherine Kohler Riessman, 2008, p. 194). This approach provided contextual knowledge and put a useful emphasis on and highlighted the potential threads between context, affective states (in particular the role of and build up of emotions), meaning that participants attached to the experience of self-wounding and the complexity of the biographical experience. It also had the potential to bring out the uniqueness and the differences between narratives , as well as the participants' shared experiences. I therefore chose to explore each participant's narrative separately and not leave anyone out. Re-immersion, continuously going back and forth between recordings and transcripts allowed me to get a sense of the many dimensions of each "case": temporal, emotional, historical, sentient etc., and to "reconstruct" the narratives from the relative chaos of the interview .

b. Chronology

Often, when accounts stories were told, they were rarely in strict chronological order (beginning/before; middle/first episode; subsequent episode and end). Often they jumped, thus reflecting the chaotic nature of retelling these; sometimes information was given seemingly out of context or was remembered at a different stage of the interview process. Nevertheless, I chose to reconstruct the stories and articulate the participants' accounts as case studies around the chronology of the pathways leading up to the first episode of self-wounding, and beyond. This was important. Rather than disrupt the story, it was hoped that it would enhance our understanding of the pathways leading to self-wounding, and the place of the first episode in between a "before" and an "after" sequence of events and actions. I only stepped out of the chronological order when there was a valid analytical reason, as with David.

c. Using longer excerpts

I was not in favour of reducing the text to short extracts out of context or using structured models, such as Labov's (Labov, 1972). I felt this was an opportunity for

testimonies of self-wounding as "truth-claims" and bearers of knowledge (M. Cresswell, 2005), which are rarely allowed in this way, to be given a more open and wider hearing and, as such, it is one of the core political elements of user research. This stance was also in the spirit of enabling Levinas' "alternative ethic of responsibility to the other" (Freshwater, 2007, p. 112) to take place. I felt the use of longer excerpts (when relevant) would make it possible to pay "serious attention to stories as topics for investigation" (Mishler, 1986, p. 68). They would also would act to "generate detailed accounts, rather than brief answers or general statements" (Catherine Kohler Riessman, 2008, p. 23). Sometimes, as with David, I took the stance of juxtaposing longer excerpts to illustrate the details of the unravelling of a particularly complex set of events.

d.   Post-scriptum (PS) and Codas

These are devices used to close certain case studies. A PS marks a situation when the participant described themselves at the time of the interview. When the PS was at the time of the follow-up interview, this is clearly signposted as such.

Codas signpost a new piece of information of particular relevance to the narrative or to the interview. I was inspired by musicology and cinematography to create this closing tool.

3.10.3   Analytical tools

a.   Identifying shared elements

In the study, I use the term 'elements' as a concept to describe what is happening in the narratives. Elements are useful as they refer to fundamentals, to building-blocks; as such they can be brought together or merged. As opposed to 'patterns' which would fix and categorise experiences, elements enhance the idea of fluidity and movement that pertains to narrative landscapes. Here the purpose is to highlight common experiences across the stories.

b.   Identifying narrative structures in the stories

Narrative types

They are useful to clarify the stories as data and define the quality of narratives; quality here meaning content and dynamics. This tool is taken from illness narratives in psychology, specifically from the work of Arthur Frank (1995) and Huband and Tantam's

study (2004). It aims to describe the narratives recounted by the participants according to the models Frank assigned to particular narratives. It was felt that his grounded approach to such narratives was appropriate to the context of self-wounding. Huband and Tantam's "Spring" and "Switch" pathways are also used to clarify the narrative types. Their presence is noted and described.

Turns in the narrative

A 'turn' here is taken from narrative inquiry (Clandinin, 2007; Löyttyniemi, 2011) and is defined as an event which is significant enough to change the course of a narrative (causing wreckage, or a positive or a negative trend).

Developments or shifts

This tool is loosely inspired by narrative enquiry. A 'development' or 'shift' here is not quite a turn, but may contribute to one. Something changes which may indicate the beginning of a process, which may set things in motion.

c.   Identifying the landscape of narratives: movement, ambivalences and contradictions

This tool is used to identify the importance of the landscape of narratives that surrounds their path, to further how understanding of the quality of the first episode of self-wounding.

3.11   My "first person voice"

As a survivor researcher, my 'first person voice' is deliberately inherent to all parts of the thesis. In the 'Narratives' chapter, this is achieved in an ad hoc fashion, using occasional boxes. I took some inspiration from Curt's *Textuality and Tectonics* (Curt, 1994) in which an 'Interrupter' character/voice regularly challenges the writer with requests for clarifications, 'nagging' questions, pertinent or humorous comments and so forth. The purpose of these boxes is to ensure that the political voice of the service user or survivor is not forgotten in the study. In this context, while its purpose is to comment and be a critical instrument of the received knowledge about self-harm/self-wounding and the way it is perceived, treated, mal-treated, abused sometimes and generally misunderstood, it is not designed to be louder than that of the participants. It mostly

complements the stories with further information, examples from the user/survivor experience (at times including my own), linked to the literature when appropriate or possible.

3.12   Quality criteria

The quality of the collected stories was checked in different ways:

For consistency of approach it was decided that it would always be the same person asking the questions while the other would ensure that all areas of the topic guide were covered, take notes and would look after the recording equipment;

The same questions were asked of the participants following the 'conversation' closely. An independent researcher based at the Mental Health Research Unit-AWP based at Bath University, was employed to check the coding. They read a few transcripts, created their own codes, then checked these against ours and a concordance was found with our own coding. Information about individual pathways, in particular the accuracy of the data collection and interpretation, was enhanced through follow-up interviews with three participants. They were offered a chance to comment on their own individual pathway/narrative that the analysis had revealed.

The quality of the study will be also put to the test by the participant community, here persons with experience of self-wounding. Basic inter-rater reliability for social sciences was achieved through the interviews being conducted by the two user-researchers. This enabled us to check that we had both heard and understood the same story and also helped reduce the potential for personal bias.

INTERLUDE 1

"STARTING FROM SCRATCH"

BOTH CHARACTERS FACE OPPOSITE WALL

A   I am a Spring…

B   And I am a Switch

A   I am a Spring and I get wound up, tighter and tighter

B   I am a switch and I don't understand. I didn't see it coming, it's so sudden…

A   It's been 8 hours, the tension hurts. It's been a day and a half and I am wound up tighter

B   There I am, in the bathroom and this overwhelming feeling comes over me. It's like an explosion in my head, in the pit of my stomach, in my heart…
Something in me has snapped

QUARTER TURN FACING THE AUDIENCE

A   It's been 3 days now. This tension, this emotion has become intolerable. I <u>can't</u> hold on any longer. I <u>can't</u> stand it any longer, something <u>has</u> to happen

B   I have to do something… I don't know what but I <u>have</u> to

A   I smash a window, but it's not enough

B   I know, I remember… I've got blades in the drawer. Quick!

A   And then it snaps, it happens. I use the broken glass

B   I get the blades and don't think twice

A   The relief pours out of me with the blood...

B   The effect is instant. Seeing the blood is a relief…

QUARTER TURN FACING EACH OTHER

A   I think "Why didn't I do it before?"

B   Suddenly I become aware of all this tension that had been in me and how much that had been hurting

A   It feels so good

B   It's mesmerising

A   Now it's often at the back of my mind, and I use it when I need to, but the good feeling doesn't last. In its wake I feel shame, anger, guilt and powerlessness

B   I never think about it normally, every time feels like the first time. But the release doesn't last. In its wake I feel shame, anger, guilt and powerlessness

QUARTER TURN FACING THE AUDIENCE

A/B   Sometimes we meet in the same episode, the Spring and the Switch, at a funny crossroads of mixed emotions.

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I wrote this sceynette for the Mental Health Research Network West Hub annual conference in 2007 and was played again at the "Cut to Cope" conference, organised by the Devon Interagency Forum for Suicide and Self-Harm Prevention (DISSH), Exeter, January 2008. The idea came as my co-investigator and I were talking about our own

experiences of self-wounding. There were real differences and curious similarities. One of us seemed, at first, to fit more into one pathway than into the other, the Spring and the Switch. But, as the research progressed, it seemed the boundaries between our respective pathways became more and more blurred.

PART II

NARRATIVES

In this part, I present the narratives of the participants: Jamie, Mary, Lauren, Peter, Jim, Jane, Kate, Liz, David, Jack and Tim. I use the descriptive and analytic tools outlined in the methodology section, following the reconstructed chronological order of the stories (up to, at first and at subsequent episodes). Three of the narrative accounts include follow-up interviews (Jim, Lauren and Kate).

CHAPTER FOUR: THE STORIES …

JAMIE'S NARRATIVE

Biographical information

Male, 21 at point of interview and 5 years old at the time of the first episode of self-wounding. He and another sibling (sister, two years older, unrelated) were adopted children.

Period leading up to the first episode of self-wounding

Although a very young child, Jamie describes what was happening in his life at the time,

> Um, I think I wasn't getting on with my adoptive parents . . . I think it was something to do with my adoptive parents and then, and not being er sort of like feel like I was validated as a son. Felt very alone. And er it was creating so much stress. (19-23)

Jamie felt his sense of identity as a son was not "validated" because he was adopted. He portrays a lonely child who was aware of the tensions and "stress" of the home situation. He says he felt he was being treated completely differently from his sister (338). Jamie tells of a lack of bonding with both his adoptive parents,

> My dad was at work all day so er he'd most likely come home, he'd have food, sit there, eat a meal, and that's it, there was no bonding of any sorts really, so it was like, my mother was the main focus, focus of it all, that was my reasoning, so (.) I think she played a major part in it. (339-343)

In his account, the family was the sum of disconnected parts where individuals did not seem to relate much to each other and where the mother was the centre of attention, whilst acting inappropriately towards him, "Er, my adoptive mother looked at me sexually . . . which made it even worse . . . I was aware of that yes" (330-335). This is an instance of Frankian narrative chaos, causing wreckage of family life.

Jamie describes himself as isolated and alienated from the neighbourhood, "Apart from having difficulties at home, um, [I] was seen in the neighbourhood as a bit of a problem child" (254-255), where neighbours were saying,

> 'Oh he's not coming round our place', or you know, 'Didn't want him round here', you know, so I felt even more alienated . Was persecuted, you know. But I remember feeling very very sad about it. (257-260)

His account uses powerful adjectives as statements. The experience left him with "no one to talk to" (370). Overall, he was "very unhappy" (41). Corroborating this experience, he describes how neighbours once said to him, " 'Why are you so sad? . . . Lift your head up!', 'Why do you look at the floor all the time?' and you know, and um" (66-67).

Thus, although it seems some people showed concern for this child, nothing concrete came out of it. German friends of the family once talked about Jamie possibly moving over to them but this too came to nothing. Their reason, according to Jamie, was "Because if you did that then you wouldn't be our son" (74-75). Again, he felt he did not quite fit someone else's idea of a son. In effect, his narrative was being steered in the direction of hope because it was crushed.

Jamie's narrative at that point follows the Spring pathway as there is a clear awareness of emotional tension building up related to the overwhelming negative feelings inside of him. Key emotional aspects mark this pathway: feelings of being very alone, anxious, abandoned, stressed, alienated and repeatedly dismissed by not being heard or validated as a son/person. His whole life up to that point seems to have been framed within the wreckage of the family Frankian chaos narrative.

The first episode of self-wounding

Jamie has a clear image of the first episode, "I've got a vivid – I can actually picture, I can see myself almost looking at myself um (.) er (.) just smashing my head against the wall. And that, you know, bang, and just doing that, I just (.) (37-39). He says he could only think of banging his head to achieve this goal,

> The anxiety inside me I was trying to block it out by smacking my head against the wall, knocking myself, trying to knock myself out. It was the only thing at the time that I, that worked. (23-25)

> Well I thought it would work at the time, yes, that's what I was doing↑Er because it took away the pain that I was going through, the emotional pain. (29-31)

Did he hurt himself? "I didn't fall on the floor, or anything, you know, unconscious, but it was er just like a blackout sort of thing like a flash, then smack flash. Erm, I think I might have been crying" (44-48). The experience is both a mix of a vivid picture which

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his memory can summon and a slight blur of the effect of the banging, which is confirmed when asked if he experienced any pain, "Don't remember the pain. But I'm sure it hurt↑[*Laughs*]" (50). Importantly he "might have been crying"(48), which could be an indication of release of tension, or simply of hurt.

When Jamie says, "I can actually picture, I can see myself almost looking at myself" (37-38) he distances himself somewhat from the action inside the memory. It is as if it were not him but someone else banging their head against the wall, "It's almost er it's not like I'm sad for me, it's also I'm sad for someone else. But it's me. If that means anything↑ " (350-351), "It's abstract" (359),

> I think it's because I felt sad. Because it was so long ago I think the first time I did it, and it's something that I've remembered throughout my adolescence, that um it's sort of abstract almost, like it but I can still remember the first time I did it, but like it still remains like someone else. That I feel sorry for, that I want to reach out and help him, it's me. (425-429)

There are two aspects to this. First, the impact of memory on future experience. Jamie's first experience of self-wounding had been a defining moment in the sense that it was so powerful that it is not only "vivid" but has an enduring emotional and cognitive presence in his life as a young adult. Second, Jamie's detachment, through the process of abstraction, making the small child and the memory "abstract", "almost there" or "almost abstract", are possible forms of self-preservation. The detachment still allows him to acknowledge and remember the experience and the person, the small child, who lived through it. He has compassion for this small child whom he wants to "reach out and help".

Subsequent episodes of self-wounding

> This banging of the head thing I think went on for quite a number of years after, I think it was my way of relieving my tension . But there was – I probably from 10 until 13 – I'm sure there was a good few years that I didn't do it. (81-86)

Head banging as a form of self-wounding had gone on for about five years, indicating its use as a coping mechanism in order to relieve the tension. He remembers how he felt just before,

Very frustrated. Very very frustrated. Er, (.) to the point of wanting to explode. Er but there's no way of releasing it, you don't know how to, so the only thing that I could do was just to try and knock it out of me↑ (128- 132)

"Wanting to explode" illustrates Jamie's awareness of very strong internal tensions building up,

I think it was frustration not being heard, not being listened and not being, feeling like I was loved. Erm, dismissed, pushed to one side sort of thing. And it wasn't just my family, it was the almost the whole kit and caboodle thing↑ [*half laughs*]. Other people's parents and things, and not being allowed round people's houses because they thought I was bad news, and things like that. (384-389)

There was another dimension to head banging, "I think it was almost - because it happened at such an early age, it was one of these things that you know, I could reach for almost. It would be a spontaneous result. Of relief." (289-291). "Could reach for almost"; " almost" feels like a natural reaction for him, providing a "spontaneous reaction" "of relief", like an old friend he could rely on. Head banging is something that worked for him, in all its extraordinary and disarming forcefulness.

There was a later shift,

I was in the park, I remember one time I was in the park and I remember purposely looking at the – there was this like round bit, and it's got stones all round the edge, and er looking for a place to smash my head on↑ So consciously remember looking for that. (267-270)

This is more methodical, more purposeful. Was he intending to hurt himself or to relieve the tension? "I think a bit of both, to tell you the truth. I wanted to hurt myself and just get to that stage of relief" (274-275). On one such occasion, he was brought to hospital and kept in overnight on a children's ward: the experience was like a revelation to him,

Um it felt like a nice place to be actually, you know there's caring people there, um, who actually care! So I felt really safe, and I didn't want to go actually, I wanted to stay in there! To tell you the truth, see I had to go, and I was admitted, I went 'buggar, I've got to go, got to go back home↑' . So, I remember feeling that. (222-226)

There were places, hospitals, where people cared for and about him, where he would feel so safe that he was reluctant to go home. How did that make him feel? "it got to the stage where I thought well, as well as this being some kind of relief I'm going to end up somewhere where the people give a shit, in the hospital" (235-237).

So far, head banging brought release of tension and relief of emotions and, on occasions, also gave him access to safe and caring people and places (hospital).

There was a narrative turn when he moved on to cutting, which started quite dramatically. Jamie is quite clear that his first experience of cutting is not a self-wounding episode, "actually that was actually like a suicide attempt, pretty much" (62-63); he clearly makes the difference,

> When I was 13, I was er abused and that started that – I mean made me actually get a razor out and actually physically try and - kill, slit my wrists. But in hindsight, when I told my mum, the next day, um and there was this massive open wound mind, and she was taking me to school, and she goes 'What did you do that for you idiot?' And kind of just dropped me off at school↑ And just left me there and I was thinking ok, you know, as far as I need something on that, I need some treatment, or, but she just dropped me off at school. (92-97)

Here the mother is portrayed as someone who dismisses her son's story first by ignoring the seriousness of his wound. She then reduces his experience by calling him an "idiot" as she drops him off at school, thus closing any chance of engaging with him or his story, or of showing concern. Jamie had no intention of hiding his wound, "I wanted it to be visible, the next day. And I didn't get a reaction, what I thought I'd get, um. It was 'You're an idiot, get to school!', you know like 'Gaping wound!'" (443-445). He had wanted his mother to be concerned for him and his "gaping wound"; he had wanted attention but still did not get it, despite making the wound obvious. The dynamic was repressed.

Did he want help? "Some kind of yes you know 'I need some help here', I feel - but I didn't get it↑And I was quite frustrated about that as well". (99-101)

> Because when I did get abused um the school didn't believe me, and they asked me to leave↑ And consequently the guy had been caught doing it to someone else, and he got chucked out, but I got no letter of apology. Completely fucked my life up. (277-282)

No help was offered at that point and he was effectively dismissed three times. First, by his mother who cut short any opportunity to discuss his wound. Second, when the school ignored his story and subsequently evicted him. Third when, despite the fact that he was later vindicated when his perpetrator was "caught doing it to someone else", he received "no apology". He remained a victim: of the person who abused him and of those who dismissed him and his experience. This had such a dramatic impact that it "completely fucked up [*his*] life".

At some point after this first cutting experience, there is a positive shift in the narrative when he got some help and was referred age 13 to a child psychologist,

> So it's the first time I actually got help.   Um, and things did improve. Um, that was after, yes, so I think that was a kick off point of the doctors then saying – you know, and not being believed about the ordeal I've been through, and um, having help, people having such a low opinion of me, since I can remember, it's quite shocking I think. (317-322)

Jamie however continued cutting, "I've done it loads of times since then" (440). This self-wounding is emotional,

> um when I slash my I'm crying, a lot. And I er, I wouldn't say I see anything, just a lot of sorrow I feel a lot of sorrow. I don't often, it takes out a lot of me. No, I don't normally cry . . . I would be crying while I was doing it. (456-469)

There is a possible echo of the small child who also used to cry after head banging.

Cutting also calmed him down, "Um but after you've cut yourself, when you calm down like you've still got the pain of the cut, you know, for days after" (503-505). This is also one of the rare instances when pain is mentioned as well as the release offered by pain.

Part of his cutting experience included a ritual element "it was er I suppose a way of breaking the razors open and getting it ready, and there is preparation, and - and then actually doing the act itself." (501-503)

There was another shift in his self-wounding narrative when, about the same age, "12, 13" Jamie also started abusing solvents. When he started, he did not equate solvent

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abuse with self-harming but he says "Now I do, yes. Yes. Because I was trying to get out of it" (111).

At the time he says "I felt very alone and I think that [solvents] got me out of that illness, of feeling very alone" (97-98). When asked what this "illness" meant for him, he replies "Um you're on your own, you just feel on your own, literally got nothing, no-one apart from you and your thoughts! And it can be quite a dangerous place to be" (399-401),

> And I almost felt like I was the problem. Huhm! Er, you know, so um (.) I always felt like I was the problem all the time. It got a bit serious when I did slit my wrists, because I really did want to finish. Not for my own relief, more like everyone else's, it was I was the problem child [*sighs*]. (165-169)

The "problem child", as he perceived himself, had come to the (devastating) conclusion that he was responsible for the "emotional turmoil" that underlined the family environment and that, "for everyone else's relief", he should die.

Jamie's response is to seek ways of getting relief. This motivated his solvent abuse, "Um just like um banging my head against, just alleviate some of that frustration I think" (189-190).

> Erm I just heard about it, and erm tried it, and suddenly, it was just like a drug, that um took me somewhere else completely different. But I knew it was dead very dangerous to do, I remember that. I remember people dying from it [*half laughs*] that were around me sort of thing you know, dying from it. (174-178)

The use of solvents made him feel "Relieved, actual relief. Because it did actually work. Yes, because I was I was I was no longer concentrating, I mean the frustration I was feeling", (147-150). Not only is the relief powerful but the retelling of this experience is also a powerful moment. He was very alone, feeling frustrated, in a dangerous locus with only his thoughts for company while solvents took him to a space where there are no thoughts, as a means of escape that gave him the sought after relief. He "did it a hell of a lot actually↑" (156). At the time of the interview, he had only recently stopped abusing solvents "I made a very conscious effort to stop doing it. It was difficult, I remember that, because we were round supermarkets and aerosol, they're everywhere. But I thought 'No', you know, 'No'" (180-182)

In his mind, were the head banging, cutting of wrists and the solvent abuse, some of these taking place at the same time - were they similar or different experiences?

> (.) similar. In the respect that I think it had something to do with own parents, the family structure, that I was living in. It was very unsteady. So I think so if I think about it, they are linked in some way. (120-127)

Although a couple of his cutting experiences were in effect instances of him toying with the idea of suicide, there remains a clear separation in his mind between self-wounding and suicide, and he is clear his self-wounding is not about suicide "No, they're just to (.) like bang my head against the wall" (476), pointing to his need to get out of it, to feel relief from emotional tension. Thus, at subsequent episodes, self-wounding becomes a coping (self-regulatory) mechanism and a way of escaping the negative feelings, from his "dangerous thoughts" and sense of isolation, and way of expressing himself .

For Jamie, "I think it [*self-wounding*] was a way of communicating with myself . . . But unfortunately I didn't have anyone to talk to" (410-411). No one but himself. Through self-harming? "Yes, I think that's true" (418). Jamie is describing a mode of communication where self-wounding becomes the only means of reaching out to and expressing the inside-self outwards; a dialogical conversation with himself as well as a mode of escapism.

For Jamie, disclosing his self-wounding to others is an issue, and he would rather not, being afraid of people's responses. On one of the occasions he was admitted to hospital, Jamie acknowledges he made excuses for his wounds, "Well one of those times was when I fell off backwards on my roller skates, but that's what I think I told my mum. But I think I did actually banged my head again. On the course, it was in the park" (205-207), "I think I made excuses" (231). Making excuses became useful,

> I was 14 and I remember going behind the garages with a cup, bottles, and cutting up my feet. Um, cutting all up my arms and everything. And when I got on the bus the bus driver goes 'What's happened to you?' And I said, the first thing that comes in my mind was I got hit by a car. So from there he got an ambulance. (620-624)

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On occasions, Jamie felt that people's reactions on seeing his wounds were stigmatising,

> Um, (.) things that spring to mind is is recent events of self harming, er like people in the pub, they'd notice, and then there's the stigmatisation to that, that I'm an idiot↑ And er treat me like some kind of (.) outcast. So you know why I was↑, you know, plastering them up, you know, or whatever and, you know, even when, when you've got a sleeve all the time, you know, you're drinking, the sleeve kind of comes down a bit, and you can see what – [*sighs*] (584-594)

Most of the time, Jamie did not seek or need medical attention for his self-wounding. Overall, his experiences in hospital were good, as long as he could use excuses to hide the true nature of his wounds. However there was one instance in A&E when he experienced negative attribution, "I had a bad experience in the hospital like I was wasting their time, so, like, you know, 'You're an idiot!', you know 'I've got real patients to see', do you know what I mean↑" (595-597). At least, that was the impression Jamie got,

> Negative, negativity. Of the whole scenario, um, you know I've got cuts to my arm and that, they need to be dressed, when she is under the - she thinks there's more important things she can be doing, than me coming in. (608-610)

There was a silver lining to this experience in so far as it encouraged Jamie to seek help for his self-wounding, "I managed to talk that over with my support worker and stuff like that" (602).

Post-Scriptum

At age 21, Jamie now describes himself in a different locus, where thoughts of self-wounding have changed,

> Well I haven't done it, haven't self harmed for a while now, but if I were depressed and or hum I've had to change anti-depressants and given me Valium and that to er – I'm a lot calmer now, and also the thought of hurting myself is different now, it's like I don't want to do that, rather than you do want to do that, you need to do that. It's do you really want to do that↑. No. I think it's because I've got a support structure. I've got help. I've got people I can talk to. There's things and people. There's a network out there I can reach out for should I take those steps that will stop me doing it. (517-525)

Part of his support structure comes in the shape of a local self-help group for men who were victims of sexual abuse as children, "I've just started speaking to them, so there's a lot of things I've kind of put on hold for years, and I'm starting to talk these things through. They were obviously having an impact on my life today" (555-557). Jamie's self-awareness and the fact that he has been able to find an outlet for his experiences are helping him to "take those steps that will stop him" self-wounding.

Being able to talk to a support worker and to join the group seems to point to hints of a "restitution" narrative as Jamie is striving to find ways to end his self-wounding and heal the wounds that have wrecked and scared his life so far. He would like to see more help for men,

> I think it would only be fair really. I, I, I don't know how many men actually do do it, yes↑ Well I think it would be a wise idea. Because I was a bit perplexed actually, when I was looking through that leaflet, on male self harm. (562-568)

In this respect, he was also glad about the existence of the project, "I'm just glad that you're doing this research, you know, with males in mind, in fact I'm very happy." (617-618)

MARY'S NARRATIVE

Biographical information

Female, mid to late 40s at point of interview and early 40s at the time of the first episode of self-wounding. Married with one teenage daughter. There are very few historical or contemporaneous biographical details available.

Period leading up to the first episode of self-wounding

Mary started "five years ago, and um I started harming myself um (.) I was going through a very bad patch, um, and (.) sorry" (19-20). This statement was blurted out and apologetic offerings such as "sorry" are a recurring feature throughout her interview.

During this period there was a gradual build up of emotions: "I started by silly things in a way, it was like anger, anger and desperation, really, um," (22). The status of powerful emotions is apologetically downgraded to "silly things".

At this difficult time, Mary felt constantly under attack, "I was being bombarded with problems, and and my mum had died recently, well two years before, my mum had died, and that had a big impact on me, a very big impact on me" (608-611), "I'd been getting worse sort of over a few years" (179). Although Mary does not talk again about her mother, she seemed to have been an important element in her life. It may be reasonable to speculate that Mary was still grieving this intimate loss.

Mary was going through a lot of emotional turmoil, "I mean I was very anxious and very stressed out at the time, but um, I think a lot of it was in my head, sort of thoughts, a lot of very bad thoughts" (264-266). The onslaught of problems made her feel "completely out of control at the time . . . I couldn't control what was going on outside really" (49-54), "It all just built up really, it built up to a point in my life I just could not cope any more, and cutting seemed to be the answer to me . . . Just came into my mind. (521-525). She says "I was very desperate." (450). In fact, at the time, she was waiting to go into hospital because of "the state of mind I was in" (205), "the feelings were just so overwhelming that I didn't, I'd gone past caring really" (173-174).

When her mother died, Mary described how this had had a "very big impact" on her, "so inside is almost my little, my 'me'. [*laughs*] Does that make sense↑ . . . It's me, outside is everything that's going on at me " (610-614). And 'me' suffers from low self-esteem, "I don't like myself a lot really, um. And I put all, all the blame is on me. Of anything that happens really↑". (623-624)

Then comes a turn in the narrative when "a final thing" (179) occurs while waiting to go into hospital, "They were going to take me in, and there were no beds, and and I was really bad" (193-194); "But I had to wait, and um, and I was getting worse and worse all the time" (207-208). The turn is in the "no beds" and in the "getting worse all the time".

At that point Mary was experiencing: being out of control of overwhelming emotions and events, frustration at having to wait to go into hospital and feeling worse all the time. The idea of self-wounding presented itself as a solution to an impossible situation. Mary's narrative at that that point follows the Spring pathway: there is a clear awareness of tension building up related to the overwhelming negative feelings inside of her (despair frustration, anger, and grieving in the background). Mary's narrative also approximates a Frankian chaos narrative with narrative wreckage brought in the wake of her mother's death which leaves her vulnerable to the tension between the "constant bombardment" life throws at her (the outside) and the her inner self ("the little me") which causes her to feel out of control.

First episode of self-wounding

Faced with this impossible situation, Mary took action,

> I think it had been building up, to be honest I don't think it was something I did on the spur of the moment, I think it was something that I'd sort of been – feelings had been building up to and I just wwhhfff. (186-189)

> It was a need, I mean I wanted to, I desperately wanted to cut myself. (72)

> I hadn't thought of, you know, I just started, I can't say er... You know, just suddenly one day I'd done it, And that was it really. (528-530)

"wwhhfff" is the moment the decision is made to self-wound.

In "wwhhfff", there is a sense of surrender, of giving in to the tension, to the build up of and to the overwhelming feelings that she had been experiencing for a long time.

"wwhhfff, as onomatopoeia, graphically expresses her feelings being acted out, "I was taking the anger out on myself, um, I started with anything a comb, a serrated knife, anything that was would hurt me, really. That sounds awful but that's how it was" (22-25).

For Mary, the purpose of self-wounding at first episode is: to gain/regain control, to hurt herself and to reach out:

1. To gain or regain some control over the bombarding outside: "There was more anger involved at the beginning, whereas now it's (.) I do think a lot of it was something I could control, anger, desperation, um". (78-80)

> And er, I think that was it really, yes . I wanted somebody to take away all the things I was out of control with, really, you know, so that I could be a bit more in control. That word again, in control↑ . . . I felt I had asked for help yes, and things were just getting worse and worse and worse. And that one thing I found did help. When I wasn't getting help from people it was help from that bit of pain really↑ (691-708)

She is also keen to stress that she was in control of her self-wounding, "I knew, at the time I knew what I was doing, it wasn't as if I didn't know what I was doing, I knew what I was doing". (75-76)

2. To hurt herself: reiterated several times. "Anything that hurt really" (89), "It would be anything, really . . . That would cut me!". (100-104)

There is desperation in this quest for pain and Mary is desperate. When asked if she was consciously aware of the pain, she replied, "I was consciously aware – Yes, that it would actually hurt . . . My out of control state I call that [*half laughs*] you know, but, um yes. It works better (when it hurts)". (117-126)

"I mean I think probably the pain is part to do with the angry, because I'm angry, and and the pain sort of just relieves that anger a bit" (139-141) which

seems to confirm that anger feeds her need to hurt. The effects brought on by the pain of cutting are "immediate relief from doing it" (270), and release "The first time there was sort of a big sigh, because I had so many pent up feelings and it just released them" (109-112). The "big sigh" evokes the deflation of the pent up feelings which, once released through cutting and the experience of the pain, made way for relief.

3. To reach out (by making connections and seeking acknowledgement for her suffering)

> I think I'm trying to reach out to something really. I don't think it's the hurt that appeals to me, I think it's - I just wish somebody would know how I was feeling. You know I through the pain I was hoping somebody would perhaps reach out to me, you know. And notice that I had this. (130-133)

> Um, but still I, I still hope people will – I don't know, I suppose it's the actual wound itself, maybe I'm thinking people would realise how desperate I felt. (141-143)

> I think um partly (.) partly it was to show people how bad I was feeling. Um. Oh it just sounds so terrible, speaking it. (196-197)

There is a very complex set of thoughts, emotions and feelings in this account which reflect the inner chaos Mary was living. Her lack of control over external situations has been internalised as an "out of control state" for which self-wounding offers many functions. The transfer of emotional pain and her "out of control state" into physical pain provides relief and release.

The help she asked for never came, so she found a solution to show "how desperate [*she*] felt". The wound effectively provides her with tangible proof (when emotional pain is invisible) of her suffering, hoping "someone would perhaps reach out " and "notice" her suffering. The wound becomes the text and the locus of her suffering.

This is very reminiscent of many testimonies: Pembroke's seminal work (1994) or Strong's collection of accounts (1998), in which individuals talk about their hope that someone will notice the depth of their emotional pain without them having to say anything. It is also a genuine echo of the statements one can find on websites such as that of the National Self-harm Network. For instance one individual says: "It's a way of expressing negative feelings about myself that build up inside me. As someone who finds it difficult to put things into words, it can at times be the only way of expressing how I am feeling". Letting the wound, as text, speak for you. Sometimes the strength of despair is such that it robs the words from the person's mouth and only actions such as self-wounding can "speak" for them.

There is no suicidal intent in Mary's agency through self-wounding; she clarified without being prompted,

> I mean I can remember using a serrated knife . . . But um – because I certainly wasn't trying to kill myself, it wasn't that, I definitely wasn't going to do that, it was definitely to hurt myself rather than kill myself. (82-87)

> But it wasn't, it was never an attempt to kill myself. So, no, you know, I've taken overdoses in the past, which might have been an attempt, they felt different, it felt different . . . At that time I just wanted to hurt↑ (453- 458)

Subsequent episodes of self-wounding

In Mary's case, it is more akin to one extremely long episode, with better and worse spells, instead of 'subsequent episodes'. Mary was admitted to hospital a few days after she first self-wounded when a bed was finally made available. The knowledge that this was happening brought some relief but did not stop her from self-wounding again. In hospital, she self-wounded shortly after admission. And again, repeatedly thereafter: "It would have been the next day. You know. It might have even been more than once in the day" (273-274). However her need to repeatedly self-wound while in hospital brought a negative reaction from staff, from the very first time,

> I carried on self harming, and then they got funny. They got very funny with me in hospital↑ . . . Well, you know, I shouldn't have been doing it. They were quite angry with me . . . Um, well I had to sign something to say I wouldn't self harm. So if I didn't sign it they'd send me out. (228-242)

She did sign the document but it did not stop her,

> No↑ [*half laughs*]. No to be honest. I mean it – perhaps it wasn't so bad,
> perhaps it – but it was with you know I mean occupational health and things
> like that , I'd take bits of wire (.) (254-256)

> *The practice of using no self-harm contracts on wards is still active in many mental
> health trusts, although there are disparities between teams and wards. These
> contracts are attempts at controlling someone's actions through arbitrary and
> punitive rules, ignoring the self. Mary is a case in point; the threats of being "sent
> out", or discharged, did not work. It is an infantilising way of dealing with acute
> distress.*
>
> *Besides, signing a contract does not provide any safeguard to anyone, the patient
> or the ward which produces the contract, nor does it provide a guarantee of care
> to the patient who is indeed in need of (timely and appropriate) care. Signing a
> contract does not make the 'problem' go away or the issues linked to it. This
> sounds like a truism and yet, such bad practice persists. This is what Walsh calls
> "Contracting for safety" (2007, p. 1061). Which begs the question: Whose safety is
> it if the outcome is a worsening of the person's self-wounding? Who are they
> trying to 'protect'?*

Her random choice of method in hospital (as opposed to the use of a specific tool) was,

at this stage, still driven by one motivation, the desire to hurt herself

> Well I would probably look for something that would hurt. But not, you know
> (.) Yes anything that was to hand, yes. Yes, and when I went into hospital I
> would break up cassette cases. (94-98)

> *In hospital, patients become 'creative' when choices and or opportunities are
> limited. Mary uses bits of wire, broken up cassette cases... Others have used bits
> of crockery, cutlery, bits of glass, blades from disposable razors carefully
> dismantled, basically anything that is sharp and will procure what they seek: pain,
> a wound, blood...*

She realised the feeling of relief she had sought and found at first episode could be

repeated; self-wounding became compulsive. The compulsion was driven by the

almost instant gratification she got from cutting, "it's just a relief after I've done that

movement almost"(350) . It has at times become difficult to resist. It makes her feel

"Er, very pent up, very pent up and, and not in control, if I can't do it." (373-374)

Her need to cut is driven by memories and stressful thoughts,

> I often think to myself I'm going to have to cut. I'm going to have – cutting
> comes into my mind, quite quickly. And then other thoughts of things that
> have happened to me in the past, and you know, quite a lot of emotions come
> up, and more and more of these emotions come up and then, then I have to do
> it↑(390-394)

Together, difficult memories and the emotions linked to them form a potent formula
for distress, wound into a tighter and tighter spring that creates an imperative desire
to self-wound.

She describes her need and compulsion to self-wound as addictive, "Now, the longer
it's gone on, there's a need that I feel um" (64), "And then I got the relief and it was –
addictive – there's that word again!" (532). When asked to define a bit more her
feelings of addiction, (is it to "doing it"?, to the pain? to seeing the blood?, the feeling
of relief?), she replies: "It's all those things actually. It's all those things. It's not – I
don't think I can pick out just any one really. Maybe the relief is the biggest addiction"
(312-314). However, as is often the case with addiction, there came a point when her
choice of methods was no longer offering her the right amount of relief. She switched
to razor blades "Because it [*comb, serrated knife...*] wasn't doing what I wanted it to do
anymore" (326). Razor blades offered something different, "It's a deeper cut, so it had
to be more deep . . . Probably because it bled more. Yes. Yes. Because I don't always
feel it. [But] I get the relief" (337-347).

Over time, there was a shift in her narrative with the advent of shame, and then guilt .
"As time's gone on, it's guilty, I'm feeling guilty. More and more, yes" (169). It was
months before her self-wounding became more apparent to the world. Like many, she
hid it,

> [*People, unspecified*] Um no, no they weren't aware for (.) several months
> probably, several months. Um, yes, I yes, just used long sleeves. Well it was
> very mixed feelings I know, but I used to always bandage it up, and hoping
> people would notice the bandage in a way↑[laughs] Sounds so childish↑ Oh
> God, I'm sorry↑(.) Oh dear↑ But um (.) I mean I'm ashamed of it in many ways,

but in other ways I think surely people understand how bad I'm feeling, at the time, you know whether they do I don't – it's a hard thing to understand anyway. (145-158)

"I go to great lengths to keep my injuries and scars hidden at all times. I am ashamed by what I do, so the last thing I would want is attention for it".

National Self-Harm Network website.

Hospital lobby, 7am. Nightshift workers chat around a cup of coffee before going home. Suddenly one of them notices my scars. She whispers to one of her mates who looks round at me. I am invisible to them. All they see is my wounded skin and it shocks them. They whisperamongst themselves, but it's loud enough for me to hear. I am meant to hear it. But I am still invisible to them. My scars offend them so much. I want to disappear. (A-L Donskoy)

And yet, there is a degree of ambivalence in her discourse summed up in "mixed feelings". Something of the order of 'Will they, won't they? See? Understand?'. Going back to her previous account of the wound, hoping that someone would notice, this might seem contradictory. The bandage which protects the wound, and the wound itself are, in effect, forms of text and proxies for her emotional pain.

Her ambivalence is almost certainly due to her anxieties concerning people's reactions. "Well my husband gets very cross↑ [*half laughs*]"(169). She seems to be debating with herself about her self-wounding,

> I do think it's [self-wounding] wrong. For other people to witness and be aware of, but I don't know whether it's particularly wrong - this is going to sound really bad – I don't know if it's particularly wrong if it's giving you relief, if there's nothing else in your life that gives you no relief at all. And that works, I'm not hurting anybody else. (633-637)

Mary is accounting for her action. In her mind she feels self-wounding is "wrong " but she positions herself as someone who is not getting the help or support she needs. She is aware of both her own, internal, perspective, the one that needs self-wounding as a form of support and coping strategy (and "sets her up for the day") and the other, the

external, that of other people who may have to witness the aftermath of her self-wounding and live with her needs.

Her self-wounding has changed over time, but the feeling of guilt is still present. This is an issue, especially when other people, in particular her family, become aware of her self-wounding. Then guilt sets in as she clearly cares, "Yes, yes, yes, if I could have kept it to myself completely, um, I would probably merrily go on and get that relief↑ And and – but um, when it affects other people, yes". (640-642)

The family is not only a very cross husband, it is also a teenage daughter who has become aware of her mother's self-wounding. This knowledge has increased Mary's sense of guilt and shame,

> It's a guilt about, I feel guilty to cut. Um, I feel a guilt of other people knowing, my family, how they must feel, because I try to make myself think what if it was my husband doing it, how would I feel↑ Um, and my daughter, I worry quite a lot about her. Because she knows I do it, and um, it's had quite a big effect on her, so that, that's the guilt really. It's how other people feel. I don't know, I mean all I can think is how I might feel, and I would feel devastated for them really. Um, I don't know whether they feel that↑ I don't know, I don't know, I, no, I don't know. (587-596)

There is an extraordinary amount of awareness, love and empathy in this statement towards those dear to her. Her worry for her daughter dominates the statement and yet this is a topic that has not so far been talked about within the family unit, "No, no. We will be talking about it soon because my daughter's got an appointment at the consult – CAMHS [*Child and Adolescent Mental Health Services*], so I'm sure there'll be some talking going on" (598-600). There is hope in that statement.

Over time, this has brought her to look for other ways of getting relief,

> Um, but it just carried on, I can't, you know, I try not to, um, I mean for the family's sake I try not to, but um . . . Er, well I use other things, and that's the problem is I use other ways of relief really, you know, I'll take Valium and well, I'll drink . . . [*It does not work*] Not to the same extent. Not to the same – I haven't found anything that gives me that same relief. (543-554)

With the advent of razor blades in Mary's self-wounding narrative, came rituals. "Well it is the whole idea, I do have a, yes, I didn't used to, but I do have a sort of little

system now, where everything's out, and just so, um" (318-320). There is something comforting about this ritual, where everything is "just so". Rituals also gained a purpose,

> It became a way of helping me, without having to ask anybody else. Only from the relief, it was the feeling. It was the feeling helped me cope for the day. Because another thing, it's always in the morning. Always in the morning. So it's that sort of waking up and [sighs] . . . When I first started doing it, it was through the day, it was - I needed more↑ I needed more . . . I was going to say it sets me up for the day ↑[*laughs*]. That's awful↑ I've got that awful feeling in the morning you know, that – get through this day, and it's there, it's just – I can't explain it really, it's just there. (712-736)

Saying that self-wounding "sets her up for the day" is a very strong statement. It turns an extra-ordinary event into more than a coping strategy; it turns it into an ordinary event, one that becomes part of her routine. It is a representation of the silent scream "without having to ask anybody else". Here Mary also creates a meta-analysis by observing the effects of her self-wounding and the rituals that accompany it.

Post-Scriptum

At the time of the interview, self-wounding is still embedded in her daily routine, "At the moment we're alright with razors↑" (648). This very strong statement is in complete contrast with her opening statement where she presented herself as someone who was unable to cope. It also points to her self-wounding as being something in the order of the totally mundane, of the totally ordinary,

> Um, I'm even in more control of it now. Or should I say it's in control of me perhaps really . . . I mean it used to be every day, whereas now it's not every day. Um, and it's perhaps not – yes it's more controlled, because I'm not sort of so out of control. If you know what I mean. (437-445)

Is she in control of "it" or is "it" controlling her? Here Mary acknowledges the question mark and her reply echoes another "battle" that is going on in her life, between the inside and the outside.

Finally, there has recently been a degree of hope but also of self-awareness that seems to indicate a change. Over time her self-awareness about self-wounding has transformed her outlook on the experience and its impact,

Um, I got more aware of it as time's gone on really. One time I thought oh well, blow it! But um yes, I, I, I am worried that somebody will notice and think 'what on earth's she been doing!' Um. I mean I can be quite honest about it. You know, if people, if people do enquire, if they do enquire I can - I can't make any sense of it but I you know I can explain that it's a problem I have. But um, I don't know what I'm going to do this summer↑ So, you know, I I I'm in a way I'm hoping that I'm getting more in control of it because I'm a bit more - I'm worried about what people might – whereas one time I wasn't worried, so I'm hoping that that's a good sign that I'm a bit more in control of it and that then maybe I can stop. (668-678)

There is hope in her statement, that things can change for the better, that she can be more in control, thinking ahead. She has also grown more confident in so far as she is now able to be "quite honest about it" if people enquire. Already the frequency has dropped "I mean it used to be every day, whereas now it's not every day." (441). This seems to point towards a restitutive narrative, moved by the guilt she feels towards her daughter's well-being. These were, at the time of the interview, tentative efforts.

LAUREN'S NARRATIVE

Biographical information

Female, 25 at point of interview and 21 at the time of the first episode of self-wounding. Lauren took part in a follow-up interview.

Period leading up to the first episode of self-wounding

This period is made up of two parts. The first starts about four years prior to and the second, which sets events in motion, starts one year before the first episode.

First, the earlier part (1999-2003), during which Lauren went on a journey of self doubt about her sexual identity,

> I think, well I know that one of the behaviours I was so angry with in 2003 was the relationships I was having with men. Since I was raped at the age of 17 yrs (1999) I had frequently been having one-night stands with men. There were reasons for this; I was trying to convince myself that I wasn't gay, and I was afraid to say 'no' to any man that approached me because I believed that even if I did say 'no' then he would do whatever he wanted anyway. Between 1999 and 2003 I went out clubbing a lot, this inevitably led to advances from men and consequently a one-night stand. I hated it every time; I felt dirty, ashamed and confused. I had no self-respect and hated myself for what I was doing. I was raped for a second time in 2002 but continued to behave the same. At the beginning of 2003, I began having relationships with women as well. I had my final one-night stand with a man around the same time as I first self-harmed. I can't remember if it was before or after but I slept with a lot of men that summer of 2003.
> (fnfi, document handed in, 5-02-2008)

When this testimony was handed in, Lauren did not want the researchers to read it in front of her. Nevertheless she had wanted to share with the project what had been going on during that period and how she had been feeling.

This was a challenging course fraught with very real dangers. Her being raped was not only a turn in her personal narrative but added to her already emotionally charged self some serious questioning about her sexual identity. Lauren revealed, at follow-up interview, that the rape had been her first sexual experience.

The account suggests confusion, doubt and unhappiness about her sexual identity. It also suggests denial. She acknowledged that she would put herself in situations that

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would make her vulnerable; if she started chatting or accepting drinks from men, she knew that she would end up doing something that would eventually hurt, (fnfi). Reflecting, she says she was aware that, if she wanted to, she had control over the situation but somehow she was not able to retain or affirm this control (fnfi). In effect, Lauren seemed to have also convinced herself that if she said 'no' to a man, "he would do whatever he wanted anyway" (fnfi). A second rape incident did not change anything in her "behaviour with men", that behaviour that made her so "angry" (fnfi).

What comes out primarily of this account is her anger. Anger at men for raping her; anger at herself for having no self-respect leading to repeated one-night stands which her heart and body did not want, "I hated it every time" and anger at herself about the confusion she was experiencing over her sexual identity.

During the summer of 2002, while she was living at her parents' who were away on holiday, there was a dramatic turn in her narrative when she made a definite suicide plan,

> Yes, well, I was thinking um – I didn't want to give up medical school, because it was where I'd always wanted to be, but I'd got there and it wasn't what I thought it was. And I couldn't cope with it. So, I didn't want to leave because I'd always wanted to be there, but I didn't want to go back because I knew I couldn't do it and I knew if I went back, then I would fail and I would be in danger of myself if I had gone back. Which is why I came to the conclusion that suicide was the best option because then I didn't have to give up and I didn't have to go back either. (222-228)

"It just didn't enter my head I don't think. To cut myself. Because I don't remember that being on the list of possible ways of killing myself . I got a different list" (681-686). "I was going to drive the car into a wall (690). The intent was clearer, "Hmm. It was definitely far more final" (694), "Yes. It was all or nothing really" (702). Lauren makes lists and there was a list about what she could do to achieve her goal, clearly differentiating between self-wounding and suicide. Was the reason because she did not want to die or because she cared about other people? "No, I couldn't care less about anybody else at the time" (707)). It ended up being "nothing",

I was in the car, ready to go. I was driving. Because I'd been sat in the house
and decided, and then I was in the car, and I'd even decided on the wall (.) Then
I don't know why, I didn't drive into it. Went home, took the dog for a walk,
and pretended nothing had happened. I know driving always makes me feel
better↑ [*laughs*] so I don't know. Actually getting to that - I should have picked
a wall closer to home↑ [*laughs*] (712-720)

It is as if Lauren realised that she had left too much thinking time between the house
and the chosen wall in that time- space locus. That did not prevent her, looking back,
from showing a -black- sense of humour about her choice of wall. Above all, she
"pretended nothing had happened".

> *The time between when a decision is made and its application has a crucial role to
> play. There is also evidence from the field of experimental psychology that "the
> more you think about a decision consciously (that is, with attention), the less time
> remains to think about the same decision unconsciously (that is, without
> attention)." (Dijksterhuis, Bos, Nordgren, & van Baaren, 2006, p. 1007). Lauren
> had possibly taken too long to think and apply her decision for it to become a
> reality. Driving possibly also played an unconscious part as she enjoys it.*

Then came the one year period 2002-2003, which overlaps partly with the first. Lauren
was quite keen to talk about this period in some detail, "If I explain more about the
situation that I was in" (19),

Yes. Um. I think at the time – because I'd given up medical school, and then
gone off the rails [*the abandoned suicide attempt*], and I still didn't understand
why that had happened to me, and then, I'd moved into a shared house, with
people that I knew from medical school, so I had friends from medical school
and then I started nursing so I had friends from there, and (.) I was – I suppose,
I was struggling to keep up friendships with both lots of people, and (.) didn't
know really where I wanted to be, because half of me still wanted to be back at
[name of] Uni doing medicine, and the other half of me wanted to be doing
nursing, so I was sort of stuck between the two. (21-28)

Lauren depicts a state of confusion, having given up medical school which had not met
her expectations,

The first week of medical school, erm, so lecturer stands up there and he says
um in the next five years we are going to convert you from human beings into
doctors. And I think from that moment on I thought - oh, what am I doing

here?- But then my brain wasn't working and I was depressed and I couldn't cope with the work anyway. (346-350)

There was a shift when she decided to leave medical school, "Um (.) I think (.) I reasoned with myself that nursing would be better because erm you had more, more patient contact". (343-344)

The year between medical school and nursing school was a blur, "I was walking around in a fog". She does not remember how she went through the application process although she was offered many places. Nursing school brought further disappointments,

> But when I started nursing, I started it without any expectations really, and it was very very easy. Erm, and because I'd been used to - it's a different culture at [*name*] Uni compared to [*other local university*], . . . and thought that [*other local university*] they all seemed really quite incompetent and – very disorganised and - I decided from day one that I didn't like it. (351-355)

Nonetheless she persevered with her training and was soon sent on placements. It was during the first of those that some of her colleagues made comments,

> I did my first placement (.) I think I think that was alright, erm, I know they thought I was a bit strange. They made quite clear . . . Erm. You know, things like knocking on your head 'Is there anybody in there?', you know, 'Are you with us?', that sort of thing. (362-368)

Lauren acknowledges she was very unhappy. There had been some contact with the Mental Health Services Crisis Team at the beginning of 2003. Friends who had been concerned about her depressive state and at how poorly she had been looking after herself, had called her GP who had then called the team. However, after a week of intensive support, she was discharged from mental health services and no further input or support was offered, which puzzled her,

> Now, I don't really understand how I could have needed the crisis team for a week or whatever period of time it was, and then – maybe nobody really seemed interested as to why that had happened, why I required their input. (280-282)

Looking or asking for help herself could have been an option but her upbringing discouraged her strongly from choosing it,

> No. I didn't - erm, I didn't ask for help, I'd never asked for help, up until then. Um, I was pretty useless at that really. Um, because - I was brought up not to express emotions, and not to say how I was feeling, and brought up to be at this this constant, where you couldn't, you couldn't be sad and you couldn't get too excited either, you had to just be the same all the time. Erm, and with that, with not being able to say how you're feeling, also you couldn't ask for help. Because none of my family ever would ask for help from anybody, and I was taught the same thing. So whenever I did see people, for example I saw my GP, I couldn't express myself, I couldn't tell him how I was really feeling because I didn't have the words, and also it was ingrained in me not to say anything. (259-268)

Lauren felt emotionally 'inarticulate', her emotions had to be contained within this "constant", since it had been "ingrained" in her "to say nothing".

A few months later, towards the end of spring, beginning of summer, Lauren's level of confusion became quite high, and she struggled to keep up with most aspects of her life. She was still living in a shared house with other student friends from medical school,

> Erm, and – of course the summer comes around, and everybody disappears, so everybody that I was living with disappeared from the house, so I was living on my own in a three-storey house for a couple of months, erm, everybody from nursing had disappeared, er, so I think I, I felt quite isolated, and I was still, I was still confused about how I'd ended up doing nursing because I don't really remember getting in to it at all, erm, and I was confused because since I'd finished medical school I didn't feel my brain was working how it used to. Erm, but that was because I was depressed, and I had low concentration and really bad motivation, and my brain just wasn't doing what I was used to it doing and what I expected it to do, erm, and I think, I started getting very frustrated because I couldn't do the things I wanted to do, and the things I used to be able to do. (28-39)

The "fog" she had been living in since she left medical school had never lifted. She had "low concentration", she was feeling "depressed", she felt intellectually incapacitated, indicating a frustration with herself. She was also, all of a sudden, feeling "quite isolated", all alone in the "deserted" student house, while her housemates were away for the summer break.

It was also about that time that Lauren had her last one-night stand with a man. This was a catalyst moment (fnfi) and signalled a shift in her personal life. We also know that she had also started having relationships with women. Overall, she was angry,

> Yes I was angry with myself. Um, and very confused. Um, I was angry about my behaviour, I didn't like the way I was behaving when I was around other people, I couldn't say specifically what it was that I didn't like, but I used to come home and I'd be thinking - why did you, you know, why did you say that to somebody? – there was no need to say that. Or, the words that were coming from me weren't actually mine. Which is another thing that I got angry about because I thought - I felt like somebody was speaking for me. I thought – you know, nobody's speaking for you, get a grip, [*saying*] things that I wouldn't normally say . . . I think - I did manage to offend some people. But I didn't feel as though it was me saying those things . . . Because I was so angry with my behaviour, that I thought I deserved to hurt (158-178)

There is a self-demanding, self-punishing, self-critical and judgmental voice winning over any other in Lauren, and she felt she "deserved to hurt", turning her anger onto herself. There was no room for self-compassion. For someone who did not have "the words", she is surprised at the words that she used, behaving in an ambivalent way with her friends. The resulting guilt was the reflection of how distressed she felt internally about all the issues that had gone wrong in her recent life.

At that point, Lauren follows the Spring pathway: there is a clear reflexive awareness of emotional tension building up (anger, frustration and depression). Lauren's narrative is Frankian as she cumulates inner chaos (long period of confusion about her sexual identity) with narrative wreckage (deliberately and repeatedly putting herself at risk and instances of rape), further compounded by ensuing chaos in her personal and professional life. This is characterised as a year-long sleepwalking through life leading up to first episode.

The first episode of self-wounding

> I remember the night that it happened, and I'd decided that I wanted to die. But and I'd made all these plans that you know you could do it like this, do it like that, do it the other way. And then I think I'd come to the conclusion that I was way too much of a coward to ever go through with any of those things, which I think made me even more frustrated because I wanted to die but knew I couldn't kill myself. (63-71)

Erm I well I was very angry about that and I was very confused, and I was sort of crying uncontrollably and screaming to an empty house for somebody to help me, which of course there was nobody there to do that, erm, and I've been trying to remember (.) where I got the idea from. But I know I'd had a couple of glasses of wine, which the idea was to numb the pain a bit, but um that wasn't doing anything . . . Erm. I think I probably got the idea of harming myself because one of the options on my list of ways to kill myself was slitting my wrists . . . Erm. I am still trying to think of where I went from I want to die but I can't, to deciding that cutting myself would be a good idea. (79-92)

I know I was in the living room, when I was making those decisions, and then I went upstairs to bed, and, I cut myself in the bedroom, and (.) I made three cuts that night, erm (.) and I think (.) I think possibly as I was doing that it was still in the back of my mind that you could make these deep enough to kill yourself. (103-106)

Lauren was keeping her options open. Self-wounding was there on the "list" as an alternative to suicide and at some point during her deliberations with herself, the line between self-wounding and suicide attempt was a little blurred.

Lauren took a kitchen knife with her. It was not a random choice, "Erm (.) no, I deliberately picked that one . . . it was to see what I could do with it↑"(740-743).

[*Sighs*] It was, I'd obviously got it in my head from somewhere that I was going to cut myself whether it (.) I don't know, I think I just got so angry and frustrated I wanted to do myself some harm (.) But I think as soon as I made one cut, I realised that no way was I going to make it deep enough to kill myself. (114-121)

Between killing herself and self-wounding, the latter option was gaining ground in her mind. She made a number of cuts,

Three, yes. I think - I did a practice run, and then the other two were on the veins on my wrist, heading for the – well heading past the vein for the artery. But, the result that I got from it was probably was (.) was better than I expected. That sounds strange. Medical school had taught me something, yes↑ (751)

Medical school had taught her control and how deep she could go without damaging an artery and potentially risking death. Yet something happened, "I think. Yes, I think so. I think if I hadn't had any change, then I suppose maybe I might have carried on"(151-152). The strangeness was in the so unexpected effect,

> Because afterwards there was like this um – I was just completely calm and all the anger and frustrations and everything had gone. I wasn't crying any more, and I wasn't screaming. It was a bit like I was sort of floating on a little cloud. (123-128)

More crucially she says of the first episode, "Um, yes, I didn't want to kill myself after that, it was alright, because it had done the job. It had released whatever it was that I was so angry about." (155-156)

She was expecting pain, instead of which she experienced a release, " disappointed me because I wanted to hurt. Um, which is why, I think, which is another reason I think why I didn't just do it once, I thought - 'You will make this hurt!'" (142-143). Her anger fed her guilt, "Because I was so angry with my behaviour, that I thought I deserved to hurt" (178).

There was some bleeding,

> Deep enough to bleed a lot, and not deep enough to require medical attention . . . I think after I'd made the first cut I thought I don't want anybody else to see this, so I think then I made a conscious effort to make sure that it was something that I could patch up myself. (130-137)

This too indicates that Lauren was in control of what she was doing. Overall, she had control: over attempting suicide or self-wounding, a decision influenced by the positive effect of self-wounding; over the depth of the wound, and who would know or see, by patching it up herself.

After the first episode, she only told one friend. "I told one person. Yes. And hid it from everybody else. Erm (.) she was the one that said those are just cat scratches, 'what are you showing me those for?' " (792-793).

Subsequent episodes of self-wounding

This period lasted for about two years. Lauren's feelings at subsequent episodes remained the same: anger and frustration as well as her difficulty at outwardly expressing her distress. Anger was still, however, the driving force and dominant feeling. "Yes. And always angry with myself". (433). When she was angry with her friends, it was out of frustration with herself, again,

> I think - I did feel angry with them, but only because they didn't - I think I spent
> a lot of time sort of trying to cryptically tell them I'm scared of what's going on
> in my head. But could never actually come out and say I don't know what's
> going on here. And I think when I sort of tried to suggest things and they didn't
> pick up on them, I think that made me angry with me, because you know why
> can't I just come out and say it↑ And also angry with them because they didn't
> understand and they didn't pick up on it. Which, looking back on it, nobody
> would have ever picked up on what I was implying↑ [*laughs*] (440-450)

The words were still missing to express herself in the way that she wanted to, thus reinforcing the dominant self-critical self-narrative where anger and frustration were the loudest voices, fed by perception of her behaviour towards her friends, towards men and by the memories of the rape incidents (fnfi). The outcome of the self-narrative was always an increase in tension and emotional build-up, which indicates the presence of the Spring pathway, resulting in self-wounding because those loud voices could not find a different outlet.

There is further evidence of the presence of the Spring pathway as Laurence continues to have clear awareness of an emotional build up of powerful emotions and she says her experiences are alike,

> The same, yes. Yes it was the same every time. Erm, there was this build up of
> feelings and anger and then sort of after the first time, and I suppose after the
>
> second time I'd learnt that when I felt like that if I cut myself it got better.(423-
> 427)

Lauren though is only aware of the tension building up quite close to the point of self-wounding: "A couple of hours beforehand" (fnfi). She did not usually think about self-wounding, "No, because after I'd done it, I, er, there was no need to think, for a while. Because everything was alright, and I could just wait for it all to build up again." (804-806). When needed, self-wounding was there to serve a new function, "So it just became quite a useful coping mechanism." (429). In fact, Lauren felt unable to resist self-wounding,

> No, I think I always did it. Um, there was a time when I did try and resist it, um,
> when I was on holiday with my friends in France, and I'd crashed my dad's car,
> and well it all got very messy. (518-520)

"Messy" refers to a state of "depersonalisation" where she experiences something akin to altered consciousness that increases her frustration. "When I was in France and I tried to resist cutting myself because I decided this was not the time or the place erm, I ended up having those episodes continuously, until I did [*cut*]". (546-548)

Lauren also used cigarette burning. This was linked to her "worst times". This gave her pain but no release; therefore Lauren did not feel it was a satisfactory means for her (fnfi).

Her self-wounding seemed to have echoed her state of mind,

> There was a time probably when it was every two to three weeks, but then I would go through a, I think I went through a phase of doing it every day. Hmm. But then the time period in between got less and less . . . I presume, I, I can't remember, I can only presume that I didn't have the feelings of anger as strongly, so didn't need to do it.   (571-579)

There was otherwise no pain associated with cutting, possibly due to the fact that Lauren remained in control of her self-wounding throughout.

Cutting offered a way out of the turmoil and the emotional pain associated with it. It allowed her to almost seek a lack of awareness, the "little cloud" effect (128). The release meant that often she was so exhausted, she needed to sleep,

> I think perhaps why I'm struggling actually is because a lot of the time I would get so wound up that I couldn't sleep which is why I did it so I went to sleep straight afterwards. (839-841)

Sometimes, there would be feelings of guilt about self-wounding,

> Um, I was disappointed with myself in the morning (.) because I sort of think well isn't – there must be another way of coping with this apart from doing that, but then that would fade and I'd think oh well it did the job, why look for anything else↑ (841-844)

As well as feeling guilty, Lauren seemed to have had ambivalent feelings about who saw, whom she let see her wounds but also where she cut on her body. She describes how those of her flat mates reacted in different ways,

> Um, my friends that I live with – there was four of them, and three of them didn't mention it, one of them said please don't do that again it frightens me,

and it looks a mess, just don't do that anymore. Erm I had a good friend who (.) said 'they're just cat scratches, what are you worried about?' Hmm. I don't think anybody else really mentioned it. (627-631)

Showing or hiding implied choices, which Lauren made, "But I had consciously changed location because in the beginning I cut myself on my arms. And then I made the top of my leg the spot instead. Which is far easier to hide." (590-595)

I've always been interested in why I initially chose my arm when I consciously I didn't want anybody else to see. But then if (.) you know I'm in control enough to do this and decide that yes this is what I want to do. Then I'm in control of deciding where. On my body. Erm. I think the only conclusion I can come to is that unconsciously I knew that if it was there and somebody could see it then somebody would do some- would you know, would help me. (769-777)

Lauren offers this conscious meta-analysis. Letting the body, the wound on the body become the space and text of her pain when the words fail, hoping that someone would reach out to her (if she could not reach out to others) and help her. "Yes. "Because, because I'd tried and failed, to let anybody know how I was feeling, Then maybe that was my way of saying erm (.) I don't know what's going on here" (779-781).

She did not think about consequences when she self-wounded. Nonetheless, showing or allowing other people to see signs of self-wounding, even inadvertently, sometimes carried negative outcomes on a professional level,

I mean there were there were consequences, and when I was - it   was about, it was a year later, when I had quite obvious, there were obviously fresh cuts on my arm, erm and I was working, I was on a community placement, and I was suspended from that placement because they had noticed that I had cut myself and they were worried that I might take sharps from the treatment room and use them and cut myself whilst I was on the premises. So I was suspended from my placement. (604-609)

"I was suspended until they could get a report from my psychiatrist" (613). The psychiatrist did not offer any help "Erm, not at that time" (616).

She eventually stopped self-wounding,

Ok. Um I stopped, the last time was (.) at the beginning of (.) umm (.) there was about a year between the beginning of 2005 and the beginning of 2006 where I didn't do it. Erm, but then the final time was at the beginning of 2006,

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after, after I'd split up with my girlfriend I was then again angry with myself because of the way I'd behaved over the couple of weeks when we were trying to split up for the second time, and then recognise those feelings as the same feelings that I had before I'd previously self-harmed, so I thought right, got these feelings, know what to do, cut yourself. So in a way it was forced, um, but when I did, it hurt, erm, and it didn't work either, because I didn't feel any better afterwards. (465-473)

For Lauren, self-wounding had lost its appeal. She went through the motions without any conviction, "in a way it was forced". This, in turn, did not produce the sought after effect of release which she had had previously. Instead she got pain, which was now a disappointment, because she "didn't feel any better afterwards".

There was a significant turn in her narrative during the period Easter 2005 to the beginning of 2006 which was free of self-wounding. It seems that a new partner had a positive effect by allowing her to reflect and learn about herself,

I don't know if I hadn't met her because it was quite interesting meeting her and going out with her, because she'd been through a lot of things that I'd been through and she was considerably older than me. And she possibly taught me, I wouldn't say - she didn't teach me new coping mechanisms, but I think I opened up to her and she sort to helped me to understand some of the things that I had and some of the reasons I behaved why I did. I think, I suppose I wasn't as angry with myself whilst I was with her because she'd helped me find out why I behaved like I did and I think when you know the reason for your behaviour, and that reason's ok, it makes sense, that I'm behaving like that, then I wasn't quite so angry with myself for doing it. (498-507)

This person performed a heuristic function. Lauren acknowledged at the follow-up interview that she really felt that without this relationship, she would not have been able to make the benefit of what she had learnt last. Now she was able to. (fnfi) The appearance of this stabilising and supportive new partner also creates a definite narrative turn towards a more restitutive narrative.

Post-Scriptum: Follow-up interview

Lauren has stopped self-wounding, "No. Never feel like self harming" (722). Her perspective has changed. She has a more nurturing approach to her feelings and she manages her anger better, "Erm (.) I don't get quite so angry any more. But I think now I've got a lot more understanding of (.) what goes on in my head and why" (726-727). Lauren now "recognises the signs of anger building up" and tries "to deal with

them there and then", partly by "trying to get out of the environment" she finds herself in "lion in a cage", "go for a walk" and finds "physical activity helpful" (for instance, walking on "hilltops, taking pictures")(fnfi). There is an element here of needing to make links with life and ordinary things.

While her narrative stated how for a long time she did not have the words to express herself, crucially now she says "I think I'm now able to say 'Help me!' " (732). This has allowed her to find it easier to ask for help, she has people to talk to and is learning to cry. She also says she has better self-respect in sexual matters (fnfi).

PETER'S NARRATIVE

Biographical information

Male, 42 at point of interview and between the ages of 10 and 12 at the time of the first episode of self-wounding. He and another sibling (brother) are the adopted children of an older couple.

Period leading up to the first episode of self-wounding

This period started when Peter was about eight years old. His account of this period is marked by violence, fear and loneliness. He describes his upbringing as "very draconian, volcanic" (12). He remembers one incident in particular,

> He [father] always used to have a temper but I suppose the violence started – yes it's been about – try and work it out – it must have been about eight, or nine. He tried to suffocate me, with his hands. I can remember that. And er he wouldn't let me watch *Dr Who* for a couple of weeks after that. (26-29)

He says the family lived in a climate of fear, "always every day was a frightened day" (48), and feared of reprisals,

> And um, yes, if I used to piss the bed, I'd be – you know, it weren't my mother's fault, but she used to say I'm going to have to tell your father, but why I don't know but she was in fear herself anyway. (168-170)

> You know, like a punch across the back of the head, in the face" (175)

> And er one time, because I kept, like I said, pissing the bed, Um he got a big meat knife from the kitchen and he pulled my trousers down, and he put them up by my scrotum, and he said 'You piss again tonight and I'll cut this off'. Well, you're going to keep peeing the bed, aren't you↑ (408-414).

As Peter sees it, he and his brother were adopted purely because they were boys, which made him feel "used and abused" (513),

> Because we were only adopted for the solely of doing things for our father. Had to do the gardening, had to do the washing up. Shopping, right, Christmas eve, this when we were little, we used to have to walk from [*place*] to [*place*] right, with our dad, and we used to have to walk back with all the shopping, and he'd be walking in front reading the Sun newspaper. And we had to do the garden, we had to do chores. That's all he wanted us for, he didn't want us because our mother couldn't have had children. And that's why he wanted two boys not girls. (515-523)

In this account, the two boys were used as workers for the benefit of the father. In this environment, Peter describes himself as "quite a loner as well – and sort of busy on myself, shall we say" (33-34); friends were not allowed to visit.

Living in a constant ("everyday") climate of fear, violence and loneliness inspired him to dream of the perfect family. Peter used to dream about the fantasy world in the television sitcom "*My Family*",

> I always used to look at that and think, what an idyllic family, go round to friends – because we were never allowed friends around, so we used to go to friends and think what a lovely family, what a lovely mum and dad, and don't they look the same, why don't I look the same↑ (142-146)

Life elsewhere was better and people looked "lovely. Peter says "look", not "be", which is interesting because "look" could imply a detachment as if he did not allow himself to think he too could be the same ("why don't I↑"); even if looks can be deceptive. Thus the visual texts from the sitcom and from life at the neighbours' offer different vistas for Peter which made him reflect about his own predicament.

> *In this particular sitcom, the fantasy feels credible despite the failings of the characters who seem to "have it all" but are very poor at communicating with each other; where individuals are egocentric and capable of the worst tricks for maximum fast gratification at the expense of others. Maybe it is credible because at least no one gets hit for their eccentric or bizarre behaviour, however appalling, and some form of redemption always takes place to make the whole narrative gel and "acceptable" .*

At this point, Peter's narrative follows the Spring pathway: awareness of tension building up/ overwhelming feelings (anger, to the "point of explosive" although anger is turned onto himself). It is also a Frankian chaos narrative. From an early age, there was narrative wreckage within the family setting which prevented him from believing in himself as he experienced abuse, fear, social isolation, loneliness, anger and violence (mostly from) the father. The wreckage turned the coils of the Spring to their extreme point.

The first episode of self-wounding

That day, there had so far been no particular trigger or violence, "Not at the time, no. Just put up with it I suppose" (132) and yet, immediately before he first self-wounded, Peter remembers feeling very tense, "I can remember being so sick, and just so angry, almost to the point of explosive" (162-163). This particular day marked a very important turn in Peter's self-wounding narrative, when he made a dramatic decision,

> Always a Sunday, always Sundays for some reason. I can remember when er it was quite a violent Sunday, and I wanted to kill my father. And er I can remember going into the old garage and finding a chisel and just start chiselling away. At myself. (12-20)

The narrative turn lies in Peter not being able to "put up with it" any longer, his anger having finally reached a threshold to the point where he felt "explosive". However, instead of killing his father, he turned this "explosive" anger onto himself and self-wounded with a chisel that he found in the garage.

It had not been his intention at all to self-wound, "No, I went there – I had to do something. To stop me doing what I wanted to do I had to stop myself in some way. And the only way of doing that was centring it on myself" (76-81). The resulting physical sensation was just as dramatic, Peter was on a high,

> It was great. It was great. It was a sense of - I suppose it must be like for a drug addict for its first fix. You know, phyorr↑ You know, your serotonins and everything straight up the roof, great↑ And er I was shaking at the time, I can remember shaking, really bad. But after, the sort of thought of doing harm to my father subsided. (110-117)

Although it had not been the intended action or result, self-wounding had worked. There had been a release of the explosive feelings, of the tension he had been experiencing. He did cause himself physical damage, "Er quite bad. I done a good job." (100) and, when asked, he made excuses, "Um. Father wanted to know what I'd done but I just said I slipped on some metal in the garage". (102-103)

The first episode of self-wounding shows no suicidal intent; it was anger aimed at his father but redirected at himself. He does not report suicidal feelings either. Those developed much later, "The thoughts of suicide started when I left home at the age of 16". (97-98)

Subsequent episodes of self-wounding

There are two distinct periods after the first episode. Between the ages of 10-12 (when he first started) until the time he left home (at 16) and again from the age of 19-20.

First Period: Peter still at home

Life at home continued to be marked by violence from the father towards Peter (there is no information about his brother) and his mother.

After the first episode, self-wounding becomes a coping mechanism, " just a way of dealing with violence within the family home." (163-164). Somehow, the pain from self-wounding was easier to cope with than the pain inflicted by his father,

> Um. Do you know what (.) it hurt, but not to the point where you had to stop. I don't know whether (.) you got the pain but the barrier was just so – I don't know, it hurt. Um, - it hurt, but it's what didn't hurt as much as the physical side from the family home . . . so if I do that, um, if I got, thrown against the wall and stuff, then that was nothing, do you know what I mean↑ Because I (.) I suppose in a way I'd be – on the front end of the violence, because our dad used to say why you know, 'I'll do it until you cry', but I didn't cry, you know after a while you just don't cry. (177-190)

He says his father wanted him to cry, as a mark of submission to his authority, but Peter could not cry after a while, highlighting once more the effect the relentlessness of the violence at home had on him.

Fear and tension building up were always mentioned as the source of Peter's self-wounding during those years. "It could be fear and an event, definitively . . . It used to build up. But also the fear as well" (232-242). In particular, Peter was in constant fear of how his father would react to the latest news of his incontinence, "So you'd, just waiting, so you'd be cutting, because once you got that pain, nothing else can be any worse" (172-173). Self-wounding then helped him cope with waiting for his father's wrath. Peter's cutting took on different modes,

> I was cutting, I've put glass into my skin. I used to put bits of glass and pens actually underneath the skin, um but when I was first sectioned [*years later*], obviously when they take you down, suddenly one of them was screaming about, and they couldn't believe it. That it was that extent shall we say. (64-69)

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Self-wounding was comforting,

> I found solace then. In myself. I can remember one year it snowed so bad, must have been 1979 or 1980, and I built an igloo, out in the garden. And I can remember sitting in the garden and giving myself a good going over. (152-156)

For Peter, this is a "higher pain, but comforting" (194), although it did hurt afterwards,

> Oh God yeah↑ And I admit that . . . and I think when you're doing it that chemical's being released, personally for myself, it's being released. But then after, about 10 minutes after, when you've sort of you come to, and you start relaxing, um, mentally wise, and you've got more control over your body like your breathing, and obviously oh yeah did it hurt like buggery. (200-209)

In those days, Peter did not want or seek medical attention, he did not want to have to answer questions, "I made excuses" (215). However bad the home situation was, for Peter it had to remain private,

> Oh God yes, wouldn't want anybody else wanting to know family business. Phrour↑ Frig me↑ No. I could even, even see it now, if I did, and I went to school, and if something was said and I said why, in those days you wouldn't be taken into care, you just got to go back home, and well, I may not even be here if that did happen. (395-402)

However, not revealing the truth was, for him, the best way forward in order to survive. And so he deliberately hid signs of self-wounding, "Oh yes. Yes. And I didn't like my body anyway. Even at a young age our dad used to say things about my body and stuff [*linked to his incontinence*]" (404-406).

There was a development in the home narrative when one incident in particular created a small turn. This took place again on yet another Sunday when, this time, Peter retaliated. His father had intended to hurt his mother by throwing a boot at her but Peter interposed himself and threw the boot back at him. His father took fright,

> He just said 'You're demented!', you know, 'You're possessed!'. And I think that probably frightened him as well. Knowing suddenly I'd lost complete control . . . And knowing him probably thinking 'Oh I won't be able to go to sleep at night', do you know what I mean↑'(303-312)

For Peter there was a sad consequence to this, "So I think because of that incident, um, yes. He put more of his anger then, sadly, God rest her soul, to our mother. Because she tried to leave home as well, but couldn't". (314-318)

There was another consequence. His father realised that Peter was getting stronger emotionally "I was a right little weed. But I think for my father to see me just lose all control (.)" (322-323). The power to frighten his father made him stop self-wounding.

There was a more definite turn however when, on Christmas day, a few months before his sixteenth birthday, Peter received a clear message. It took the shape of a suitcase and a verbal announcement from his father,

> So I thought oh great – I was 15 then by the way – and I thought oh we'll be going on holiday somewhere, probably abroad or something. 'No', he said, 'That's because you'll be packing your bags by the time June, the summer arrives, you'll be leaving the family home'. I thought 'Frig it!', so yeah, left home. (270-273)

These developments serve to illustrate compounding family narrative wreckage where each event creates more chaos and pulls individuals further apart with no hope of healing.

Second Period: Adulthood

By the time Peter left home, he had become alienated from the parental culture; his leaving marked a definitive rupture and the beginning of a new type of isolation which drew him to an "underworld" of prostitution, abuse and hurt. This second period starts when Peter was 19-20 years of age,

> It was um I started I restarted again er must have been 20, selling sex, getting used, and then it was just to find solace again. Those were very dark dark days. Believe me. Very dark. Yes. Nobody wanted me or if they do it was only because - they had to pay for it. (424-431)

> er homeless, sold sex, anything, just to get through the day to day. The sex weren't just for the money either. But um, as time went on, you do more damage to your body. And people don't really want to know. There's all questions as soon as they see you taking your clothes off, it's like they don't want to know, do you know what I mean↑ (36-43)

Peter did not prostitute himself only for the money. There is real desperation and loneliness in his account and it is a period when self-wounding is reactive. The scars on his body were too much for some punters and he talks about a particular event which triggered his self-wounding again, "I didn't get paid" (496). This is delivered bluntly, reflecting the bluntness of the experience. This made him feel,

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Shit. Really bad. Suddenly - you do what you need to do and you don't get paid. And then it's just like, just like, you know, although I was only 20, being like 10 to 13. Ain't that long ago, so it's very very fresh in your mind. So it comes very, it comes flooding back very very quickly, yes. (500-505)

What made Peter feel like "shit", was the memory of his younger days "Yes, used, abused, and it was just – you're thinking of like when you were younger. Again, used and abused" (510-513). Such lingering memories in Peter's adult life are a text of many parts, a fluid text that is so painfully imprinted in him that it carries with it the power to resurface at a moment's notice, opening the gates to floods of memories every time he is being mistreated by a punter. These intrusive traumatic memories were cued by an external element, linked to earlier powerful emotions of childhood (Berntsen & Rubin, 2002), resulting in a "painful affect" (Conway & Pleydell-Pearce, 2000, p. 282). Self-wounding would then bring comfort, "Very warm feeling yes . . . Just felt, you just – it's solace – you feel comfortable" (532-536). Peter continued mostly to cut, because "it's just something I suppose you're comfortable with." (490-491). So these are two aspects of the memories which he could hold on to: the abuse and the soothing effect of self-wounding.

About age 20, there was another turn and his journey moved him on to find new social groups in which he became progressively socialised. He became engaged in the "vampire", the "underground" and finally the Goth movement to which he still belongs. This finally gave him an identity and a sense of belonging where he could be himself (Berntsen & Rubin, 2002). His "dark" days were, in parallel, becoming darker. By the time he was 21, Peter was also referred to mental health services,

I was admitted into what was then [*name of hospital*], and it just started from there with mental health problems, screams in the head, and it was just cutting, just get rid of the voices. But I now know that's been brought on from you know early childhood. (51-56)

Once in hospital, he became creative about self-wounding methods. "CD cases, in hospitals, I didn't realise that, until I got in. And then they've had to remove them all then" (348-352).

Peter would self-wound about twice a month but there were more dangerous times, especially when he was on his own with his memories,

> Loneliness. Thinking about - all you do is just thinking about the past, family
> home, when you're not busy, you know, times you have spurts you know to
> meet people, you go out you have drinks, yes, you stay round people's flats or
> houses, keep going, yes, that's fine. Then when there's a lull. That's when it's
> dangerous. That's when you've got time to think. (473-480)

One of the most important aspects of Peter's self-wounding narratives as an adult is

control, which encompasses agency, being in control and who sees his scars and pain

Peter took control of his life through self-wounding (when everybody else had control

over him) which remained a coping (self-regulatory) mechanism. He had control and

he did not have control: self-wounding became addictive and dissociated from the

original source of stress. Today self-wounding still appears a source of solace but it is

also a source of control, therefore an expression of agency,

> In that particular, in those times that you do it, you are in your own bubble.
> And you can do what you want to yourself because it's you doing it. It's not
> somebody else doing it. You're doing it because you want to do it. (539-545)

The bubble feels protective; it allows him to be in control. Or does it? There is a sense

of ambivalence which seems to highlight some of the contradictory nature of self-

wounding,

> Do you know it's really weird you say that because you're in control but you're
> not. You know what you're doing. You don't want to do it but you do it.
> Because after the first time, like I said, it's that rush. (329-336)

This contrary nature became more potent when self-wounding would often be an

event of its own, separated from any particular trigger (thoughts, event, feelings,

memories), "It almost got to the point of an addiction. It was almost an addiction. Now

some people, even the profession I work in, probably would laugh at that, But then

they don't understand, they haven't been on that end" (661-668). It was "almost" an

addiction to both the pain and the release, although "I'd have to say the pain first. The

release second. Because the release then got to pain factor" (673-676). During his

worst times, Peter would self-wound "Worst off, weekly. Definitely weekly" (649), and

he started to crave it,

> I'll be honest, yes. Yes. Like I said, it's almost taking somebody who's
> dependent on drugs, you know, it's wearing off, if they're wanting another fix,

your wound's healing, you can't feel it anymore. <u>Do it again</u>. And this time do it <u>deeper</u>. So it lasts <u>longer</u>. (653-656)

There is no doubt that control is a very big issue in Peter's life,

> All my life somebody's been in control, me father, punters, work, because you've got managers, and then you've got the mental health services controlling you, do you know what I mean, and it's just all control, control, but at least I have something that I'm in control at. (793-796)

That "something" was also two periods of eating disorders,

> Well put it this way, um, I've always been conscious of my weight, but I was hospitalised in 1986 because I got down to seven stone so they said I had to go in, give me medication to make you eat. [*mimics with his hand someone being fed*]. And again that happened only three years ago, I was seven stone. But again, I was abusing my body, it was great, I just thought I can abuse it, nobody else can. It got to quite a dangerous point. It was, it's control, you know. (778-791)

Abusing his body, whether through self-wounding or not eating, felt great because <u>he</u> could, because nobody else could and <u>he</u> had control. The accent is on "nobody else".

He did not self-wound and abuse his body through his eating disorder at the same time though. It is interesting to note that he does not talk about self-wounding as abusing his body whereas he does when he talks about his eating disorder. They may therefore not be construed as versions of self-harm.

For Peter there is at least one positive outcome to self-wounding, outside of the release and relief: wounds. Above all for Peter, self-wounding, the wounds, are part of him; they define him – as an individual in control-, by the sheer quality of their felt presence,

> it could be the winter, you've got your coat on, you can feel it, it's still there, it's with you, it's part of you, it's almost like a comfort blanket, so even, even though it hurts after, you're walking around, you feel it, your wound, your fresh wound, rubbing, it's there, it's sore, but it's not sore. It's almost like a comfort. I got – I'll be honest, um, it got to the point where once I couldn't feel it any more, I'd do another wound. Just so you've got it there. You know it's there but – like I said, it's a comfort blanket. (623-639)

They bring solace and a virtual layer of identity, "Because I'm in control. Nobody else is controlling me. I'm in control, I done it, it's great" (642-644). Again, the accent on the "nobody else".

With wounds come scars. We know that when he was a child, showing or telling wounds associated with family violence was an issue; Peter did not want anyone to know about the family's business. As the adult person who has embraced the Goth "religion" [this is how Peter defines the Goth movement], he does not have to worry any longer about exposing his body or his scars to the gaze of others, be they punters or anyone else, "I mean I have had people look over in the past, and they stare" (1067). He has also gone to great length to hide his body. He recalls one trip to Whitby where he isolated himself in order to have a swim. One of the strangest reactions came from mental health services,

> They thought I was a vampire, urghh↑ Oh frig me↑, and being in our religion it was really difficult, do you know what I mean↑ And there was an issue about 'Were you wounding to drink blood↑'. And stuff like that. Oh yes, they thought I was cutting because I needed blood. Oh flippin hell↑(936-943)

> And that's why I like the way I live my life now, because in our movement, even the women, and they're not allowed to show much, if they show their arms they've got to be covered up to the neck. If they cover their arms they can just show a little bit of cleavage or small dress. And it's all about respecting privacy. (1057-1061)

When asked to talk about his experience of pain associated with self-wounding, Peter wished to share a recent anecdote. He had wanted an extra piercing but had cried and felt sick when the needle had been used. At the sight of him his girlfriend was "hysterical" with (kind) laughter. Later that day she said to him,

> 'Do you know what, I don't mean to be funny love', she said, 'but with what you've done over the years to your body, and you have a little piercing', she said 'You're worse than a baby' And suddenly I thought, she's right↑. But then, it's a different sort of pain . . . Well it is, because it's done for vanity. (683-692)

Peter makes an important point here about the different experiences of pain. As a child, the pain of self-wounding was preferable, in fact it was "nothing" compared to the pain of the violence imposed by his father. As an adult however, the pain of piercings is a strange surprise for this Goth,

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From what I done, and, sadly I've got to live with for the rest of me life, it's just really bizarre feeling. Yes, I – don't know if it's somebody else doing it or whether it's just I'm – maybe because of <u>medication</u>↑, I'm <u>unstable</u>↑, it's <u>different</u>↑, I don't know. (700-704)

As Peter acknowledges he feels mentally and physically different when he has piercings, "Where you're relaxed" (748) and the decision-making process is very different, "for vanity", and "somebody else is doing it". When "someone else is doing it", control is in someone else's hands and, considering how important control is for Peter, this is a deciding factor in feeling pain; this shows that he is aware of his own pain threshold. And yet, Peter cannot help cracking a joke comparing the pain of piercing to that of self-wounding, "If it was the same pain, I'd probably be in the *Guinness Book of Records*↑" (710), "Ooh yeah I'd have loads of piercings then↑" (757). Peter offers a form of meta-analysis, "Ain't it weird though↑, that I've got a fear, a phobia of needles, and yet I could quite happy cut myself to the point that I'd need treatment, do you know what I mean↑" (721-723).

The presence of the Spring pathway is clear prior to self-wounding; Peter says he is extremely tense, wound up, "Yes, oh definitely." (745),

I've made myself sick. I've made myself sick, and then clenched my teeth. Really really, and just said you yourself it don't hurt, it don't hurt, and by the time you look, you think frig me, why didn't that hurt↑ But like I said, it does, but not, I don't know, it's just extraordinary. (733-739)

He feels no guilt at all after self-wounding "Not at all" (623).

As part of the experience of self-wounding, Peter also experienced sensory hallucinations, or auras. He had a heightened sense of colours,

Yes, become very very prominent, very. And my colour was orange. Um that was during, and after, oh yes, definitely↑ I was almost seeing things. Absolutely seeing things. To the point it's almost what we would class as, in my partner and I's religion, an energy. You actually can see this energy. That's how I'd describe it. And it was orange, very, great big orange balloons, but not 3D. Almost just circles. (901-917)

Peter used to look after his wounds as much as he could and would only resort to seeking nursing help when left with no other choice,

I mean like through the years I've had infections because I haven't had the wounds treated, and then I've had to go to the drop-in centres. I thought they're confidential and they're not. Because they do go to your GP and then the GP goes to the consultant . . . Yes, it's er pretty angry at that. Let's put it that way. Because I went to a drop in because I had a serious infection, from a wound. And I say two days later they had me back in hospital. And that was down because of going to the drop in centre. (358-370)

This is a classic case of wrongly interpreting the rules (ignorance?) about immediate risk to self or third party. In this case, Peter was not at immediate risk to himself since he was seeking, of his own initiative, medical treatment for his infected wound. Yet, the heavy machinery was set in motion and he was forcibly readmitted into a psychiatric hospital.

This can only put off individuals who may need to seek medical attention.

Others make sure that they never need to seek medical attention and keep their wounds to such a depth that they do not need this help. This in turn is often wrongly interpreted by health professionals as "lacking severity" and the emotional and psychological pain underlining the wounds get dismissed upon this arbitrary judgment.

With regard to psychological help however, mental health services did not offer any effective help for a very long time, considering that he first came into contact with them when he was 21. He says it took another 16 years before he felt he had found the right help; the advent of a new psychiatrist created a new turning point, "In the end um I had quite a few consultants and they didn't last long funny enough, um but I've got a really really good one" (966-967). This practitioner has since challenged him and helped him rebuild himself. He says this has not been an easy process,

And he was, excuse my French, but he's – and he knows who I'm talking about, Dr [*name*], a right bastard↑ But he had to be hard, he had to be hard. He basically he knocked me down to the lowest pits that you can't get any lower, and he's built me back up. (969-972)

For Peter, it has been a long journey where trust had to be built and earned between him, the consultant and the team

And he's actually, because he said to me, when I was in hospital, he said we could do this informally or we can do it by the red book. (987-988)

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Peter's life narrative continued on a chaotic path, with a number of tragic events creating narrative wreckage, which resulted in hospital admission, "I lost me wife, she committed suicide, last year [*2006*], she set fire to herself, lost my stepson two days before New Year's day, which was 2005" (761-764). This information was offered almost as a casual aside, but not to be discussed. Out of tragedy however came one of the most important turning points in Peter's narrative, when a long time female friend became his partner and brought some long sought-after emotional support, "It's been er been very long, lonely, dark path, especially when you're on your own. And er the winter's the worst. And I've come through, I've got a really good, I couldn't ask for a better partner" (860-866). They had been together for a while by the time of the interview but had known each other for 13 years. He says,

> She used to come and visit when I was hospitalised. And she didn't realise the extent at all. And she just said 'If I knew all this I would have given you my dying love, you know', etc, etc, 'But I was worried of losing you as a friend, and I'd rather keep you as a friend than lose you altogether'. So, so like I said, she's very strong, very strong minded, and my present consultant at the moment has got a lot of respect and time for her, as well. (769-777)

The arrival of a more understanding clinician, someone Peter felt he could work with and that of a truly supportive, positive and non-judgmental partner, are helping to tame the chaos and stop the wreckage. Each in their own way represent the beginnings of a restitutive narrative of healing.

Post-Scriptum

At the time of the interview, Peter had not self-wounded for two years. He was aware of the long journey of recovery ahead of him,

> Although there's a temptation for harming still arises, if you've had a bad day at work, but I've made a promise to my partner, and I know promises, you shouldn't make promises, but (.) she's - for somebody to see you as at that time a friend and see you literally being carted away with a load of Police and the paramedics, going completely ape up and down the street with a pair of garden shears saying 'Now I've seen you at your worse I love you'. Seeing you

in that state, and somebody wants to be with you for the rest of their life – I'd be a fool to let that go. And I've got no pretence because we've known each other for 13 years. That's why I'm pretty comfortable with her. (1016-1029)

This is a powerful testimony to the strong bond that links these two individuals. At the same time, he is aware of the risks, he is aware that the temptation to self-wound "still arises". He compares himself to an addict in recovery, "And I think that's like anybody in recovery. Whether it's alcohol, drug-dependent, I think it's anything. Because to me, it's an addiction" (1033-1036).

He is grateful for the positive presence of his new partner in his life, "so it is different I think, your mind, psychologically" (730).

There is also the presence of Frank's quest narrative as Peter makes a passionate plea of help for men who self-wound; in particular, men-only groups focusing solely on self-harm issues,

> Men only, because I know for a fact if it was mixed, there'd – and I'm not sounding sexist, but I really think the women would take over. I really do, because women, self harm - and it was only on the – I hear it on like radio 2, and on radio 4, they have discussions and stuff, and it's always about girls, whether young teenage girls or their 20s, it's always girls↑. And I get so annoyed↑, I'm screaming in my head. A couple of months ago there was a big topic on self-harming, and I'm in a car, and I'm just losing, I'm almost losing control again, because they're making me so angry, that you want to cut again just to prove a point to the person on the radio. So if you had a self-organised group for just men and -like I said- not alcohol or drug <u>related</u> self harm, where people had been drinking or taking drugs, because they can't get a fix, so they self harm. Just <u>solely</u> wounding – burning or cutting. Just listening to other people, so you know that you're not on your own. Because when you come out of hospital it's like once again I'm an oddity, there's nothing out there – am I the only person that self harms? Even when I was in hospital, I didn't talk to other patients that seemed to self harm, to a serious degree. (823-842)

He resents being considered an "an oddity" and is thankful for the project,

> No, I just want to say thanks actually because this is the first time I've actually managed to actually talk about it, not just in (.). Because you're not allowed to self harm in hospital, not allowed. Not allowed to self harm, so that means you can't talk about it. (1084-1089)

Peter seemed to have translated the very strong message "not allowed to self-harm" into "not allowed to talk about it", almost as a subliminal command. Hence he did not feel he could talk to any serious degree about it with the patients. Being able to talk about it in a non health environment seemed really important to him. All the more reasons for Peter to want to see specialist help being established, in particular for men who self-harm. There, Peter highlights a masculinity issue by expressing his very strong frustration at the self-harm agenda being virtually considered the domain of women, ignoring men. His frustration is expressed as a "scream in [his] head", highlighting the high value this meaning has for him. Being so angry made him feel like cutting, which also indicates the presence of high stress and anxiety caused by the frustration and anger.

It was his partner who, seeing the project's flyer in hospital, urged him to take part "She said 'You do it, give them a call, give them a call'" (563).

JIM'S NARRATIVE

Biographical information

Male, 45 at point of interview and 38 at the time of the first episode of self-wounding. Jim's mother had an alcohol dependency and his father (deceased) suffered from schizophrenia. He has many siblings but only gets on well with one brother. He made a suicide attempt age 12, using a rope.

Period leading up to the first episode of self-wounding

This had been a very intense period for Jim,

> I'd been working a lot . . . which was actually working with young homeless people. I'd also had a very prolonged period of bad chest infections . . . I was sleeping very badly, so I was physically and mentally exhausted. And the thing that prompted the suicidal thoughts to go in deep was someone stole the hub caps off my car. And I suddenly broke at that one, I became really suicidal, because it was probably one of my clients that stole the hubcaps, and there was a very strong sense of betrayal, and anger. (397-416)

Jim describes losing control over life threads, which contrasts with his need to be in control: "that's a big (.) big part of my life, control" (315). The theft, the last in a chain of events, proved just too much, especially when coupled with the perceived betrayal by individuals he cared for,

> I've always had suicidal thoughts in my head. But on this occasion, really intensely suicidal for about two weeks, two or three weeks . . . My admission was prompted by my suicidal very advance plan suicidal thoughts. (385-391)

Jim was admitted to hospital, as a voluntary patient and, at first, things seemed to be going well for him,

> I'd actually er retained my status of voluntary patient by being slightly compliant (40). During my first stay on the ward, I had a massive upturn in my mood. I came home, with anticipation that I was on a couple of days leave, I'd actually go back just for a meeting to formally discharge me from care (55-61)

Jim had crystallised his thoughts on an imminent discharge from services. However, there was a turning point during those couple of days on home leave,

> There was something happened in between, is that I phoned my mother, to have a brief chat with her when I got back. She's not a particularly nice person so I went downhill. (169-175)

His difficult relationship with his mother led to a turn in Jim's narrative when he went back to the ward. Not only he experienced a deep downturn in his mood but from that moment on a number of elements slowly started coming together. He describes how things had changed,

> And when I got back, er, that room was occupied, and I was shoved into the nearest vacant room. Initially that was further down the corridor, but the ward senior nurse on the ward for the shift came to see me and he said he didn't like me being so far away from the observation desk, so he moved me to a room closer, but the room was a lot more claustrophobic, a lot smaller than the one I'd had previously. (140-146)

> I was put in a different room, without things like a lock on the door, so I didn't feel my privacy was protected when I was out of the room. It was different orientation in the building, so I felt quite disorientated. (69-71)

> And it wasn't as near to things like the toilets and that. So I felt quite frustrated and er – I suppose was disappointed I didn't get the same room, because they'd said when I left you'll have the same room when you come back. And they decided to give it to somebody else. I felt a bit frustrated at that. (148-156)

What upset Jim were broken promises, "they said your room will still be here for you when you come back. And – but I didn't think about it, but they said 'Your room will still be here and you can have the same room" (134-138). [That] "really did er piss me off" (133). He describes how he was "shoved into the nearest vacant room" (140-141). The use of the verb "to shove" brings a very powerful statement of rejection and aggression on the part of staff. To shove is a physical act; as if he had been thrown into the room, like an object of no value. With the break of the promise and the change of room associated with it, Jim experienced betrayal. It is a betrayal of trust in the staff and in mental health services.

> *When everything is chaos, as patients we need to hold on to something. An object, a song, people, a promise, a room...*

Jim also reports a development in his relationship with staff, which also changed from the moment of his readmission, "[*Staff*] were disappointed I hadn't been discharged.

So I felt like a lot of resentment from the staff, that I'd actually come back on the ward after apparently being well"(125-129).

> *This is something that often happens on wards. It is not always clearly or overtly expressed by staff who are otherwise usually very happy to see patients leave. However if patients are rapidly or unexpectedly readmitted (or unexpectedly retained by bureaucracy or other issues such as housing and risk of homelessness) they are then often seen as a "bed problem", an added bureaucratic problem. This creates resentment that is possibly understandable from a management point of view but which should never be experienced by patients.*

Thus Jim was formally readmitted, implying that he needed care and treatment, "I was also told that if I tried to leave I'd be put on a section" (36). This injunction from mental health services at a Care Programme Approach (CPA) re-admission meeting is used by Jim to support his story. Even then, nothing seemed to be happening regarding his care and he felt "very much abandoned on the ward" (754),

> I was feeling incredibly frustrated, and distressed by the lack of progress and lack of support from   the mental health system. (8-10)

> because I felt I'd gone into hospital to get better, and I wasn't getting better, I was actually getting worse. (44-45)

He says he was not engaging with activities on the ward and he often did not touch his food although no one asked him why. He was especially frustrated by the type of care he received which he describes as a "mechanical kind of thing" (820),

> There was no way they encouraged me to do anything on the ward. If you didn't want to do something. The only thing they did encourage you to do and did, were very proactive in, was giving you medication. That was very proactive. They actually woke me up once to give me my sleeping tablets. And that was a real paradox for me because I was actually really heavily sleeping. And they also used to wake me up to take my asthma inhaler, even though I controlled that myself, I kept that in my room, they'd knock on the door and say 'Have you taken your asthma?'(838-851)

Here Jim describes a situation where he feels treated like an object and abandoned in a place (the ward) where one least expects to be leading to loss of identity and agency. He also says that "no one was offering any psych support at all, anything, to come and

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talk to me" (29-30). So on the one hand, he reports being given "a lot of medication", and on the other there was "no one there to talk to", leaving him without the support he wanted on the ward.

> *This is ironic. During day time, nothing of a therapeutic nature happens, nor is it on offer. However, at night, quite proactive (and intrusive) basic nursing takes place which could be handled better. For instance, in Jim's case, by checking with him <u>before</u> bed time if he needed help with his inhaler.*

Jim describes the tension that was building up between him and the team, "What it felt like is they were playing a game of brinkmanship with me. They were not reacting, perhaps the way they thought I might want them to react, give me some attention" (827-830). His relationship with staff deteriorated further, winding the tension spring up. It was fuelled by the contradictory messages from staff which made him feel abandoned and frustrated at not getting the -right kind of- care while being threatened with sectioning if he left,

> I was actually quite angry, and I was frustrated with the staff, but then again it is a psychiatric unit, and – you don't go on a psychiatric unit because you're feeling normal. You go on because you're feeling out of your sense of normality. So there wasn't any help, it was basic they were keeping me contained. (756-762)

> I'd never been in a psychiatric unit before, and er, I was suddenly feeling er like a prisoner. (459-463)

Jim wanted help, but there "wasn't any". He was only "contained".

> *"Feeling like a prisoner" is a very powerful statement: describing someone who is "contained" with medical nursing of a "mechanical kind of" care and has little say over what happens to them, while being threatened with sectioning if they left, despite their legal status. Indeed a prisoner.*
>
> *His experience is unfortunately common on many wards, as highlighted in the latest report from the* Mental Health Act Commission 2007-2009 on Coercion and Consent *(p72-74). In this report, patients also talk about "being contained" rather than treated. In this scenario patients lose out, not only in terms of care but also in terms of human rights (rights under the UN Convention on the Rights of Persons with Disabilities, 2008, signed and ratified by the UK in 2009.*

As part of his readmission Jim was put on "15 minute observations because I was suicidal" (74). This implies a close level of monitoring by staff and is one of the reasons he was moved to a room closer to the nurses' desk (sometimes known as the 'observation desk'). However Jim reports that these observations, which should have been strictly implemented, were not and he quickly became aware of the gaps in time, "I had actually noticed that they hadn't been doing the observations anyway . . . I didn't like the observations, I'd noticed it had started slipping" (508-513). At the follow-up interview, he recalled a gap of 25 minutes. At that point, about two days after his readmission, Jim felt "anger, frustration, it was a one time in my life that I felt really out of control" (456-457). The power of his emotions is compounded by the fact that one type of anger (directed at the self or at others) feeds the other.

Jim has a deep functional need to be in control but sees his agency forcibly taken over by others (clients, colleagues, staff in mental health services). At that point, Jim's narrative follows the Spring pathway: awareness of tension building up/overwhelming feelings. Jim describes how he became motivated by his frustration, his lack of trust in staff and a growing sense of fury, "By this time my confidence in the nursing staff had completely and utterly diminished to nothing (265-266)", "My attention had been shifted from being I suppose mildly angry to being furious" (867-868). There is also strong narrative wreckage experienced within the family setting from an early age as well as during the period prior to first episode: combination of poor physical health and psychological distress fuelled by anger and betrayal, leading to deep depression, suicidal thoughts and plan which led to hospital admission.

The first episode of self-wounding

We learn that self-wounding had been a running commentary while he was becoming increasingly frustrated,

> So I had to dig out one of my safety razor blades and actually had to dismantle it with er quite care because of the fact that it's a very small unit and I didn't have anything to take it apart with so I was actually breaking it apart with my fingers. So it was a deliberate decision to cut, I'd thinking about it for a while. (114-119)

Taking such a unit apart only with fingers works to show a lot of determination, even though the choice of the safety razor had been purely opportunist (what was available to him at the time),

> I had a feeling that they wouldn't catch me. I didn't feel worried about them catching me or didn't really care, whether they caught me at all. (511-515)
>
> I think also it was two fingers to the system because I was supposed to be on 15 minute observations. (15-16)
>
> I managed to do that whilst sat on my bed, with, in full view of the door, just dismantle a razor blade, and nobody actually noticed me doing it, so I supposed I was partly trying to show a weakness in the system, that I could take control, and if I wanted to harm myself I could do. (18-23)

Jim constructed his self-wounding as an act of rebellion that enabled him to show up the contradictions of a system that is meant to be caring but is not (rules not observed, lack of support). He also constructed it as a means of regaining agency. It could be said that Jim's narrative turns at that point. Indeed, his rebellion takes him out of a passive narrative into a political narrative which aims to denounce an aggressive and powerful discourse that denies his suffering. This new narrative has aspects of Frankian restitutive and quest narratives.

Was there an ambivalence about the fact that he could have been caught? After all, as he says, there might have been a part of him wanting to be caught, to finally get the attention he had been craving, "although I said it was control it may have also been a bit of a cry for help, you know like 'See my distress' sort of thing" (748-749).

"I could take control" is used by Jim to evidence his ability to show up a dysfunctioning system, "And also it probably was a bit of pride, the fact that I took control of things and it was two fingers to the nurses" (262-263). "Two fingers at the system" and "two fingers at the nurses" represent quite potent symbols of rebellion which puts him in direct opposition to a system which makes rules but does not follow them, at times contradicts itself. Taking control is a form of resistance which allows him to make a truth claim about his subjectivity as a patient in distress on a psychiatric ward which is that the medical system is more concerned to contain him than to acknowledge his suffering or to give him the emotional support he so badly needs.

There was a development as the act of self-wounding provided him with the release and relief from those powerful emotions of anger and frustration he had been experiencing up to that point, "like it was almost like I could see things happening, but I felt slightly outside of myself" (257-258. Here the feeling of dissociation provides him with a way of distancing himself from everything that is going on. It is also associated with euphoria, "it's almost like a euphoric feeling as well, cutting. During. During the cutting" (101). Sometimes these experiences merge for him, "It's like euphoric balls, a slight numb feeling" (258).

There was no suicidal intent at first episode, "I, if I was going to, I wouldn't kill myself with cutting, I'd either use rope or I'd use self-poisoning, take tablets" (80-83). Jim says he knows how to kill himself, he details a seemingly thorough knowledge of what to do,

> If I was going to cut my wrists to kill myself I wouldn't cut sideways, I'd cut horizontal, very close to the thing. So you don't cut a tendon, so then you can't cut your other wrist. (1015-1018)

Jim was careful not to cause severe damage, "I cut mid forearm, not near my er any major arteries" (23),

> I was also cutting away from my main veins, and I deliberately didn't cut enough so I would need stitches, so I cut a lot of cuts fairly close to the surface. Deep enough to cause a - like a splitting of the skin, a cutting of the skin, but not too deep to actually need to have stitches, because I didn't actually want anyone to know on the ward. I wanted to be private about it (86-93)

Afterwards Jim hid all evidence of his self-wounding,

> I just put a long shirt on. And I used some toilet tissue to clean up the blood that had actually come off it, and I wrapped the damage razor blade into the piece of tissue and threw it into the bin, so I just put it in the bin so wouldn't be visible, and I also flushed the bloody toilet paper down the toilet so it didn't look like the obvious. (290-294)

> *The literature often refers to self-wounding as a visible call for help, when words and other forms of communication fail.*
>
> *Sometimes it is. Yet it is not always the case. Many individuals who self-wound keep it private. In my experience of using mental health services, clinicians are often uncomfortable when faced with an individual who is on the one hand very confused and depressed but is able to act very clearly on the other (e.g. making a decision to self-wound).*
>
> *However clinicians, in particular psychiatrists and psychiatric nurses, often seem to prefer much clearer clear/visible "calls for help", which directly appeal to their professional training (professionally enabling process) and which fit so well in our post Christian ethics of compassion, rather than the more fuzzy or more private forms of coping strategies or sheer distress (professionally disabling process).*

Here Jim constructs his privacy not only as an issue of rebellion but also precisely as a way of managing his privacy, that is to say who is allowed to know about his self-wounding. This becomes more apparent when, the following day, a close friend visits and notices that he is bleeding; she alerts the staff.

Subsequent episodes of self-wounding

Once staff were made aware, they responded,

> Only in negative way, they told me off for it . . . So they said 'If you do it again' (.) – that was actually written on a piece of paper, on a so called care plan that the ward manager put together, if I self-injured again on the ward I'd actually be immediately discharged, for that. And I've got that paperwork still. (207-213)

The response from the psychiatric institution was two-fold: a threatening and repressive care plan and basic nursing only, "I mean one of the nurses did clean the wounds, and sterilised the wounds and dressed the wounds, but that was just dealing with the cuts themselves and the physical side of it" (220-222). His distress, which had partly resulted in his self-wounding, was once again dismissed through the absence of, or lack of wilful engagement, "there was no talk about why I'd done it. No-one even asked me, it was almost like they didn't want to talk about it" (222-223). The relationship with staff broke down further when Jim started an official complaint against a member of staff about an unrelated issue. He states his anger helped him retain his focus on staff.

Staff took the blades from him and he did not self-wound again on the ward. However,

> Once again, as a way of control, when my friend actually brought me home
> [on home leave], I went to my tool box and gathered together about four
> Stanley knife blades, and put them in . . . my wallet, that goes in my back
> pocket. (186-191)

> Just having the blades in my back pocket, er, probably stopped me doing it
> rather than making me do it, because I had the control there, to do it, - I had
> the blades there, and I felt quite smug that I had the blades and they didn't
> know about it. (307-311)

> Yes I had the blades . . . what I wanted to do was get revenge on the staff
> then, I wanted to get even with the staff. (932-933)

Control is thus the main focus and core value of Jim's self-wounding at that point. His powerful and discrete rebellion-cum-revenge is sustained by the knowledge of having regained control . It also prevents him from self-wounding again on the ward. He compares this practice of keeping blades to that of those who "give up smoking, will always keep a packet of cigarettes in the house". (334-335)

Back home

Overall, there were different phases of self-wounding which span a six year period; two years on, one year break, two years on, six months break, six months on and the final episode.

Once Jim went back home, there was a troubled phase of about two years during which he self-wounded quite a lot. It was sustained mostly by the stress provoked by the official complaint he was pursuing (he was eventually vindicated),

> I felt like self injuring quite a lot when I got home and used a bit of razor blades
> and Stanley knife blades. (201-204)

> I mean actually that sometimes I think my cutting in the few months after the
> discharge would often be reaction to bad letters I got from the complaints
> process. (940-941)

It seems that a large part of Jim's narrative after he came home focused on the validation of his distress through self-wounding. He sought help from a psychiatrist who "Laughed at me. For cutting. She actually physically laughed and said 'Oh, they're not very deep are they?!', things like that" (710-711). This made him feel angry so he

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did not see her afterwards nor did he seek help again from mental health services for his self-wounding. While he had access to his medical records as part of pursuing his complaint, he also noticed that,

> The incident where it talks about my self-injury, it says 'cut himself on the ward, but this was not a serious attempt at suicide'. So they had quite a low insight into the fact that it wasn't my intention to commit suicide at that moment in time. So they actually wrote down that it was er cutting but not a serious attempt at suicide. So the ward didn't know the difference. (796-803)

Jim's self-wounding experience had been reduced in his medical records to a statement about suicidality. Staff had made the classic and quasi automatic link between self-wounding and suicide ('not a serious attempt at suicide') where self-harm is wrongly treated as a form of suicide ideation.

The depth of someone's cuts is often used by clinical staff and by non self-harmers as an indicator and a means of measuring someone's degree of distress and intent. This is quite indicative of the lack of awareness and training about self-wounding that still prevails in mental health services (and elsewhere).

The issue of recording or poor/wrong recording of information in someone's medical records is critical as this gets passed on from staff to staff, ward to ward and so forth, potentially perpetuating the wrong picture about this individual, as well as misinformation about self-wounding.

His medical records indicate that a judgment of Jim's intentions had been made based upon the depth of the cuts. He felt his experience had been dismissed through this form of judgment, especially since, more crucially in his eyes, no one had asked him his reasons for self-wounding at the time, "they didn't ask me whether I was suicidal, no" (805). This potentially indicates that staff had made assumptions not based on proper clinical engagement with him but on reductionist perspective.

During the later phases it seems that self-wounding became established as a habit rather than as a response to an event (such as bad news in relation to the complaint process) or a craving. It was "something that was very much conscious" (365), "like a ritual thing, which was like I'd actually cut at weekends, would be the time I'd probably cut, when I was on my own, during the week I'd try to keep some sort of routine". (632-634)

Whereas Jim mostly self-wounded by cutting his arms, he also sometimes hit or punched walls, a method often favoured by men who self-harm, and where injuries are easy to pass as DIY accidents for instance (Frost, 1995; Taylor, 2003).

There was a development in Jim's self-wounding narrative when at times he was not able to retain control of all the elements linked to his self-wounding. He was on fairly heavy medication (Valium and sleeping tablets as his asthma prevented him from sleeping properly). He was also drinking sometimes. One particular episode of self-wounding had a profound effect on him, recalled here from different parts of the interview,

> I'd sit in the settee and one night I sat there and I suddenly looked down and I'd been cutting my arm without realising it. (495-497)

> After the time that I cut when I was drinking I stopped drinking then. Because I didn't particularly want to do that again when I didn't have the consciousness about doing it . . . Because I didn't want to – my mum was an alcoholic, so I didn't ever want to go into her direction. So I didn't want to have that lack of control. (646-662)

Thereafter, drinking while on heavy medication had to stop because consciousness and control are intimately linked in Jim's mind. Here his agency and determination to retain control over his self-wounding was constructed as an opposition to his mother's pattern of dependency on alcohol, even if there was some similarity in the practice,

> So I'd actually debate between about 6 and 8 or 5 and 8 about whether I should cut or not and whether I needed to leave it or not do it or try not to do it, and invariably most times when that thought, them thoughts were made, I would actually end up cutting. (1203-1206)

However, the similarity stops there. Whereas his mother's drinking pattern would start with a promise not to drink early in the evening for her to then give in quite quickly, drink, and express no guilt at having been drunk the night before, he says "the next morning I'd feel really disappointed" (1280). Lauren also felt disappointed the next morning for having self-wounded the night before.

The last phase of self-wounding was again sustained by stress at work and in his personal life, and yet,

> After a while of cutting, er the euphoria wasn't so strong, and it became a thing like I started to get a bit more ashamed of it, and a bit more shy about it. So I'd try not to do it, and then I'd cut and sometimes I'd have to find clean areas to cut because there's quite a lot of scars. So it's more the mechanics of it rather than any emotions in it. I think by the time I started cutting my emotions had been switched off. (1227-1237)

Jim describes how self-wounding was starting to lose its appeal. Shame was no longer associated with the spectre of his mother's dependency but more likely with having to find "clean areas".

There was another turn when the final episode of self-wounding saw him being confronted once again with the troubling issue of loss of control which alcohol had brought before,

> I can actually remember the moment very distinctly, is because I was actually an *X Files* episode, on TV, and I used to watch a lot of TV to stop myself [*from self-wounding*] and I must admit I did actually had a few glasses of wine as well . . . I think I was feeling so low that I decided to have some wine . . . I can vaguely remember getting the blades, but I can't actually remember much about cutting. I just sat there, I was probably a little bit drunk, because I was taking quite a lot of medication as well, including Valium, and er things like that (.) I can probably remember something about getting the blades, because they were in my living room, in fact sometimes I actually would keep them adjacent to the settee but in a little stash near the radiator . . . but I can't remember the sensation of cutting and I can't even remember looking at my arm when I cut. (535-553)

Whilst in hospital, Jim would keep blades in his back pocket as a means of having options and of retaining control over the system. At home he kept blades just like former smokers keep cigarettes. The blades then take on a symbolic function, that of an insurance policy. The combination of being "a little drunk", of losing control and of watching an intensely emotional episode of his favourite TV show at the time, triggered a profound reaction in him. It certainly represents a narrative turn in itself as a decision is made: to stop self-wounding.

Post-Scriptum: Follow-up interview

At the time, Jim was experiencing a very similar situation (instability) in his life to the time of the first episode; this time with loss of job, uncertainty about the future and bigger financial risks. However, he was keen to highlight that he had no desire to self-

wound because he had become "a lot more emotionally secure than I have ever been" (fnfi). Jim had had to find his own way of building his own coping strategies in order to achieve this state of being. However, he was also aware of the fragility of his situation, **"**Sometimes, the thought [*of self-wounding*] crosses my mind, in particular when very stressed; very briefly, little flashes." (fnfi). This statement may illustrate a tentative restitutive narrative.

JANE'S NARRATIVE

Biographical information

Female, 30 at point of interview and about 20 at the first episode of self-wounding. Jane offered little information about her background although she gave the impression that she came from a caring family.

Period leading up to the first episode of self-wounding

The narrative starts with a dramatic turn in Jane's personal history,

> Er, I, I'd been at a party and was assaulted, erm, sexually assaulted, and couldn't cope with it at all. (5-6)

Jane offered this double and powerful statement quite quickly and quite simply. The period gathers momentum over two to three months during which, what she describes as an "awful thing" in her, "a ball", made up of powerful ingredients, grew,

> I remember just hating myself, and feeling that I wasn't worth anything really. (8)

> Er I was extremely distressed, crying constantly for hours on end, not, the crying I just couldn't stop crying. I'd taken some time off work, and I wasn't able to leave the house, and I was just crying all the time, and feeling that I had this awful thing inside of me that I couldn't get rid of, and no amount of crying seemed to ease it. (35-42)

> It was just these really strong emotions. And the feeling, you know, no self worth, just being really upset, and It was – I don't know – it was almost like it felt like a ball inside of me that I just couldn't get rid of. (55-60)

What Jane describes is growing tension building up over time, fuelled by feelings of anger and self loathing. Her web of feelings was also fed by the intense frustration and sense of powerlessness she experienced from the criminal investigation,

> I remember the lack of communication. People just didn't get back to me, erm, and I would be phoning to find out what was happening, and messages would be left, and no one would call me back. And, that - you had that feeling of being out of control then as well. Not being out of control, but not having any control. Over the whole situation and what was happening. (725-734)

Waiting for news kept her in an expectative state, driving the narrative towards hope. However, not being kept informed stifled hope and the narrative is wrecked.

It could be construed that the assault derailed this young woman off the life course she had imagined for herself. Up to that point, Jane had constructed her identity as a strong and capable individual who is in control of her life,

> I've always been a very stubborn, independent person, from when I was a child, when I was very young upwards. I've always been someone who tends to just get on with things regardless of how bad they are and if something goes wrong, you know, I do what I can to change things. (266-270)

This narrating "I" is Jane appraising herself in a critical way, presenting the person she used to be, and she does this in a quietly assertive way.

Not having control is out of the question for Jane. Jane has a deep functional need to be in control but sees her agency forcibly taken over by others (assailant, Police and judicial system), leaving her "not having control". Being in control is part of who she says she is and possibly of who she needs to be seen as. Indeed she acknowledges there are two different 'Janes', like adaptive narratives swapping roles. The public personae, the one described above, which she says "it's the character that a lot of my friends would say I have" (273), or one she later describes as the "Fighter in me" (718) (which is quite a strong statement of identity and self) in relation to the court case. There is also the inner Jane, "it's a different person inside you know, people weren't seeing." (275-277), hinting at a vulnerable person.

Jane was also angry. It was anger directed as much to the perpetrator of the crime "the anger was that someone had done this to me" (169) as to herself. This is the victim talking. There is a sense of Jane's agency also being driven by despair for her to think about self-wounding in order to be believed while the legal process was on-going,

> I remember thinking that if I had these self harm scars, that it would also help to show that something had happened, because a normal person wouldn't just self harm. So in a way I was thinking well you know maybe people will believe me. (677-681)

It seemed that her need to have external evidence of her internal pain, as an extreme substitute text and words for her emotional and psychological pain (since according to Jane a "normal person wouldn't just self-harm"), partly drove her to self-wound.

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Jane tried to get help. It did not work, "Although I was talking about the way I was feeling with a counsellor I didn't feel it was helping me, and I toyed with the idea of self-harming for a while" (10-12), "there wasn't the rapport there between myself and the counsellor" (235). In fact she reckoned she started to think about self-harming "about two, three months" (178) after the assault while she also admits later "I don't even know where the idea came from" (44).

The case never reached court: "As is often the case, there wasn't enough evidence for a conviction, so, it was just thrown out" (692-693). It made her feel "awful" (695). "But at the same time I understand it's extremely hard to prove. Because you might have the lab evidence but you don't have witnesses and it's very much your word against theirs" (711-715)

At that point in her narrative, the ball, this "awful thing" inside of her, feels quite compact, tightly woven and animated by the strong internal dynamics of feelings of self-hatred, self-loathing, frustration, powerlessness and anger. Although Jane did try, she could not find the right therapeutic space where these could be safely unpacked. It is almost as if the ball had taken over her sense of self.

Jane's self-wounding at that point follows the Spring pathway: awareness of tension building up/ of the strength of overwhelming emotions (frustration, powerlessness, self-loathing, guilt and anger) gathering their own momentum in the shape of a demanding emotional "ball" growing inside her. She also had some difficulty reconciling the two sides of her self as she struggled to get help from therapy and from the judicial process. She also experienced narrative wreckage from which a Frankian chaos narrative emerges, as she tries to deal with the many dimensions of the aftermath of the sexual assault while feeling out of control and having little agency in the criminal process.

The first episode of self-wounding

Shortly after the assault, unable to cope, Jane stayed with her parents. During that time, there is a turning point in her narrative, "one day things got – my emotions got too much for me, and I just went ahead" (15),

> I just remember I think I'd opened the medicine cabinet to get cotton wool out or something and saw the razor, - I think that's possibly what happened, and thinking, you know, I wonder if I should cut myself. (44-48)

 "One day" creates the turning point. Jane was overwhelmed by the culmination of the powerful combination of very intense emotions, previous thoughts of toying with self-harm, lack of appropriate support which had finally "got too much".

This started a decision-making process prompted by the combination of seeing the razor (visual trigger) associated with latent thoughts of self-harming. The threshold had been reached, "got too much", and she "went ahead".

Jane found blades from "an old fashioned one [*razor*] my mum had, where you took the razor apart. She had spare blades so it was those I used" (25-29). "I cut erm the top of my thigh with a razor blade. Erm, I did a couple of thin cuts initially, And then a couple of deeper cuts" (17-20).

Then came a realisation moment,

> And it was almost like – erm – like my emotional pain had transferred to the physical pain. But it wasn't enough, so I cut deeper. Er, and again I felt like a slight release of emotion . . . it did feel good. It just felt as if there was a release of emotional stress. (67-79)

The realisation produces a shift in her emotional journey whereby she became acutely aware that through cutting "the physical pain was a lot easier to cope with" (476). It allowed release from "this awful thing inside" of her, the emotional stress that had taken over.

The choice of where she cuts is important at first episode and for the future. She cut "near the top of my thigh", close to where she was assaulted. She talks about it more at subsequent episodes when the location of her self-wounding takes a symbolic purpose. Jane's scarring brought guilt,

> But I also had the feeling of guilt because of what I'd done. And I also felt slight regret, because I knew that I was going to be leaving a scar from what I'd done. (104-109)

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According to Walsh (2006) and Favazza (2002), cutting near where she was assaulted is characteristic of trauma related behaviour.

There are further aspects to her feeling of guilt; about self-wounding and for not having been able to deal with things "And I felt guilty, because I was, to me I was being weak. I wasn't fighting it" (279), in opposition to the sense of self she used to have, that of a strong capable individual. There was also guilt for having let someone sexually assault her. The inner, vulnerable, Jane was fighting the public, strong, Jane.

Once she made those cuts she experienced some pain "It felt - it was - I wouldn't have said it was painful, it was more erm what I would say nippy - slightly, stingy" (65-67).

Subsequent episodes of self-wounding

We know that for Jane, living with the aftermath of the assault was very distressing. She had moved back to her parents' home and she did not feel she could talk about her thoughts of self-wounding to the counsellor she was seeing.

In hindsight, she realises that the first episode represented a tentative beginning, " in a way it was a trial run because I did it lightly, to see initially" (463). Cutting provided her with the sought after release, "And, it seemed to make me go from being extremely anxious and wound up to very calm and, quite peaceful feeling actually" (174-175); "It was a small release and I remember thinking well I wonder if I cut harder, if it's going to be a stronger release" (470-472).

Nonetheless, it was not enough. There was a gradual development in her self-wounding narrative as cutting did not meet her needs enough. In order to get the level of release which allowed her to reach the transformation of her emotional pain into physical pain, she had to reach the right pain threshold. At first she cut deeper,

> Erm, I think I didn't get enough of a release, so I then cut deeper, larger cuts. And I had more of a release, erm - I almost felt relaxed after it. As opposed to being really tense and wound up. After – er – I suppose during as well actually. Yes, after I still had that feeling. (92-104)

That was still not enough,

> I felt as if (.) it wasn't taking away any of my feelings. Whether I got used to the pain of doing it I'm not sure, erm, I just remember thinking one day that I can't, I need to self harm but I can't cut because it's not going to make me feel any better. (138-140)

She moved to another method, burning, hoping to get more pain, therefore more release and relief,

> I laugh, but it's more embarrassment at what I did. I turned the gas hob on, and I heated up a cheese slicer. And once I'd held it in the flame for a few seconds I then pressed it onto my thigh. And I held, I held the cheese slice on for longer, rather than just placing it down and removing it, I held it on for as long as I could, before taking it away, and it was amazing how, how much of a release I had in doing that. Erm, it felt really good. Erm, I felt as if I got anger out of me as well. (142-155)

Burning represents a turning point in the narrative as it seems much more associated with punishment than cutting had been, and much more about anger redirected at herself,

> In a way I feel that I was punishing myself erm, by doing it. It's hard to explain, I got a release but at the same time, I was punishing myself and I felt I deserved to be punished. Almost as if everything had been my own fault. (157-162)

This has echoes of the victim blaming herself for what happened, as before.

Self-wounding allowed her to regain control over the situation, "Because I was controlling it" (478). "I was", not someone else highlighting control as a key element of Jane's personal narrative. This confirmed self-wounding as a coping strategy.

This difficulty in reconciling the two sides of her self is also reflected in who she chooses to talk about her self-wounding. Jane relates a positive encounter in A&E that made a difference,

> There was a nurse actually in the accident and emergency department, who I saw, who was fantastic. And I completely broke down when I was with her. And told her everything, and why I was doing it, and she was great . . . I think it was her approach in general . . . She came across as someone who – was very sympathetic, very understanding, and completely non-judgmental er. . . She got me referred to psychiatric hospital, to see a psychiatrist . . . It was, it was very helpful. (240-261)

In this instance she allowed herself to trust this nurse and "completely broke down" to reveal, to a complete stranger, the vulnerable individual inside, the one in distress, and go beyond the physical evidence offered by the wounds and for which she had gone to A&E. The nurse offered the right space for Jane to open up. In so doing, Jane also took the risk of not being in control of the situation.

If talking about self-wounding is difficult, for Jane showing it is just as difficult, if not impossible. For her, self-wounding is private, secret. She has so far managed to hide it from her family,

> We went to the beach one day, and I wore a pair of sort of cropped trousers, that I rolled up as far as I could without anything being seen, and a bikini top. And a couple of times my mum said, 'why are you not wearing your bikini bottoms?' I said 'oh I just didn't want to'. (341-344)

For Jane, it is quite clear that friends and family don't need to know about her self-wounding, it is her conscious choice (implying control too),

> It's - well the way I see it now is they don't need to know, and I'm not in a situation where they're seeing anything, so I don't need to explain the reasons behind it. However at the back of my mind is in the future if I'm ever on holiday with friends or anything. And having to wear a bikini. (350-356)

The act of self-wounding acquired, by default or unconsciously at some level, a new function, because of the location of Jane's self-wounding, mostly at the top of her thighs. This is a highly symbolic and emotionally charged place, near to the heart of a woman's intimacy.

> I just - I remember thinking that having a scar there would make me appear ugly to everyone else. Em, but at the same time I remember thinking well I don't want anyone near me right now, So, maybe that will act as a deterrent. (118-124)

The last sentence is a very powerful statement: the use of the word "deterrent" seems to imply force of intent, capability, effect, meaningful posture. Self-wounding was an act of defiance to any men who dared approach her and protecting her from further assaults. The victim retaliated and became defiant. It is as if she was intending to transpose this now scarred area of her body, not habitually visible, to the whole of her

person. The victim became defiant, wanting to use ugliness as her weapon of choice. It's a shift in her narrative and sense of self, from victim to potential "retaliator", no longer a hapless victim.

As Jane cut deeper, she was somewhat aware that it might leave scars, although not really engaging with that thought or the full consequence of the act, "I (.) I don't think I thought too much about it at the time of whether or not I wanted it"(115). In that sense, she is steering her narrative somewhere towards the future when this issue will have to be dealt with. Jane's scarring certainly had the effect that she sought, although it also had a perverse effect. Indeed the first man she chose to be intimate with after years of pushing men away, rejected her when he saw the scars,

> I purposely avoided all relationships for a long, long time, until I felt comfortable to start seeing men again, and the first one I got intimate with obviously noticed and mentioned it, and he was completely unsympathetic, didn't understand it at all, erm, just felt that I needed help. And it was such a huge step for me to get into bed with him, you know, it built up over quite a long time. I told him I'd had some problems with relationships and I just wanted to take things slowly, and his reaction just gutted me. You know, it was, I felt I trusted him and that he let me down. Erm and soon after that the relationship ended. (309-321)

This created a setback in her healing narrative, a further instance of chaos.

Overall, at subsequent episodes, self-wounding always remained at the back of her mind, sometimes linked to specific events which might have had a bearing on her emotional state,

> Erm I'd been out - I think I'd been in the garden, and went back in, you know, just to get some fresh air, went back in, and put the radio on, and there was a song came on. After a few minutes, you know, it was a song that had been played at this party. It immediately brought everything back to me again. I remember crying and curling myself into a ball, and, and it couldn't have been long after that I went upstairs to cut. (197-212)

Her self-wounding was cued, just like for Peter, by an external event. When Jane hears the song, it gives her an emotional flavour which is a proxy for the original assault and is an example of event specific knowledge (ESK) (Conway & Pleydell-Pearce, 2000) entering the retrieval process rapidly thus allowing the construction of an involuntary,

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intrusive memory (the sexual assault) cued by an external element [the song] linked to powerful emotions (Berntsen & Rubin, 2002), "a memory that may evoke much painful affect in the rememberer" (Conway & Pleydell-Pearce, 2000, p. 282). Jane had constructed herself as someone who will cope and cope until something apparently fleeting and trivial, something in the air (the song), wrecked the fragile state she had managed to preserve until then, leading her to self-wound.

However her self-wounding at subsequent episodes was not always linked to those memories,

> I'd have some days where I was tearful, but relatively calm. It was rarely on those days, it was the days when I was highly emotional, extremely distressed, distraught. (383-389)

Later on , self-wounding becomes an event of its own as thoughts linked to it are often disconnected to the original event, "isn't related to what's happened in the past"(663), and to not being able to cope. This reinforces her self-wounding as a coping (self-regulatory) mechanism when she has lost control over everything else.

The intensity of her distress would take her to a point of no return when she would have, in her mind, no other option but to self-wound. The Spring pathway tension building up to a threshold/point of no return remained,

> Building up and building up and building up, and I'd get to the stage where I'd just feel it was too much, I just couldn't deal with the emotions any longer And so I had to then cut. (393-396)

Cutting also started to take the shape of rituals in terms of location, preparation, self-wounding and cleaning up from the time she spent at her parents',

> I was always in the same place when I did it, it was always the same type of razor blade. It was always in my bedroom . . . my bedroom at my parents. There's a corner, and there's nothing in the corner, and it's near my bed, and I always used to crouch down there and do it, and I was very methodical about it actually, because I had everything I needed beside me, including the dressings for afterwards. (521-534)

Post-Scriptum

Jane's self-wounding journey lasted six years overall. One gets a sense of a long intensive period, with peak times, until it started to decline progressively. It is unclear whether the decline can be associated with particular positive developments in her life. There is some kind of a resolution to this story in the sense that Jane has stopped self-wounding and she has found a new partner. This seems to indicate the beginnings of a more restitutive narrative, partly thanks to the support of the partner who does not judge her scars nor her self-wounding, allowing the inner strong-willed personae to find her voice again.

And yet, self-wounding, four years after she had stopped was still clearly on her mind at the time of the interview. At the same time, she was planning plastic surgery to attempt to "minimise the appearance" of the scarring,

> I still have thoughts about self harming. Um, it's still on my mind whenever - it's always whenever something isn't going right in the life. You know, if I'm not happy with work, or I've had a really poor night's sleep, and I'm really tired, or I've had an argument with someone, I always have those thoughts. But I've always been able to stop myself doing it. I think because now I look at my leg and I hate what I see Erm, you know, and I have actually thought about saving up to have some sort of plastic surgery on to minimise the appearance. (611-631)

Coda

Jane was in control of the language she used throughout the interview. She made strong, careful statements, and uses carefully considered words. Jane talked about sexual assault rather than rape. One gets a sense that this is careful consideration or possibly holding back and reserve, as if she was looking to the researchers for cues "in an attempt to evaluate whether [*we were*] able to hear details of self-injury and remain psychologically present"(Shaw, 2006, p. 167). For instance she talked about pain (of burning) being "so uncomfortable"(147) before finally saying it was "very painful".

KATE'S NARRATIVE

Biographical information

Kate, female, 20 at point of interview and "nearly 16" at first episode. Her early life narrative is one of the responsible eldest child, taking on a supportive role to her mother and a parental role towards her two younger sisters as her father was often away for long periods at a time for his work. She has retained a very strong sense of protective duty towards her family; she says,

> But I'm worse than them [*parents*], when it comes to my sisters. If my sisters go out I want a full written list of where they're going, because my middle sister is now very good friends with a lot of the people I used to be very good friends with. As a result, I know what the boys are like, and I know how they treat girls, so if she comes home going 'I'm staying at so and so tonight', it's like 'No you're not!' (696-703)

This controlling parental role is very apparent in the "full written list" and in the "No, you're not!", as if her sisters were primarily accountable to her.

What characterises Kate's emotional and cognitive narrative is control and conflicting emotions. This was apparent from the moment she contacted the project (see Coda).

Period leading up to the first episode of self-wounding

The period starts at the time when Kate was preparing for her GCSEs. She was also in her "first serious relationship".

The first turn in the narrative took place when her maternal grandfather died. At the time of the funeral, she reprised her supportive parental role in order to look after her sisters since, in Kate's own judgment, their grieving parents "weren't in a fit state for doing anything" (17-18).

The second turn takes place about three weeks later when she found out that her boyfriend had been cheating on her for some time. This could be construed as a narrative diversion from the grieving and funeral narrative, something that added stress to an already sensitive situation. For Kate, being cheating on by her boyfriend was made worse since, "it turned out that a lot of my friends had known and had neglected to tell me, which also was quite a bit of a kick in the teeth" (25-27). Kate felt that she had no one she could turn to during this period to talk about this event:

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Not her parents or sisters,

> Um I just was sat in my room, and - I couldn't really talk to my parents because obviously mum was still devastated and my dad was dealing with her, my sisters are both a lot younger than me so I didn't want to bother them. (29-31)

Not her friends,

> I didn't really want to talk to my friends because I felt that they'd kind of stuffed me – obviously they hadn't in hindsight but at the time it felt very much like I'd been ganged up against. (34-38)

Not her boyfriend,

> Couldn't speak to my boyfriend because he was an absolute [*participant mimics a swear word with her mouth*] (.) for lack of a better word. (40-41)

Kate felt her options were closed to her mostly because of feeling betrayed and of her concerns for her family, not wanting "to bother them" while they were grieving. This is also someone who says she does not "talk to people about things very often" (227), "it's just sort of who I am, I don't talk about things, I'd much rather deal with them on my own" (232-233). Her sense of friendship led her to position herself as a victim although, reflecting back, she realised later that they had not really betrayed her, "obviously they hadn't in hindsight, but at the time it felt like it" (35).

Throughout this period, Kate's narrative reveals no hint that Kate had any awareness of tension building up; this is characteristic of the Switch pathway. There is a sense of two narrative wreckages competing for her attention, which took her by surprise: the bereavement-grandfather-funeral-looking-after-the-family narrative and the boyfriend-friends-betrayal narrative. Kate does not talk about the loss of her grand-father and the dominant narrative-wreckage in the interview is anger with the boyfriend, and with her friends. This creates a Frankian chaos narrative.

The first episode of self-wounding

Kate was in her room [*student halls*], feeling that she could not talk to anyone, "I just think I snapped, to be honest. Just absolutely lost it" (20-21) and "just sat in my room and absolutely lost it (.) and started hacking away at my wrists, just used my nails to be

honest" (42-45). Kate describes this sudden onset of self-wounding and we know there has been no sense of tension building up prior to the event.

When asked if she had had any intention to hurt herself, she stresses repeatedly that she had not. In fact, for Kate it had not even been a conscious act,

> I don't know, I don't think I even realised I was doing it, to start with, I was just literally just sat there, you know I was just so frustrated and then I looked down and I'd taken heck of a lot of skin off (.) (49-51)

> But at the time I didn't realise I was doing it. (60)

> I don't think it – it wasn't even a conscious, not even a conscious thing, I didn't realise I was doing it. (83-84)

> it took me about, I mean it took about five minutes to realise I was doing it to be honest. (67-68)

Kate is the only participant to have used her own body, rather than objects, to self-wound, thus attacking herself and her self (outside and in). She says she did quite a bit of damage to her skin. She showed her nails which were quite long and cut straight across, making them potentially harmful "instruments". Hacking denotes a strong intent to cause harm, even though Kate says she was not aware of wanting to do so.

There is a very strong element of surprise at engaging with self-wounding which comes either after the event, "looked down and (.)", or at some point after having started to self-wound, "after about five minutes",

> I think I was just kind of sat in my own little spaced out world to be honest. Just sort to you know everything just sort of comes in and I think you kind of escape just go inside, to some extent. And everything else just disappears and it's just kind of – I suppose it's like you know when people into shock and they just sit and stare. It's just kind of one of those sorts of things, I just literally um completely not there. And it's just kind of no realisation of what's going on anywhere. (253-265)

At the first episode, self-wounding had different functions for Kate:

1- It offered protection and a way out of a difficult emotional situation,

She did not just go, she escaped into her own bubble, her "own little spaced out world", locked away in herself. It protected her in the sense that it allowed "everything else" to "disappear".

2- It gave her time,

To think, away from the frustration she had been experiencing, about how to handle things,

> It's more of a trying to stop myself doing something, I think, trying to stop myself thinking about things I think is what it is, trying to give me a distraction and help me work out how I'm going to deal with things. (529- 532)

The bubble gives her an opportunity to distract herself from what she is feeling, in particular her anger and her frustration, "you know I was just so frustrated↑" which she mentions for the first time as being prevalent at the first episode.

While this happened, which is akin to a state of dissociation "completely not there (.) no realisation of what's going on anywhere": a threshold was reached and she started to self-wound.

3- It brought her out of that state and back to reality,

half kind of bring me back to the real world . More of an anchor to the real world, realising that I can't just disappear, it doesn't work. (618-622)

In the "real world", one has to deal with problems. She later stated that out of all her peers at university she was the only one with a job, "sort of towards the end of the year, when they're living on baked beans, I'm still eating quite well and still going out every night because I can afford to do it" (731-733). The sub-text is a meta-analysis of her sense of responsibility, because "I can't just disappear, it doesn't work".

Kate does not report experiencing any pain at the time, only afterwards,

> Didn't feel it at the time, at all. Afterwards for about a week it was absolute agony. Every time you catch it, and it doesn't heal, because you keep catching it on clothes, watches and everything, it really hurt. (53-60)

At the first episode of self-wounding, there is no suicidal intent. Kate is quite clear; she never had any intention of committing suicide. "Oh God no, no, no, no↑" (634-635). She enjoys life too much, "I love my friends, I'm happy at uni" and thinks that people who commit suicide "to an extent are very selfish" (638), leaving "behind families, friends". (641)

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Kate had some awareness of self-harm through friends but does not think that this knowledge influenced her,

> I did know that people did it . . . I knew that it actually went on, but I've never seen the point of like taking a knife to your skin, or anything like that because - I mean especially when you're on your wrists, it's just too dodgy, because that to me does seem like a, more of an attempt to kill yourself than opposed to hurt yourself and escape from it, never ever seen the point in doing anything like that. (453-469)

This statement consolidates her non suicidal intent through self-wounding.

One of the effects of the first episode of self-wounding was that "Um, I think I freaked myself out to be honest" (75). As it "freaked her out" it created a turn in her personal narrative as it helped her realise that she needed to change certain things in her life. When asked how it made her feel afterwards, she says,

> I guess it sort of, to an extent gave me a bit of time to reflect, it was like restarting everything, starting from scratch, and being able to say 'right I've got to deal with all this', giving me a chance to sort of put it into boxes and deal with one thing as opposed to try and deal with 9 or 10 different things on top of me in one go. (191-201)

The experience of the first episode is thus a 'revelation moment' in her personal narrative and her use of the very expression "starting from scratch" is extremely powerful and evocative. It quite strikingly marked the very beginning of something else, "restarting everything", while describing the use of her own body in the act of self-wounding. As such, it is a turning point.

By putting issues "in boxes", she feels she can control them. Control (and lack of) is a recurring feature in her story and across various contexts of her life (her sisters, boyfriend, friends, dealing with issues by herself and boxes).

Kate's self-wounding is unique in the sample and clearly follows the Switch pathway. There is no awareness of tension building up coupled with a dissociation state: the bubble effect, overwhelming feelings (anger, frustration, sense of betrayal and bereavement in the background), self-wounding is linked to impulsivity.

Subsequent episodes of self-wounding

Kate says she was subdued after the first episode and that she had "freaked herself out", "and for a heck of a long time didn't do anything" (75-76). At subsequent episodes, she repeated the same pathway as at first episode, retreating into herself then starting to self-wound unconsciously, "Yep, complete ignorance to having, to the fact that I'm actually doing it to start with and then sort of dawns on me . . . but it's just complete ignorance of the fact that I'm doing it" (143-146). However, we know that she had learnt about the protective value of self-wounding which offered distraction from her feelings and pressures, its bringing-back-to-reality function,

> I think the whole thought, sort of not being anywhere, sort of, where I said, I kind of zone out, and completely – that's definitely escapism, because I just don't notice anything going on around, and I think the sort of scratching at my wrists is kind of half escapism because it gives me something else to concentrate on, and half kind of brings me back to the real world. (614-619)

Kate is very aware of this dual purpose, "Kind of at the same time but they're both totally opposite purposes. Entire juxtaposition here" (628-631). This concurrence of opposites highlights the nature of self-wounding for Kate, taking place while she is "zoning out" of her habitual mental locus and into her bubble.

It is possible to speculate that, although these two purposes may be opposite, in effect they possibly compete, in her mind, at the same time, until one becomes stronger and takes over: switching back to reality always 'wins'.

Self-wounding was still firmly in her unconscious mind where the decision to self-wound was made seemingly without her knowing and there was still no awareness of tension building up. And yet her "complete ignorance" changed over time, highlighting a shift,

> To be honest I didn't even think of it as self harming, I just thought you know it was an accident I'd scratched it and didn't really think anything else of it, and then sort of as it went on, it became a bit more apparent that I was obviously doing it even, subconsciously intentionally, not nec [*word not finished*], not meaning to do it. (94-101)

The contradiction implied in the choice of adverbs *"subconsciously intentionally"* is interesting. It hints at possibly a slow awakening ("bit more apparent") amidst that blurred mental state where self-wounding becomes a way of shocking herself back into reality.

At subsequent episodes, self-wounding "sort of became a coping mechanism whenever I had a really crap day" (76-77). Kate is referring to powerful emotions, intense and intensive, in particular destructive relationships with her boyfriend. She stayed with him although, unbeknown to her he continued to cheat on her for two years. When things were difficult between them, she turned to self-wounding, "if ever me and him had a fight, or you know it got really bad and stressful and couldn't deal with things . . . it was just whenever we had a big thing, I tended to do it" (308-311). The destructive nature of a subsequent fraught relationship also triggered her self-wounding. The need to escape overrides any need or wish to self-wound. " I've never had any desire to want to do it" [*self-wound*] (153). There is no craving.

There is another development in her self-wounding narrative when a new form of escapism appears. It is physical escapism. Kate recalls an example when there had been a very stressful situation at the flat she shared with other students, giving rise to practical financial concerns, "I did have a slight problem where I was getting very stressed, so jumped on a plane and went to Spain for four days" (541). She was able to have a certain level of awareness of tension building up and to make some decisions. This resulted in a more conscious though impulsive form of escapism. She did not tell anyone, did not take her phone with her and only pinned a note on her door saying "In Spain, back soon" (551). She took some clothes and her passport. She had no specific destination in mind, except it had to be cheap,

> I just sort of wanted to be somewhere where I was just – complete – if you're faced with something every day it makes it very hard to deal with it because you've got the irrational thoughts as well sort of irrational thoughts of wanting to scream at somebody or deal with it in completely the wrong way, I think if you can sort of step back and take a break from everything it helps you sort how you're going to deal with it and if you've got a plan of how you're going to do something, it's a lot easier to carry it out than try to do it spur of the moment. (556-564)

Kate chose a drastic way of escaping a difficult situation and fraught feelings and emotions. That time, the only right way she felt she could do it was by escaping physically, as opposed to the alternative "wrong way" she had imagined.

Escapism, whether physical or in the bubble and through self-wounding, brings her relief in a powerful way, "I just have feelings of escapism, wanting to escape and you know, just go and sit in your room for three days and wait for everything to get better" (149-151). It is her way of regaining control over a situation and gives her time to sort her feelings and issues out,

> Just a relief, to be honest. I don't, like I said, I don't have to deal with anything, I was out there, I had four days of not having to talk to anybody, not having to answer to anybody, to having to sort of be - when - like I said, when you've got something constantly in your face it's really hard to get over it and to work out how you're going to deal with it. (596-601)

Once in Spain and away from her immediate problems, she felt able to sort things out, and strong enough to confront her problems and people.

Overall, Kate's narrative is mostly a Frankian chaos narrative which comes out of narrative wreckage. Chaos is not possible in Kate's world who has to have control over all aspects of her life, and over some people. By confronting her demons, she has been determined to put a stop to the chaos and claims to have stopped self-wounding.

Post-Scriptum: Follow up interview

Four months after the initial interview, Kate highlighted a new turning point: she had stopped self-wounding. She reported a dramatic change in her mood since coming back to university after the Christmas break. Kate explained it by saying she had matured and was feeling more emotionally secure because she was more aware of her feelings and of the build-up of tension associated with them. She had not self-wounded since, "No wish and no need to" (fnfi).

Coda

This participant put quite a bit of effort into being selected, sending a number of insistent emails and leaving a number of telephone messages to the researcher. She also responded straight away to a request for a follow up interview. On both

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occasions, Kate seemed to be looking for answers. She claimed in the interview that she does not really talk "about stuff" and would not contemplate talking to anyone in particular in professional, formal situations such as counselling. Nonetheless, she talked very freely, very rapidly and abundantly during the interviews and her narrative was extremely dense and extremely intense.

LIZ'S NARRATIVE

Biographical information

Female, 40 at point of interview and 14 at the time of the first episode of self-wounding. She has another, older sister.

Period leading up to the first episode of self-wounding

Liz could not remember exactly what was happening at the time of the first episode,

> Um, I can't remember exactly what was happening at the time, but in <u>my</u> <u>life</u>, what was happening at the time was um I was starting my periods, I was going through puberty, um, I didn't like myself, um, I was told at school I was ugly. (22-25)

Behind this compact summary, the period leading up to the first episode effectively spans the whole of her childhood, revealing a web of narratives.

One of those, which seems to have played a major background role in Liz's story, is the story of her deceased sisters,

> Um, I'd read an article when I was 12, 12 or 13, about um my two sisters dying, and um I wonder if that had anything to do with anything in my head is the fact that would I have been born if the two of my sisters hadn't died, um, and I probably yeah I felt I wasn't wanted. (152-156)

> I had two sisters, one died at two years old, one died at 7 months, then my sister was born still alive and then me, so I'm the last, so yes, and I've asked my mum, and she said you know of course I'd have been born, but that's that was planted in my head when I was that age . I was always aware I had two sisters, it was just the newspaper um articles, it was very sad. I think that's probably why my mum's always been in hospital, um. (176-185)

The discovery of the newspaper article created a turning point in the way she perceived her place in the family narrative, possibly as an "unwanted" child, despite her mother telling her otherwise. The death of the two sisters is also how Liz explains why their mother was "always in hospital", presumably with episodes of depression.

Liz grew up feeling unloved. This had repercussions across aspects of her life, in her story and in her sense of self. There were times when she experienced cruelty,

> Um because I mean I – I wouldn't say there I had there was much love for my mother and father, and there wasn't any abuse of um violence or anything like

that, but there might have been cruelty, but um, it might be seen as cruelty now but it wasn't that cruel then, but now that I think about it yes my mum did put us outside in the cold in our nighties and cut my sister's hair off, and things like that, but then, um, she was ill as well, but all she ever says was them bruises on you and there was a bit of, quite a bit of neglect, but she was ill. (440-448)

By adding, "but she was ill", Liz finds excuses for her mother's behaviour towards her and her sister. If Liz did not feel loved or "wanted", she also says "There wasn't many, any love inside me" (69). She was angry with both her parents for different reasons. She was angry with her mother for being ill all the time and with her father because "he wasn't very helpful either, he doesn't understand depression, so, um, well I was angry with him for being angry with my mother"(681-682).

Her relationship with her sister was not warmer, there was rivalry between them, "Um, I always had fights with my sister, I always thought my sister was much prettier and everything, better than me, um, (434-435). Liz measured herself up against her sibling, and saw herself as second best to her. This linked to another major story running throughout Liz's adolescence: feeling ugly. This is a very potent part of how she constructed her identity during those years, "I was told at school I was ugly, and um that was, this was a way well ok I'm ugly I will make myself look ugly"(24-25). She was not only told, she was also "picked on in school anyway . . . I was told I was ugly" (149-150). It was "boys"(311) who told her,

um I don't think girls told me I was ugly. I was insignificant really. But. I was insignificant 'leave me alone', but they didn't, and had quite fuzzy hair and um um - that's what people pick on I suppose. (312-314)

This form of body alienation affected her sense of self and consequently her self-esteem, 'well ok I'm ugly I will make myself look ugly'" rings like a self-fulfilling prophecy.

At that point, Liz follows the Spring pathway: she has awareness of tension building up, of her overwhelming feelings (anger, sadness, low self-esteem, frustration). There is also evidence of Frankian chaos narrative: the family narrative is wrecked by the enduring legacy of the death of the two sisters on the mother's mental health, and Liz

who does not know how she fits in the fragile family unit and who has little sense of agency and control over her life.

The first episode of self-wounding

Liz's anger was not expressed outwardly at the time of the first episode. Instead, anger was re-directed at herself as a form of self-loathing and frustration at what was going on at home. Liz is 14 at the first episode. She was at home, in the garden,

> I remember cutting my hand <u>with</u> <u>a</u> <u>flint</u>, about 52 times, and um, I then had to wear mittens, fingerless mittens, um, and I can remember a teacher asking me what it was when I couldn't wear the mittens and I said 'it was a cat', and they said 'That's a very vicious cat'. (11-14)

> *Excuses that people make... Individuals who self-wound make excuses, either because someone asks, intrigued by the presence of wounds, or scars or other "unusual" skin marks such as scratches; many of us do not really care whether people believe us or not. See also* Interlude 3.

> I know I had fifty-two scratches on my hand because I counted them, um, and I remember that to this day, counting them all and um, and basically I felt a freak, to tell you the truth, I was in school, um, some other people, um, pupils, people at school would ask me why I was doing it and I said 'because I didn't like myself'. (59-65)

Liz's counting of all of her "fifty-two scratches" suggests that the experience had quite an impact on her; she says she felt "a freak". Although the teacher picked on the "cat" excuse they did nothing further while Liz seems to have been quite open with some about the reality behind the scratches. This openness suggests a degree of wanting some attention and the dynamic here is not repressed. When asked how self-wounding had made her feel otherwise, she said "it must have felt good otherwise I wouldn't have kept doing it" (57). Her self-perception, which she told us was already low, coupled with the self-fulfilling prophecy, seem to have created a leitmotiv from that point on,

> that has sort of carried on through the rest of the um you know through my life, in the way and how I sort of perceive myself and and when I – just want to let it all go I self-arm. (28-33)

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"Letting all go" is explained later on in her narrative. Liz uses a powerful image, "at the time I'm just all knotted up inside and I suppose it's the unwinding of the, unwinding yourself" (257-260). This strongly suggests an awareness of internal tensions building up through the designation of the knot. The knot becomes unwound when she self-wounds and she is able to let it "all go". This is a powerful demonstration of the power of the Spring.

There was no suicidal feeling or intent at the first episode of self-wounding "Not at all" (359).

Subsequent episodes of self-wounding

At subsequent episodes of self-wounding, her anger had not subsided. She rebelled "age 14, 15, 16, leaving school, became a Gothic" (67). She also remained angry with herself. There was the instance of "the writing on the wall". By writing "I'm a failure"(202) behind a curtain on a wall in her bedroom, when she was 15, Liz created another leitmotiv for herself. This time, the hidden text is a portent of doom. Liz says, "I felt a complete failure in what I was doing, I was quite a good student, and sort of gave up from school, I left when I was 15" (150-151). She is very aware of a negative turn in her personal narrative when she was 14,

> but I was very I was a very good student, and then when I got into this self harming stuff I wasn't such a good student and I should have gone to university and stuff like that so I was probably a – that's why I thought I was a failure and um but something just all went wrong, at 14. (465-468)

She has already told us that "things carried on" from that point on in how she perceived herself and her need to "let it all go".

Liz "kept doing it" [*self-wounding*]. She remembers using a razor blade quite quickly after the first episode, "It was the same hand, so, and it was probably in the same week" (41). She used to cut, using what was to hand, such as bits of broken glass and razor blades, sometimes dismantling them,

> I had to take lots of measures, so basically the Ladyshave I shave with that's what I've got, I tried to pull them apart with my teeth, um, which could cause lots of problems, it never has done, but I usually can't get the razor blade out, because the razor blade on its own causes a lot of damage. (622-627)

Often, "It was a random thing, and it was a cut and then you could see the blood, and it felt very good" (50-51).

There was a turning point when she became a recluse aged about 15. Socially isolated and feeling unloved, Liz needed to physically remove herself from the family environment, "I used to go into [*name of city*], I lived in a village, and um sit around all day and then go back home and sit in my room. So I wasn't, I wasn't as far as I could see loved by my family either" (163-166). In her room, the negative self-narrative would resume, "I did spend a lot of time staring in the mirror telling myself I was ugly, and I also had quite fuzzy hair, and um" (171-172). Looking back she is aware that her self-perception at the time was probably wrong,

> What I see in the mirror is different to what other people see in the mirror and I'm being very very aware of that and the fact that I spent months in my bedroom just looking at myself in the mirror. (304-306)

> Actually as you go through life when you talk to people it's not actually what people think, it's not actually the case. (435-437)

As she continued to experience alienation from her social environment, she became progressively socialised into another alternative peer group (Punk movement) which gave her a status and an identity (Berntsen & Rubin, 2002),

> my mum said she wished she'd never had me, when I was about 15 she said she wished she'd never had me, because – it's by then I'd cut all my hair off and I was a Punk and there was a case of well um you know I'm ugly I'll make myself even uglier, and um me and my mother didn't speak for a very long time, because she didn't like how I was dressing or what I was doing, and I was actually rebelling against her because she didn't like it, and if she weren't going to talk to me it didn't make any difference really and of um, you know, I thought I looked ugly inside I might as well look ugly outside. (452-460)

Relationships can admittedly get quite tense between mothers and adolescent daughters, and the tension between Liz and her mother is perceptible in this account. As time and years progressed, there was a shift in her self-wounding narrative in the form of an escalation. This was due in part to what she had learnt through self-wounding, to having reached a threshold of pain and a need to reach a further threshold that would satisfy her,

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I think you learn and I think you can you learn how much pain you can take. And when um something you've done um has reached the level of pain or, or um you go a bit further, because it's then not helping you, you need to go a bit further to make whatever it stop and it made you feel a bit better, released everything. (218-226)

The amount of blood she is able to see plays a similar role,

Then I think when you've got to the part when you've seen enough blood or you've hit yourself enough, then you've got to that stage and then it will hurt and then you can stop. (235-237)

"Feeling good" after seeing enough blood is one aspect of how self-wounding makes her feel,

Does it feel good or does it feel I'm exhausted↑(.) I think it's because I'm exhausted, and I actually – if we go to now, um, I can think about it for two hours and how I'm going to do it and what I'm going to do, and I've actually talked myself out of it, um which is also makes me feel quite good because I've achieved something. (251-256)

This is also going back to the theme of letting go of the knot inside her. When she is feeling so tense, she may or may not self-wound. If she does,

Well when I do it I'm in such a frenzy, and it's usually on my legs, it's – I have to do enough of it, and so actually it won't – there has to be enough blood and it also has to start hurting. (241-243)

Her self-wounding has to reach a certain threshold for her to get the relief she needs.

She has also self-wounded using cigarette burning. She was still at school the first time and remembers it vividly, "I remember doing it at a disco" (114). It was painful,

Incredibly. Incredibly painful until you get past the nerves, then it's not. But also that, the erm ones on my wrist, I can't remember where and when, because I didn't really smoke, so (.) maybe I did smoke every now and again but I didn't have the cigarette specially to do it. So I can't remember that, I remember doing that there, and that was very very er, that was pretty awful. (121- 130)

However, that particular time, she says "I would have done it with whatever was there at the time" (133), which seems to indicate a measure of desperation to self-wound using whatever means to hand.

Over the years, the frequency has been vacillated, and she has self-wounded in different places on her body,

> I think when I first started it was quite frequent, so and as I said, I cut my hand a lot, I burnt, um and I think then it might have just been I cut my thumb, I don't think I - I just, um it's really difficult I really can't remember from 16 to 17, cut myself when I was 17. I think I must have been – I was doing – because there's the scars there, so it wasn't, they weren't deep, and then I got a few here, which is when I was 18, and then I went to my legs. So my legs show um so but I think, yes, and I think I did it up here [*indicating her right thigh to the researcher*] so I could cover it, which is probably on that side, because I'm right-handed. (405-417)

Overall, she says that her self-wounding increased as she grew older, "I used to do it worse, I had a stage of doing it a lot worse than through my teenage years" (215-216). Sometimes, it is a "continuous circle" (265), feeling depressed, fighting the desire to self-wound, succeeding, feeling good about it, feeling depressed again, wanting to self-wound, not knowing whether this time around she will be successful or not, and so on.

Some people noticed her self-wounding. In the early days, it was her mother as Liz was visiting her in hospital,

> The gloves – I don't think the gloves covered it all up, so it must have gone up here a bit when she asked what it was But I didn't take my gloves off. But she noticed the cigarette burns, as well. (192-194)

Liz cannot remember what she said when her mother asked what the scars were but according to her, her mother replied that she went "round with the wrong people↑ [*laughs*]. So it was their fault I was doing this and that" (200-201).

During her Goth period, Liz would use "devices" to hide her scars, in particular during the summer months,

> Um I actually don't, I used to have, because I was a Goth, plastic, no they weren't plastic, they were rubber, rubber – they looked like Hoover rings. And I had them like that, [*shows researcher over her wrists and hands*], And then you had to keep your hands down like that [*makes a demonstration*]. (345-352)

At subsequent episodes, Liz is still angry and constructs herself as a failure, a used-unappreciated-doormat-carer, someone whose lack of self-esteem still impacts on

most aspects of her life (partners, self-belief …); and self-wounding is a coping mechanism that allows her "to let it all go".

Anger is in fact the overriding driving emotion and leitmotiv of the narrative: it is entirely directed at herself. The outward anger feeds her inner anger, and they feed each other. She is angry at, "Myself, people around me, but mainly myself" (385), and self-wounding is a kind of punishment for "Being ugly, yes" (387),

> I think I get very angry and I get angry with myself for being angry, or being used as a doormat, and that's another reason why I go and self harm. And um but that's also once again not um liking myself, having low self esteem, and um it's been kicked out of me - there's also this who do you choose as your partner, and I've chosen quite a few wrong partners in my life and I'm just wondering if that's all connected with the low self esteem, what you think you deserve, and um, - I get angry with myself for not sticking up for myself, and believing in myself which I don't do. (661-676)

According to Liz, her self-esteem has been "kicked out", which is her explanation for not liking herself and for all the things that have gone wrong in her life. This feeds an anger directed at herself,

> I very rarely get angry with people, because I don't think I have that position to be in that place, um, which obviously I do, because um I can't always be wrong, I can't always be wrong, there must be some times when I'm right but I never feel like I am. And so that's another reason for being angry with myself. (701-705)

In fact, even to this day, she does not feel "allowed" to be (outwardly) angry. However, she dares question her own reasoning a little when she says "I can't always be wrong". And yet, she soon backs down and states that she never feels like she is right.

The same goes with her feeling second best, "It's all the time. I think I think that I have to be second best. Which I don't want to be" (710-712). Has to, but does not want to be. Her lack of self-esteem ("been kicked out of me") drives this constant non deserving discourse. This partly comes from her role as carer for her mother between the ages of 17 and 18 which put more stress on her, "And so she didn't speak to anybody else in the family except me. So there probably was a bit of pressure on, on there" (689-692) and her feeling like "Being someone's doormat" (694) and "Not

appreciated (696). There does not seem to be anyone in her life at the time to give her any support.

Liz says that for a long time, she did not get help with her self-wounding outside of medical attention on the few occasions she needed stitches. She says she felt her mother was not the kind of person she could go to with problems, "Not really" (321), and she says that not being able to talk probably had an impact on the fact that she self-wounded,

> Well I didn't have anyone to talk to, that was the problem, that I didn't. Um, well there was one or two people but um no, they wouldn't have understood. Probably understand more now, but um. Because it wasn't - I mean there were people at school that maybe cut themselves once or twice, and they grew out of it. (324-332)

So she had options but on balance, Liz felt they were not the right ones for her. It was seven years after she first self-wounded when she finally felt some recognition from someone else,

> There was no one out there helping, there wasn't any understanding, I was the only person. So as I said, I felt like a freak, um, and people thought I was a freak, um but then I used to keep it to myself anyway, um only certain people knew, um and then I met somebody that said they cut their leg like a dog had jumped on her and I actually said 'No, they haven't!' and this was like when I was 21, and it was like finding – this was the first time I found someone else that was very similar. But that was like seven years later. (284-294)

At last, she was no longer a "freak" or "the only person", there were others like her, suffering like her and doing or using similar excuses like her to cover their self-wounding.

> *Such recognition in/from others can go a long way in making us feel less alone. By the same token, being in the company of people with similar experiences might 'freak us out' and make us retreat even more from seeking help. Such is the complexity of this experience.*

While for a long time, Liz's self-wounding followed the Spring pathway, today she reports no craving to self-wound. Often her need to self-wound is a reaction to an event although she would not self-wound straight away,

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> I'm at the end of my complete and utter tether when I self harm, so it's not a 'oh I've had a really bad day at work, I know, I'll go and cut myself up', and I know some people do it religiously every day. (561-563)

Again, this indicates the presence of an awareness of the "knot", of internal tensions building up to the point where a threshold has been reached and she has to self-wound.

Self-wounding is clearly a coping mechanism for her, even if she does not "see it as that",

> Well I think – it's - help me cope in a way because when someone said 'I'll help you stop doing it' I said 'Well what am I supposed to do then? How am I - oh no, you can't take that away from me, because then, what am I going to do?', and I guess that is it, that is the er – well it must be how I cope, it must be. Because, but I don't see it as that. (526-533)

Post-Scriptum

Liz still self-wounds, following her "continuous circle" of depression and battling with self-wounding. However, there has been a positive turning point as she gets on better with her sister nowadays, and does not feel like "second best" to her anymore,

> I don't think so any more – well yes, but I don't think so – we get on very well now – she's been quite ill and um we've been very supportive of each other, um, probably the best in the 40 years that we've been alive, it's been the best year ever . . . so, it's just us, and obviously her family and the baby, so that's got to be better, um, my sister's very supportive of me, but I seem to be the one that always gets into some bother. (716-722)

Even then, her lack of self-esteem still drives her to put herself down, depicting herself as "the one that always gets into some bother".

She is however inclined to take a very positive step towards self-wounding, with a view to helping others,

> Umm, I just, I would actually really like to go and help 14 year olds and talk to them um, because I felt then I was completely on my own, and it was something – I was completely off my head, because no one would understand. And I just think it would be just someone who goes into schools and talk to teenagers. Because I don't think it happens younger than teenagers, I think that might be quite rare. I think it's all quite sad. (510-521)

"It's all quite sad" sums up quite neatly how she feels about self-wounding, especially when it involves young people. This indicates a turning point towards a quest narrative as she has become interested in sharing her experiences of self-wounding with adolescents to make sure they do not feel as alone as she did. Changes in family relationships (sister) and a more positive sense of self-awareness and self-belief have allowed her to move on and gain more positive outlook.

DAVID'S NARRATIVE

Biographical information

Male, 50 at point of interview and at the time of the first episode of self-wounding.

Period leading up to the first episode of self-wounding

I am choosing to start with this early contribution by David of the dramatic turn in his personal history, because of its dramatic quality. Then I will rewind the 'film' to reset the chronology of events,

> Er I was just in a very traumatic relationship and it just never seemed to stop. It was on and off, up down, all the time, erm, then a third party was introduced into that, and I was just hanging on too much. (8-11)

This is offered very quickly and this opening statement is packed with a number of very important elements or clues.

David tells us he was a player in a traumatic relationship. Elements of time and duration qualify the trauma as something that is relentless, potent and unpredictable. He then tells us how he reacted by "just hanging on too much" although it should possibly be read as he "was just hanging on"[space]" too much", thus emphasizing elements of duration and persistence and also, possibly in hindsight, his awareness of his own resilience.

In the middle of this short opening narrative, there is the "introduction" of a "third party", which is virtually put there as a clue in the drama which David then proceeds to offer to unravel, "I can give you the actual detail I think that actually set it off that day" (16-17),

> I'd bought her a laptop. It's the very last thing I ever bought her. After many many, lots and lots of money spent. And a couple of weeks later I was on my way to work and I call in to the local village, to er go into a store, and as I come out I looked at some of the postcards in the window just because I was looking for an apartment to stay in, and I saw this very computer there with her daughter's number underneath it. Just two weeks after I gave it to her as a gift, and it was listed as an unwanted gift. Bearing in mind that even at that point, right up until the night before I'd still seen her and nothing was said. (19-29)

There seem to be different strands of stories (the laptop, the many presents and money spent, the visit to the village shop, the search for a flat, the chance sighting of

the postcard) brought together vividly into one very potent moment. This account also represents the beginning of the narrative turn in this story.

The sighting of the postcard had the effect of stopping him in his track. So let us too pause and rewind the story. Before moving on to the climax of the story, it feels important to look back and ask: how did David come to experience this relationship as traumatic? What happened for him to get the point where he "was just hanging on too much"? What follows is an overview of the web of clues in the relationship up to the first episode of self-wounding.

It seems that the theme of the "third party" had been an underlying or recurring issue in the relationship. We learn of the existence of another man who was "constantly texting her" (73). This "ex" feels like a ghost in the relationship, very present through the exchange of text messages while invisible and "causing [*him*] problems". David does not say how long this went on for. However his mentioning of a "third party" being "introduced"(10), suggests that it did stop at some point before this man came on the scene. We only find out that he was in fact an old flame, "the love of her life" (*), another on-off relationship with whom she had resumed the relationship at the time of the interview. She had told David "he does not love me, he's told me" (*); and yet she was prepared to stay with him. He says his friends reckon this is because, "he's not a threat, there's no commitment" (*).

The relationship had not always been "crowded". There had been a period where things were going on well between them. They "had been engaged" too (184) and, in the beginning,

> things were brilliant, she was so happy. She was so happy when she didn't put up these barriers, from the first however long that we knew each other she didn't put up barriers, she accepted that there was a good man finally in her life who wasn't like the rest in the past and we had an absolutely wonderful relationship. But then started coming up these barriers. (761-765)

Quite quickly, there seems to be recurring themes of something resonating in the relationship, these "barriers" which, for David, are linked to her past relationships with men. We learn about "the guys in her past who'd actually physically beaten her up and raped her and stuff like that" (186-187),

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that was the root of it all, I think , because of her past, even when she gets a good man, which I am, a man that treats her right and loves her, properly, rather than, you know, how they did, she still, she still puts up these barriers and doesn't trust it and doesn't believe it. (203-206)

The key is perhaps in those last words "doesn't trust it and doesn't believe it". David says,

look how these men treated her in the past, you know. To her I think a man is someone who hits. And there was many an occasion where she'd be doing this to me, you know, thumping the hell out of me, slapping me in the face, and my hands would be here [*David puts his hands to his face*]. I wouldn't even come close to touching her. A couple of times I held her hands because she was beginning to hurt me slapping my face but I'd just hold her hands . . . but she did it and it was almost like she was wanting me to hit her. You could see the frustration as she'd literally thump my chest to the point where she'd exhaust herself because she's petite you know and she'd exhaust herself, literally . . . and it was like looking back now I think she wanted me to hit her. And because I didn't I wasn't a man. She never actually said it but you could read it – 'Hit me for crying out loud, hit me back!', you know, because that's what she thinks. And sometimes I think maybe I should have, you know↑ At the very least I should have turned around and walked out. The guilt I'm carrying I think is a lot of that. She convinced me in the end that I wasn't a man either.   (784-811)

The "barriers" David experienced were for him the expression of something else,

I think [*she*] seems to play a lot of mind games . . . Puts up all these barriers, total self protective defence mechanism going on all the time, and I could never break through that. And er it was very frustrating over a long period of time. (78-84)

I kept thinking you know, this woman really loves me, really wants me, but it's her past that's making her cautious, it's her past that's [*inaudible*]and it didn't matter what I did, no matter how nice I was, no matter how much I loved her, no matter how good I was, I just could not break down these barriers. (391-395)

The idea of "mind games" comes up a few times in the conversation. This is how David

qualifies her side of the relationship. On the one hand, there was the "total self

protective defence mechanism going on all the time" which translated into a

relationship that "was on and off, up down, all the time" (10), with her seeing both

David and this other man at the same time, favouring one [*the old flame*] and rejecting

the other [*David*] while retaining him still. On the other, David says she had also been

offering sexual intercourse only to withdraw consent at the ultimate moment, telling

him "this has got to stop, we can't do this anymore, it's not fair to him, this guy who she was seeing once a week↑" (363-364). Those "mind games" effectively dictated the terms and the quality of their relationship,

> I just went through so much. And it [*the mind games*] became more and more and more regular. It was getting to a point where it was almost every day. (331-335)

While she was playing "mind games", David says,

> I was very desperate to try and get through to her, to try and make her see that this man loves her and he doesn't want to harm her, and he wants you know and why are you, why are you rejecting everything that I do to the point now where you've been seeing someone else for three months but still keeping me there↑ This guy was once a week, on a Sunday for a meal. And that developed to once a week plus a few phone calls. It never ever actually became more than once a week. Whereas I was there, not living with her any more, that had parted a while before, but I was there, almost every day of the week, you know, I if I wasn't there in person I was talking to her on the phone, she was always constantly asking me for space and time, yet if I left it just a couple of days she'd text me and wind me in, you know↑ Wanted to be with me but didn't want to be with me, you know. (336-352)

A desperate David was pursuing a relationship with a woman who was constantly hedging her bets and playing mind games with him.

She tried to provoke him into behaving like one of the men who used to hit or rape her by hitting him. But he would not or could not respond in the way that he felt that maybe she was expecting him to. This in turn made him question his own masculinity and he became "convinced" that he was not a man. For not hitting her, for not walking away from the situation, like other men would have. Being seen as a weak man has been haunting him,

> > Part of it I was wondering if she saw me as a weaker character, a weaker man because she quite often accused me of being weak, not because of that, I'm talking prior to that, but I wondered how she thought of my weakness after, because I kept thinking is that what a man is to her, someone who smacks her when she's naughty in their eyes, you know, I mean, erm, would she have preferred that I'd done that, you know, if I was that frustrated, that angry with her, I don't know. (213-218)

The issue of his masculinity is treated as a meta-analysis. He is desperately trying to understand how and why she saw him as a weaker character, but is left wondering whether he should have behaved as she wished.

During the period immediately before the first episode, he was "not living with her any more". In fact we learn that this happened because his sister, "she's my favourite sister, she's the one who introduced [*name*] and I, been [*name*]'s neighbour for the last 20 plus years" (626-627), did not like the fact that they were engaged . This apparently "had a big part to play in the relationship . . . in a bad way" (653-654).

He had become emotionally dependant on his girlfriend, regardless of the continuing mind games which played an active part in the relationship: constant rejection/ winding him back closer to her, emotionally, physically and sexually, the actual physical provocation ("hit me back!") which gradually made David not only more and more frustrated but also more desperate. This dependence prevented him from walking away from the situation despite his emotional resilience wearing very thin,

> I mean I've had a couple of episodes [*not self-wounding*], prior to this and it was a time bomb waiting to go off. Definitively. Definitely it was a time bomb, it was just a matter of how or when. But there were a couple of occasions leading up to it when I was in my local pub so distraught I broke down, I just couldn't control it, I was breaking – the pressure was building up so much, the tension was so I just absolutely broke down, on a couple of occasions, but I remember the first time, in the pub. And I heard a couple of men, I'll always remember this remark, men sat there, who sort of knew me but didn't, 'Oh look, we got a crier here!'. Now if that had been a woman crying, somebody would have gone up and comforted her, but men aren't supposed to do that. To the point where even though it's obvious somebody is absolutely distraught, I could have lost my mother for all they knew. But their reaction as men was, "Oh look, we got a crier here!". What do I feel immediately↑ Shame. Where do I go↑ I go into the toilet. I come out and I walk straight out the pub. Ashamed, with my head down. But I had every reason to cry at the time. I was going through hell. My heart was being broken on a constant daily basis. (705-726)

The metaphor of the time bomb is very potent. David describes a man who had been living on borrowed emotional time and who had "broken down", under a pressure that "was building up so much". His masculinity was being questioned, this time by other men, who did not seem to tolerate the presence of a crying man near them. How was

he meant to deal with feelings and emotions as a man while clearly expected to behave like one? He felt shameful. He seems envious of the locus of sensitivity occupied by women whereas "men aren't supposed to do that" (crying). So he left the pub with his tail between his legs, so to speak, "ashamed, with my head down".

Let us now rewind to where David introduced the narrative.

He was "going through hell" and his "heart was being broken on a constant daily basis"; he had been "just hanging on too much" and the mind games had been "very frustrating over a long period of time" to the point when he felt like a "time bomb waiting to go off",

> And er in the end . . . I think I cracked, I think I'd had to find so much strength for such a long time, that automatically when that strength left me it was going to be the other extreme, it was going to go from a lot of strength to a lot of weakness. (397-401)

The man who had been breaking down finally "cracked".

Up to that point, David's narrative follows the Spring pathway: there is awareness of tension building up and an acute awareness of overwhelming feelings ("frustration", "pressure", "tension" and confusion). David's narrative is also a Frankian chaos narrative: he never had any control over this relationship, his identity as a partner and lover are constantly under question. This narrative is constantly taken in different directions (towards hope and towards despair) and is rigged with confusion and ambivalences. He is drawn in, rejected or suspended by the girlfriend; he has no sense of self agency and has given up control over events until, paradoxically, narrative wreckage of the chaos he has come to accept, dramatically pushes him to do something. He experienced deep social isolation; even his favourite sister did not approve of the relationship.

The first episode of self-wounding

The trigger, and narrative turn, for this emotional bomb was the postcard in the shop window,

> All I know is I got in my car the moment she put the phone down, drove round there . . . and the door was locked and I knocked on the door and I got no

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answer and, spur of the moment, like I said, I just I just looked around, and on the wheelie bin there the rubbish bin there was this blade that I'd left there a few days before for the job that I'd done and I just grabbed it and I went ffffffffffff. And screamed through the door and got no response, walked round the front of the house, stood in front of the window saying 'What more do you want? My blood? Here, fucking have it!' That's what I said, I swore 'Fucking have it!' The next thing I know I walked back to – I was going to go and get in my car actually, I don't know why, I wasn't going to [*inaudible*] and she came round the side, and her first words were before she saw what I done, 'Who the hell invited you here?' And then she saw it. She sort of went into a totally different mode then as well. (835-848)

And that's what I did. That's how it happened, it was spur of the moment, I was just so frustrated I think, angry, I wanted to hurt her, I think.(40-41)

David is constructing the first episode as a "spur of the moment" although this spur is more like a million little pieces coming together and gathering strength, a series of small turns, each cranking up his emotional tension further to the point when the "bomb" had to go off, blowing up into a very public space, the street.

An ambulance was called by his (the favourite) sister, who is also a nurse. There was clearly no suicidal intent. This was a dramatic and desperate gesture which reflected the intensity and complexity of the feelings and emotions which had been running though him for a long time, "I think it was my way of doing what the men in her past have done, it was my way of hitting her – I couldn't do that, I couldn't hurt her physically, so I hurt myself instead"(101-103),

I've never done anything like that in my life before, I just can't understand why I did it. Not completely. As I say, the one word that keeps surfacing is frustration. So much had built up over such a long period of time, it was just the final straw. (104-109)

Women are allowed to cry and men are not allowed to cry, isn't what I did in effect, a type of crying↑ We're not supposed to show our emotions. We're not supposed to do that. (695-698)

I felt, maybe I should mention this, I also think I felt 'Here I am, notice me! . . . Stop, stop what you're doing!' I wanted to stop her doing what she was doing because I didn't, I was a good man, I did treat her right, I did love her . . . so if I was this best man she's ever had, why, why was she doing this, why was she doing this↑ And it was also like as I say, my way of hitting her but at the same time I think it was my way of saying will you please stop. (850-860)

David is wanting to try and justify his act ("maybe I should mention this") and tells us that the act of self-wounding did not fulfil one but many functions: hitting the girlfriend by proxy (by redirecting the anger onto himself), telling her to stop, telling her to notice him and as a form of crying. Throughout though, the many facets of the act construct a narrative woven in despair.

Despite the fact that there was no suicidal intent on his part, the psychologist at the hospital was adamant,

> Well the lady that saw me right at the moment I was given the bed, the psychologist, whatever she was, I had to see her again the next morning, before they released me, they were insistent, in their mindset, that I'd tried to kill myself. I couldn't convince them otherwise. (582-585)

> *As with Jim, the professional is encountered (here in A&E) was working on the basis that self-harm/self-wounding is a form of suicide ideation despite the growing awareness around the subject and the (also) growing body of literature that clearly says otherwise. This is counterproductive because it focuses on the wrong issue and may actually lead a person to attempt to take their life if the underlying source is ignored or dismissed.*

When asked if self-wounding hurt, it did not at the time, only afterwards,

> I think I was too upset to, at what I'd done, to actually even consider what the pain was like. There was more going on in my head than physically at the time. (161-164)

Above all, self-wounding meant going "from a lot of strength to a lot of weakness" (401). There was no relief emotional or otherwise, "I hadn't, it hadn't relieved any of the heart pain that I was going through" (171). On the contrary, self-wounding made him feel worse,

> Um, I felt, I felt more guilty. I think that's an obvious thing, and then I had all night in that hospital to think about what I'd done. My head at the time was really filled with am I ever really going to be with her again because of what I'd done. And guilt as to what I have done to her, how can someone see someone else after that↑ (171-180)

In effect, the climax of the story, the narrative turn, the first episode of self-wounding is also the lowest point in his own personal narrative: "That this is the worst, the lowest I've gotten and I would never ever go down that road again". (441-442)

Subsequent episodes of self-wounding

There were no subsequent episodes of self-wounding. This was a one-off.

However, it left a very powerful emotional turmoil in its wake, made up of guilt and shame which he mulls over on his own in his driving job,

> I have so much regret, I would never ever ever do anything like that again (276).
>
> I talk a lot to myself, I even shout a lot to myself, I have arguments with myself now. (756-757)
>
> I find myself thinking all the time about what I've done, what I've done, what I've done and everybody that knows me, my family, my friends, that have sort of known about the relationship as it was going along have said it's not you [*name*], it's her. (234-238)

And yet,

> I still think I was weak, I could have handled it better, I could have been more man, I could have walked away or something rather than hung on like I did, which was causing friction all the time. (240-242)
>
> Um, I don't think I'll ever get over that guilt to be honest. (282)

His feelings are an exact reflection of the constant ambivalence he was facing in this relationship, "why she pushed me so hard to do what I did, what was I doing to her to make her push so hard, I don't know" (127). He cannot completely condemn her. The guilt and the self-blame combine to create a deep sense of shame and self-hatred for the act of self-wounding,

> I'm totally ashamed of it. I hate myself for it. But here's the ironic thing – I don't hate myself for doing it because it's not something that I should do to me, I hate myself because it's not something you should do to someone that you claim to love. I should be ashamed of, I guess of having done it to my own body. To my own mind. And I am, but it's secondary. (488-498)

And yet, he is desperate for her forgiveness, "More than anybody I need her to forgive me for what I did because even though she did a lot of things to me". (551-558)

Despite attempts to explore emotional issues within a professional health environment, David did not continue, "I went twice, felt very uncomfortable, didn't bother to go again . . . The only person I really wanted to talk to about it was her " (587-590). He seems to be suggesting that if only he could do this, as a form of atonement almost, maybe he could possibly make her forgive him for his act, in spite of what she did to him. In fact, she showed him increasing levels of hatred,

> Next time you try to commit suicide do a proper job . . . a couple of hours later she sent me a text saying 'Why don't you go and kill yourself?' And there is my guilt right there, for that woman to say that to me" (520-525).

Those last few words sum up his entire emotional turmoil. This guilt is indeed there, very palpable.

His shame also means that he will not wear short sleeves, an information he volunteered,

> I never wear short sleeves anymore . . . It's left two scars, yes. And if I do wear a short-sleeved shirt because it gets really hot like it did in the summer, I walk around like this, with my arms folded. Wear a watch over one of them. Very ashamed still. (595-602)

Looking back, David wonders whether if he, as a man, had been able, "allowed" (747), to cry and not be ashamed of showing his emotions, whether "the tension would not have built up and up and up" (749-750) as it did. He has not been able to get the right sort of help. As we know, "I've had a couple of interviews here and there" (816), but he did not find them helpful

> I've always been that way. There is a strength in me that perhaps shouldn't be there, but I don't trust, and I don't believe. That's the man in me again you know? I should see this through on my own. I should be a man and stand up on my own two feet and do this. The truth is I'm not coping with it, however I would never do that again. (818-823)

Looking for help from health professionals had never been an easy option for David.

He did try to explore the issues concerning what happened to him as a child with his father (he did not elaborate) but said that "Well since I've never really gotten to the roots of what my dad did to me or even tried to understand it, I really closed the book on that one" (471-475)

Coda

David contacted the lead researcher immediately after listening to an item on local radio where she had talked about the research project and the difficulties of recruiting men to talk about their experiences of self-harm and self-wounding. This man was extremely surprised not only at the subject matter but also at being able to identify his own experiences through the content of the conversation and that a woman should be interested in men's experiences of self-wounding.

There is, throughout, a highly visual, performance quality to the narrative which comes from his detailed and highly descriptive account. David himself says, " If this was a movie on the wall and people could see everything that ever happened, then I know this, they would say no wonder you blowed, you put up with so much" (771-773).

JACK'S NARRATIVE

Biographical information

Male, 27 at point of interview and early 20's at the time of the first episode of self-wounding.

Period leading up to the first episode of self-wounding

Jack does not remember any particular event happening at that time. However he remembers feeling "Um, angst, annoyance, lack of self esteem, self worth and all that stuff. I think, er, sort of general self-hatred, just wanting to sort of end it all really" (19-22), and "Um, I think at the time I was feeling very isolated really" (267).

According to Jack, a large part of his negative emotional state started in pre-adolescence, "I mean it all sort of stemmed from like well when I was about 11 I think" and there was a big change in his life as a child,

> That's because when I changed schools, change of schools basically. Yes I went to er the sort of secondary, I dunno Grammar school, or whatever you call it. 11 to 15 year olds school. Um, for some reason, I sort of looked up at my brother for some reason, er, I wanted to go to the school he went to, despite all my friends going to like the other school. So consequently I ended up in the like school which is the biggest in the town, with not hardly knowing anyone at all, erm, and suddenly found it very difficult to actually meet new friends basically, er, and so it did end up basically spending, you know, isolating myself and taking myself off to find corners to hide myself. (299-308)

> spent a lot of time on my own, erm, and spent it being very inwardly on my own sort of thoughts and stuff like that. (284-286)

He wanted to go to the same school as his brother because,

> Dunno, suppose I sort of looked up to him in a way. Um, because he was the eldest, because he was older than me and stuff, erm, I sort of, you know, following his footsteps and stuff, dunno, he seemed to be happy and sort of stuff, so, I wanted to do that, for some reason. (311-314)

For Jack, the brother was an example to follow; by doing so maybe he too would become happy. However, the experience soon turned sour and the child Jack, having severed his old ties, found himself socially isolated, further isolated himself "in corners", as if to make himself even more invisible, and retreated in himself, with his "sort of thoughts",

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> [*I*] ended up sort of being bullied and stuff like that, because I wouldn't stand
> up for myself, stuff like that, you know, then you sort of, berate yourself and
> you know, 'You shouldn't lie in bed crying on your own' and stuff, 'You
> shouldn't be crying', 'You should be out there and standing up for yourself' and
> stuff, you know. So you end up getting a lot of downward spirals, little
> arguments in your head basically. You know, just how useless and cowardly I
> was because I wouldn't stand up for myself . . . well certainly it was almost like
> attacking myself . . . Yes, sort of flip side sort of rather than actually punching
> like other people, it would be like punching myself sort of thing. (357-376)

Through this, Jack constructs an identity of a loner who is also a hapless victim.

However, this is not a straightforward victim. This is a self-perpetrating victim. Indeed,

by running a guilt self-narrative in his head fed by berating "little arguments", Jack

virtually says he deserves to be a victim for not being strong enough to stand up for

himself. Just like for Lauren, this strong inner and hidden polemic voice won over any

other.

If school was difficult, Jack tells us that home life was not easy either. He says he

experienced ambivalent feelings towards his parents.

There was resentment towards his father,

> I don't know, see I've always had – there has been quite a lot of animosity
> between me and my dad, basically all through my life basically, er, I kind of
> often blamed him for not having like you know (.) for not being much of a
> father figure, although he paid bills and all that sort of thing . . . He did cheat on
> my mum, and there was lots of arguments in the house, and you know
> although he was working lots of hours and stuff like that and yet it weren't the
> best life for him sort of thing , I did you know hate the fact that he was like
> paying the bills was more important than spending time with his family. And it
> would have meant more to me if he'd sort of been there for me to sort of try
> and help me to stand up for myself because that's what a father figure should
> do. Rather than just make sure we had a roof over our head. (432-440)

Through his resentment for his absent father, Jack constructs his identity not only as a

loner, but also as an emotionally abandoned child, unable to stand up for himself. This

is apparent in a recurring dream he recalls in detail. In it, he is highjacked by men in

white coats and he waits and waits in vain for his father to save him. Jack constructed

his anger as victim turned self-perpetrator; it is also the anger of despair fed by his

need for a role model (Bowlby, 1973), a dominant feature of his narrative. He needs

his father to help him stand up for himself and he looks up to his happy person of a

brother. This makes masculinity issues a possible sub-text although this is by no means clear.

He also has ambivalent feelings towards his mother,

> I was always very protective of my mum, because she was the one that was always there, and she was the one that was always sort of cooking and cleaning and stuff like that, you know, making the house and stuff, and whilst being at work and consequently she was knackered as well. And I mean in hindsight, I look back now and think well, it's not necessarily strictly fair to put all the blame on my dad, you know, mum to be honest is probably just as much a big a bitch as he was a twat↑ But because she was the one who was always there for me . . . then I was very protective of her, like er the only one time where I was quite proud of myself was when people were taking the piss out of me and they said something about my mother, and I turned round to them and just was like what are you saying about my mother. (453-467)

The ambivalence of his feelings towards his parents comes out in how neither of them comes out unscathed in his mind, summed up in curt terms. And yet he was able to stand up for his mother, when he was not able to stand up for himself, in contrast to his earlier self-portrayal as a "useless" and " cowardly" person.

As he grew up, Jack's emotional narrative crises usually resulted into a state of emotional build up of tense feelings to the point of "welling up" of which he had awareness,

> I'd normally just really just get really pissed off and I'd get really angry and sort of resentful tears and stuff like that, er, I never actually physically hurting myself basically. And generally I'd sort of get to the point where I'd be such a welling up of emotion and then I'd sort of end up being asleep and I'd wake up again and it wouldn't be so bad for a while again. It would just sort of build up, build up, build up. And then it just I don't know what happens, my brain, but then it would just, sort of I'd go to sleep and then I would wake up. And it wouldn't be quite so bad. (121-134)

At that point, Jack's narrative follows the Spring pathway: there is awareness of emotional tension building up ("build up, build up, build up"), overwhelming feelings (angst, anger, worthlessness, lack of self-esteem and general self-hatred). His is also a Frankian chaos narrative as he searches for emotional anchors from early childhood, fed by his deep seated fear of abandonment (reflected in his dreams) and toying with his feelings.

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The first episode of self-wounding

Jack was in his early 20's at first episode. It seems that this time around, a turning point was reached for him,

> I think it was possibly – just sort of get fed up with it after a while. Get fed up of, like the same situation, you stop, like caring. And so just looking for something to break it to get that bit further. It's just a lot of release basically. It's just anything , getting that bit further. (137-144)

The threshold was reached when he got "fed up with it"; "it" being this constant state of feeling "Um, angst, annoyance, lack of self esteem, self worth and all that stuff. I think, er, sort of general self-hatred, just wanting to sort of end it all really" (19-22).

Jack used a knife. "It a sort of serrated kitchen salad knife thing , I just knew it was sharp, I knew it would do the job " (43-45), "I was running a serrated knife across my wrist that way, but like it wasn't across the wrist, it was the back of the wrist" (14-15).

Jack was very aware of what he was doing; his account is matter-of-fact ("it would do the job"). He did not cut himself very deeply and the wound did not require medical attention, "No it weren't that bad sort of thing" (64). In fact when it bled, he "Just licked it↑" [*laughs*] (62)

Jack says he had suicidal feelings at the first episode of self-wounding,

> I mean, I was quizzing in my head whether it was suicide or was it a cry for help. It's just like you know I've got all the respect for the people who commit suicide, sort of fair enough, fair enough. You know. Get out of it basically, you know. Why↑ (.) You know, you know, nothing, there's no shame, you know, you know, in it or whatever if you ask me. Um, I mean, I dunno, whether or not for me it was a cry for help or whether it was actually like I really wanted to do it, I still don't know, to be honest. Because that was why - I question it because, why it is on that side rather than that side. (29-39)

Jack was deliberating about the best way to "break it", and "get out of it¸ out of his cycle of thoughts. He is trying to justify his thinking process about his different options, such as suicide ("there's no shame, you know") and his motives (cry for help or dying). In the end, he opted to cut himself rather than attempt suicide.

Jack also questioned where he cut himself, "that side rather than that side" and the choice of side gave him the evidence (and the answer) to his deliberations, "But I but I

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didn't actually want to kill myself. Because that's why I did it on the back of my hand not the front" (207-208),

> I think I was aware of finding out what it felt like without actually having to do it. So I knew if I did it that side, then on that side I would hit the veins. But just see, you know, how it felt like cutting through flesh, my flesh and stuff. (210-216)

In effect, it seemed that for Jack it was a way of testing the strength of his motivation, "That was to feel that was to feel the pain" (395). However, instead of strong pain, he experienced something else, "Er, well it sort of hurt, but it also – it was weird, it was sort of transferring of sort of pain from inward pain to actually like expecting it to really really hurt to actually it doesn't actually hurt that much" (56-58). It is as if Jack had been hoping that this transfer of pain would happen, almost, "expecting it to hurt". He also wanted to test himself,

> It was you know, it was things like if I hate myself that much, then, can you do it or not, you know, get sort of calling your own bluff basically (.) I dunno, as I say, like, I didn't cut that deeply. (332-335)

"I don't know, I wanted to prove to myself that I could do it if I wanted to" (153-154). It gave him "Sort of even more control over my own life" (159). Can he do it or not? It is his choice. Choice implies a degree of control. Here it may also be about storing information for the future. If he can "do it", that would give him options for the "future".

Cutting gave him the release from the powerful negative emotions that had been constantly with him, "I just did that and then, I dunno, it was enough, I dunno it was enough of a release to know that I, it was enough and that" (221-223).

The release "was, it all really, physical and emotional, to be honest, it's just - you know, like breathing out again, sort of thing, you know" (235-236). Therefore physical relief and emotional release. "Breathing out" of the "welling up" and of the "build up, build up, build up" which he had talked about earlier. Those are powerful images not only reflect the intensity of his experience but also the presence of the Spring pathway. Here, self-wounding brings relief and release.

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Subsequent episodes of self-wounding

Jack did not self-wound again for a significant amount of time.

However he did keep his wound open as long as he could,

> just kept pulling the wound open so it would scar. Just to remind me . . . I mean, you know during, sort of healing, just sort of pull it apart basically just to (.) Yes, make sure it would scar, to remind myself. (64-70)

The scar here acted as textual memory and helped him take control, "Sort of take even more control over my own life" (159),

> I mean I sort of did it, it didn't hurt, I say, kept the sort of scar open well kept the wound open so it would scar, just to remind myself, and I thought well, ok, that's what that scar's there for. So I can you know look at it and always know . . . Just so it's like a constant reminder basically. You know, I can do it if I want to . . . it's just a reminder that it doesn't hurt and that if I - if it really is all that bad, I can just do it. (169-189)

The scar operates a potent function as a reminder that he was able to could therefore take control and "do it". In fact Jack found "inspiring" the fact that self-wounding did not hurt, which highlights self-wounding as a coping mechanism for him, something he can, if he wants or needs to, draw on.

Whilst he did not self-wound for a long time again, he nevertheless offered to talk about an episode of a suicide attempt, when he tried to strangle himself,

> I mean I have tried sort of strangling myself, which is so stupid thing really to do, because you can't actually kill yourself like that . . . Well at least not with my hands, with like just my hands like a tie and just wrapped round my neck and just pulled it, pulled it, till like ran out of oxygen, till I passed out. (80-90)

> That time was just about trying to sort of kill myself, but again that was you know I think I was calling my own bluff then because I knew, I don't know, because I you know I knew the knot I'd done, would have released basically. (397-400)

From his own admission, Jack was again calling his "own bluff", testing himself. Yet again, he was aware that, as with the cutting, his action could not lead to death,

> Um, I think again like, you know, I knew in the back of my mind there were like constraints I was putting on myself that wouldn't, you know that it weren't going to work, like you know when I cut. Back of the hand, top of the wrist, back of the hand, and the knot I did, you know, it wasn't like dangling from a ceiling say that, when I passed out, would continue to strangle me. When you

put in the knot that, when I did pass out, it would you know the knot would release. So it was still control behind it. (507-516)

In effect, he was still getting that emotion, that release "Without too much risk" (519), "I mean I think it was just a thing of switching yourself off as well. Again you're so fed up by the sort of negative thoughts you keep bringing up" (520-522). This allowed him to "switch" himself off while giving himself the time to think, "And then if you can, then it sort of, then it allows you an amount of clarity as it were to you know, to go right, actually, do I really want to do this?" (527-529). He portrays himself as someone who wants to have options, while limiting the risks. As he put it "That it is just sort of thing you know, calling your bluff, then 'Can you do it or not?', you know" (524-525).

Throughout his account, Jack has depicted a Frankian chaos narrative: he constructs his identity as both a loner and an abandoned child, (especially from his father) who has a very strong need for role models which is he unable to fulfil; as a private person (does not want to talk to others about his "business") who has had difficulty making friends for a very long time. The only way he has been able to deal with his frustration has been through self-wounding which has forced him to test his feelings.

Post-Scriptum

At the time of the interview, Jack was still battling with his thoughts although there seemed to be a change in his emotional life

> It's always been an ongoing issue in my life although to be fair in the last few years I've seem to be able to have found what I – I found a great bond with a lot of people, which is, which I'm really grateful basically. (272-275)

He does not talk about his experiences with anyone,

> No, it's not really anyone's business to be honest. I mean the only reason I'm talking to you about it because I saw your like note thing up in the er [*name of place*] basically. I thought fair enough, you know, always up for you know, about research stuff, help people out. (380-385)

Coda

Jack started the interview answering questions with slightly unrelated statements. There was ambivalence and ambiguity at times. At the interview progressed, his statements became clearer. This is something that often happened throughout this series of interviews, as if the interview process seemed to enable participants to clarify

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issues for themselves. It was as if Jack had needed to use the interview process to talk to someone, as a form of therapeutic space. There was also a process of identification when he had seen the flyer for the project "I mean that's why I answered your advert sort of thing because it said like do you know the first time you self harmed. It's like well, yes I do actually" (76-78).

TIM'S NARRATIVE

Biographical information

Male, 27 at point of interview and early 20's at the time of the first episode of self-wounding.

Information about the interview

This particular participant could not remember the first episode nor much of what had been happening in his life at all. One got a sense of Tim blocking time and certain events out. Therefore the presentation of his narrative is by necessity different: because he was able to remember the last couple of years quite clearly and was confident that the first time would "have been the same" (40), it was decided to start from those recent episodes and work backwards to get as close to the experience of the first episode as possible, gently teasing out and piecing the few available biographical elements together. His speech delivery was hesitant most of the time and he required frequent gentle prompting.

Period leading up to the first episode of self-wounding

At the time of the first episode, Tim had been living away from home. "I was living with my Nan and Gramp at the time yes" (374), "Because um (.) I was abused by my step dad like, when living with him, when I was like 13 till like 16" (378-379). It was not a particularly good environment, "Um, not really. Um I suppose it was alright, I mean, yes, just alright really yes" (376).

Some background...

His mother had been aware of the abuse but "You know, it's not talked about" (411). Tim did not disclose the exact nature of the abuse. He says that the abuse, coupled with his upbringing had a big impact on his sense of self and the way that he eventually constructed his identity.

In fact he says that he was brought up...

To feel negative about himself,

> I just always have bad thoughts, because I was abused as a child, I suppose, you know, well I know it all stems from that, and you know, and just all being told I'm a bad person and whatever, and don't deserve to be happy and all that stuff, all that sort of stuff . Bad stuff and so that's led to me having or you know, it's the way I was brought up really, you know. (131-137)

To feel pain,

> I suppose it stems from the time, you know, when I was brought up and stuff, and just you know, you know, I mean, I suppose that what, you know, what my mind do tell me that I should be cutting myself all the time anyway, because that was the way I was brought up to - you feel as much pain as possible and feel horrible, and whatever, and just, and that you should cut yourself right because it's bad for you and you know, you don't deserve to be happy and all that, just stuff like that. (451-457)

To feel guilty, the victim of hatred from his stepfather,

> I was brought up to feel that way, to feel guilty like, you know, I suppose you could be a poor family because they had, they had like a daughter at [*inaudible*] my half sister, and like I was always in the way of him you know having a proper family or whatever, and you know, that's why he hated me I suppose. And you know. I just thought, you know, he expects me to feel guilty for that reason as well. (475-479)

If someone is told often enough from a young (impressionable) age that they should "feel as much pain as possible and feel horrible", that they are undeserving, that they should cut themselves, there is a danger that the person becomes conditioned into believing the "message" and goes on to apply it to the letter. Hence, "my mind do tell me" and so forth.

Tim's history as the victim of abuse and of emotional and psychological maltreatment did not allow him to benefit from secure attachments with family members. He eventually constructed his identity as a "bad person", "guilty" of being "in the way" of his stepfather having a proper family"; who should " feel as much pain as possible and feel horrible" and who does not "deserve to be happy".

> And soon as I could, you know, was old enough to move out, I did, and move in with my Nan and Gramp sort of thing. Um that was in early 97 until um 2005. (379-384)

Up to that point, Tim's narrative follows the Spring pathway. There is evidence of awareness of emotions and tension building up. There is also narrative wreckage within the family setting (family break up, new family unit, rejection, physical and emotional abuse) which highlight a Frankian chaos narrative.

The first episode of self-wounding

(Using information from the more recent episodes)

However Tim's "bad thoughts" did not stop when he moved to his grand-parents; when asked, he confirmed that he was aware of a build-up of his bad thoughts "I mean I suppose all the time really" (541). As we already know, living at the grand-parents' was " just alright"(376). Just alright.

Tim reckons that, like at other times, self-wounding was something that "Just happens, it happened and then that was it really" (57). There was no trigger. "Just happens" seemed to indicate, like the abuse, something that is out of his control, that "just happens" to him, rather than a conscious decision to self-wound.

And yet, upon closer examination, self-wounding is not something that "just happens",

> I suppose when it is a kind of relief in a way like saying you know you cut yourself you know it's kind of giving in sort of thing, you know, to the thoughts that are you know, cut myself, you know, that's what you wanted, sort of thing, you know, like, like . . . Yes yes well can't fight against it all the time . . . By giving up I suppose, and giving in to it, and then just cutting yourself. (507-518)

Here self-wounding is constructed as giving up the fight against the "bad thoughts" and "giving in" to cutting. Tim presents himself as a defeated individual, defeated by the bad thoughts and their relentless presence ("all the time"). The only way to get them to stop, at least for a while, was to "give in".

However self-wounding does not bring relief from the thoughts themselves, only from the tension of fighting "all the time". He used a Stanley knife from his old job laying carpets.

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Previous to the first episode, Tim had no awareness of self-harm or self-wounding. He is very clear that he was not suicidal at the time of the first episode, "Um, no, I definitely weren't first time, no" (422).

Subsequent episodes of self-wounding

During the period between 2005 and 2007 [*interview took place in 2007*], Tim's memories of his self-wounding episodes are much clearer. In 2005, his stepfather left the family and Tim moved back home to live with his mother. It was not an easy period but then things were "just hard anyway, not just, you know, because I moved back for my mum really"(439-440).

Self-wounding continued to be represented as something that "just happens", using the same opportunistic methods, what was to hand, kitchen knives or the tools of his old trade. Coupled with the "just happens" is the fact that the events faded from his memory quite quickly (150).

Self-wounding had become worse more recently, "Well yes I didn't really have any scars really until the last well year I suppose now, got I suppose quite a few" (217-218). He self-wounded in patches, for a couple of days then leaving a gap of may be a few weeks.

Tim is quite clear that the "bad thoughts" are just that, "Not like voices stuff but just like thoughts"(487). This could be construed as an internal dialogue with himself, fed by the memories of the intensely negative messages from his childhood. He is perceptibly aware of the impact of his upbringing on his outlook on life and how things might have been different, "If I was bought up by (.), to feel like I'm the best person in the world, then I'd be having those sorts of thoughts you know, sort of thing" (491-493). It seems that the narrative wreckage forged out of the family narrative has put on hold his life in the present as he is not getting as much help as he could. The current chaos is about the seemingly constant struggle to survive. He does have some awareness of tension building up of a kind internalised from his upbringing and from those overwhelming feelings (the "bad thoughts") while self-wounding brings relief from "bad thoughts" by giving in to them.

According to Tim, alcohol plays a part at times in self-wounding, "I'd say definitely sometimes when I've had like a drink of alcohol sort of thing, definitely more likely to then, sort of thing" (351-352). Although that was not the case at the first episode "No, didn't start off that time, didn't start off that way. Um, but er, I'd say I'm definitely more likely to when I have had a drink I suppose . . . Quite a lot " (358-361).

Tim experiences no craving to self-wound, "Um, I don't think so. No. Maybe like sometimes, the odd time, whatever, like, you know, not, you know not the majority of the time" (269-270).

There is still no suicidal intent linked to his self-wounding in his account.

Post-Scriptum

Although he has not asked for it specifically, Tim says he would like help for his self-wounding, if it was offered, "I suppose, yes, do want to stop doing it [*self-wounding*] now"(266). His key-worker from mental health services is "just aware of it, um, as I said, I don't really talk about it much, um, so she's er just told me about this [*research project*] and I was like yes sure like you know, but (.)" (290-292). Tim does not talk about emotional issues with his mother either "It's only my mum anyway I live with, so (.) so it's that and not really talk about that stuff no not at all" (304-306).
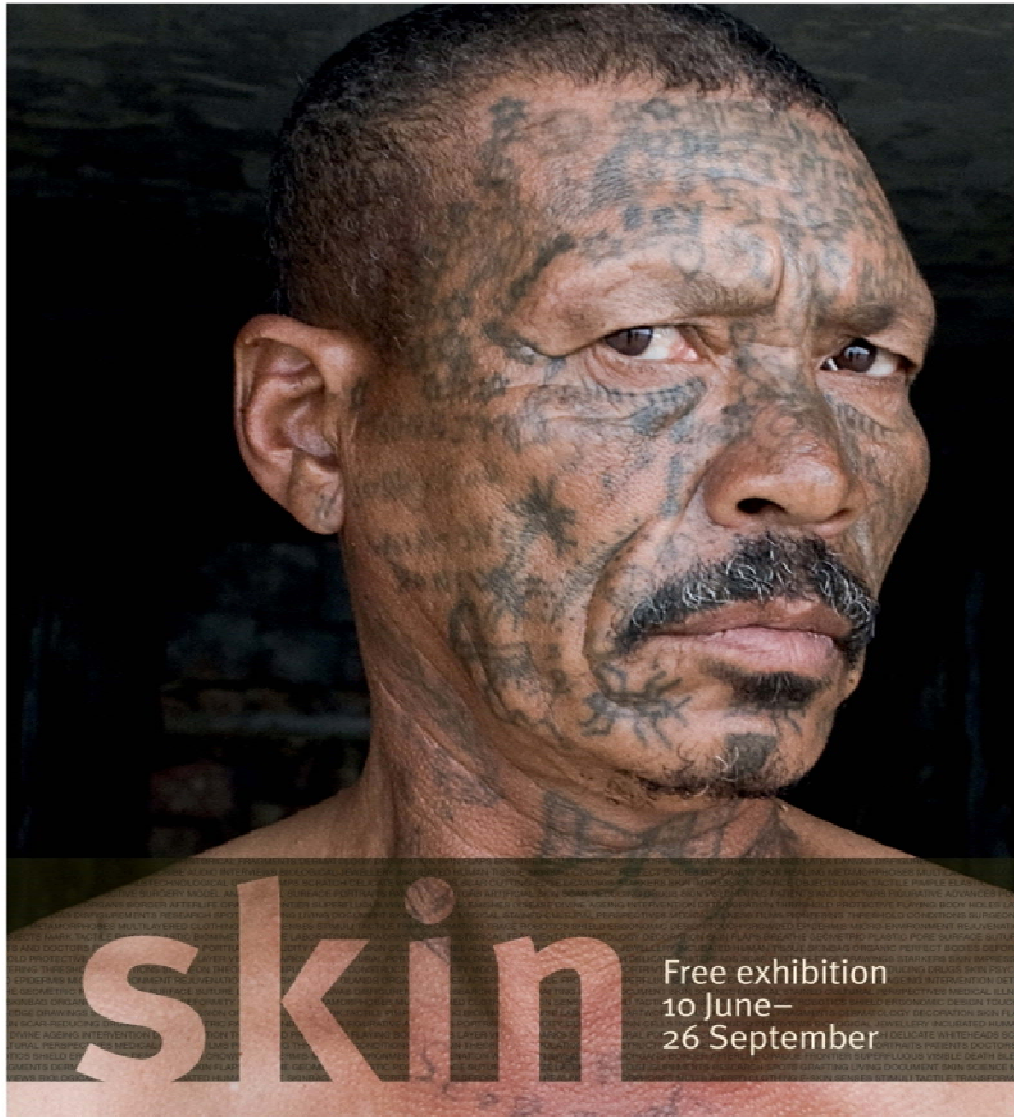
"Mr Green", 2008, Courtesy of Araminta de Clermont and Michael Hoppen Gallery.

This 2010 exhibition had striking examples of pieces of what I would call 'skin art', which showed how individuals allowed their inside selves to be exposed, sometimes through

tattooing or the effects of illness or simply life (aging, distress, accidents...). The recurrent theme was often a journey, reflecting a painful or a memorable event or time span in their life, depicting words and drawings. This is resonant of Liotard "altogether the marks on the flesh constitute a grammar of the bodies which enables us to read individual histories thanks to the (literally) incarnated signs"[1] (Liotard, 2003a).

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[1] "Ainsi, l'ensemble des marques apposées sur la chair constituent-elles une grammaire des corps permettant de lire l'histoire de chacun grâce aux signes incarnés, au sens littéral du terme", p321

PART III: DISCUSSIONS, REFLECTIONS and CONCLUSIONS

First, in the Discussion, the shared elements from the narratives presented in the previous chapter are brought together. Then the most significant concepts are drawn out. Finally, reflections and limitations of the study along with suggestions for further research are discussed, and recommendations for health services are outlined.

CHAPTER FIVE :   DISCUSSION

5.1   SHARED ELEMENTS ACROSS NARRATIVES

One of the key findings from the narratives relates to the importance of emotions and feelings and the factors contributing to the build up of emotional tension and inner turmoil leading to the first episode of self-wounding. At subsequent episodes, the functions of self-wounding are highlighted.

5.1.1   Emotions take centre stage

The narratives of the pathways leading up to the first episode highlight what can be described as the emotional 'mass' in which the participants were immersed and which underpinned the build up of emotional turmoil and tension they experienced. The most reported emotions and feelings were: anger, frustration, guilt, feeling lonely/isolated, feeling out of control (losing control/ feeling disempowered), depression, low self-esteem/ worthlessness, desperation, feeling unwanted /feeling abandoned and feeling stressed. I examine some of the more prominent emotions and feelings and their role in the build up of tension.

Anger

Anger was the most prevalent emotion reported by participants and was often represented as a driving force in the build up of emotions. It came in different forms.

There was anger towards others. This occurred when something was done to the participant, for instance when they were hurt by someone else (physical, emotional or sexual abuse); when feeling ignored while constrained by rules; as a result of extreme stress and frustration; or when something was not happening, such as waiting for a hospital bed. However, if this outward anger was felt, more often than not it was turned against the self rather than the person or persons causing the distress. This resonates with Aristotle's description of anger as a kind of impulse, "[*comparing a scientist's and a dialectician's views*] The latter would define anger as the appetite (*orexis*) for returning pain for pain . . ." (cited in Robinson, 1996, p. 20). Such anger had different uses and declensions (or tonalities), it rarely functioned as a single entity and was context dependent. It was fed by other emotions such as shame or guilt, or it

fuelled other emotions and feelings, such as worthlessness, extreme frustration and feeling of loss of control. The association between anger and low self-esteem, could turn anger onto self when the person did not feel allowed to be (outwardly) angry. These declensions show how the embodiment of anger in particular contexts highlights the complexity of the emotion.

Guilt

Guilt is interesting. As a concept, guilt brings with it a notion of condemnation and punishment. However, a person may feel guilty but not actually be guilty of anything in the criminal or societal sense and yet may pass judgment on themselves. Taylor (1996) highlights the moral dilemma at play,

> The vague and often inarticulate notion of an authority plays a role in guilt is analogous to that played by the notion of an audience in shame: in accepting what he has done as something forbidden the person feeling guilty thinks of himself of being under some authoritative command. He may of course come to question and reject the authority. (1996, p. 57)

For some, there was no room for self-compassion. If anything, they did not reject this (unnamed, invisible) authority but affirmed it and the harsh guilty verdict they passed on themselves could be construed as a form of "evidence of expectation" (Tannen (1979/1983) & Hyvarinen 1994/1983 cited in Taylor, 1996, p. 184), where there is presence of not only the narrator's voice but also that of others in the shape of dialogue within the discourse. It is possible in some instances, that guilt was about responding to or pre-empting other people's expectations, a learnt or perceived social code of behaviour.

The presence of other voices - what we tell ourselves, what we think others think about us, etc.- could be construed as a form of double-voiced discourse echoing Bakhtin's "deliberate reference to someone else's words" (Bakhtin cited in Zappen, 2000http://homepages.rpi.edu/zappenj/Bibliographies/bakhtin.htm). Zappen argues that for Bakhtin this inserts

> a new semantic intention into a discourse which already has, and which retains, an intention of its own . . . introduces into that discourse a semantic intention that is directly opposed to the original, the second voice clashing with the first and creating 'an arena of battle between two voices'. (ibid)

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Using this dialogical model, an internal "hidden polemic" (ibid) can result in a strongly critical and judgmental voice winning over any other. This was a common experience for many participants who were self-critical about their thoughts, their emotional state or their perceived behaviour. This dialogical inner struggle could also lead individuals to being conditioned to think in a particular fashion, for instance being "brought up to feel guilty", which resulted in a participant acting accordingly, even though they knew deep down this was untrue. This created an impossible tension for them to resolve.

Frustration

The narratives highlighted a frustration with the social environment resulting in a feeling of disempowerment whereby participants had little or no control over situations or individuals which had a significant impact on their life: things happening/not happening, not being heard, being ignored, broken promises, not knowing how much others could be trusted, lack of information, etc.

Feeling in / not in control

Most of the narratives revealed that participants felt they had little or no control over their lives prior to the first episode. In some instances, being very young meant they were passive 'agents' in someone else's life (parental control) without the option of being able to walk away from abusive (emotionally and or physically), difficult or stressful situations. This illustrate a slightly different picture from the literature which only describes control prior to self-harm only in terms, and only when it does, of emotion control and not in terms of having/losing agency (Gratz, 2003; Gratz, Dukes Conrad, & Roemer, 2002).

Often participants experienced a loss of control over events, such as "bombarded by problems". Loss of control was sometimes over events but it was also due to other people taking someone's agency. This was experienced as very disempowering, rendering the person helpless.

Feeling isolated

Most participants experienced social isolation, which could take many forms; it could be actual or the fear of being isolated. Isolation could be the result of being ostracised, to varying degrees, from the social environment.

Isolation was also fuelled by low self-esteem. Not loving oneself was the outcome of not being loved by others (reality or perception) since self-esteem is a measure of the way others consider us (Le Breton, 2003). In growing up teenagers in search of identity, the body becomes hostage to anger and frustration and the centre of punishment or a means to actually come into one's own (LeBreton, 2003).

Social isolation could result from growing up or living in environments where the expression of emotions was either discouraged, stifled, spurned or had been downright impossible. These participants felt unable to or unequipped to express, or find a suitable outlet to safely deposit their emotional pain and often powerful and eventually overwhelming emotions and feelings associated with it.

In the sample the stories shows a varied picture of such difficulties. Many of the participants, for very different reasons (pride and sense of privacy, family culture, etc.) would not have contemplated asking for help. Others had tried but had failed to receive it.

Presence of suicidal feelings

Suicidal feelings were clearly not the dominant experience prior to the first episode of self-wounding. When they did appear, they did not equate with intent either. They were sometimes diverted onto a new focus, fuelled by anger and frustration or they were ambivalent, as if suspended until a decision was made and sustained by different motivations.

5.1.2   A Heady mixture.... The build up of emotional tension and inner turmoil

In the study, emotions and feelings never operated as single entities; there were complex interactions between them. They were always either the product of a combination of other emotions and feelings, or functioned in concurrence with other emotions and feelings, often presenting different facets, as with anger. For instance, if anger often fed feelings of guilt, worthlessness/low self-esteem, frustration or violence towards the self or a third party, the reverse was also true at times too.

Damasio talks about the complex interactions between background feelings, drives, motivations, moods and consciousness, to highlight the complexity of the different cognitive processes, each playing at different levels and at different times depending on the level of solicitation they receive (Damasio, 2000). This points to two elements:

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first, to the diverse and powerful combinations of emotions which all the participants talked about contributed which towards the build up of emotional turmoil that all of them, except one, experienced in various degrees, prior to the first episode of self-wounding. The build-up was recounted as an inner experience sometimes taking on a personae and ascribed agency (this "awful thing", the "ball", the "knot", the "bomb") or as a mass of emotions gathering momentum and power. This clearly evidences the presence of the Spring pathway as defined by Huband and Tantam (2004) as a "steady increase in tension until a threshold is reached" (p. 413). The second element relates to the idea that emotions are about movement, whether they operated on their own or with another: for instance, participants experienced 'guilt about', or felt anger towards someone else or themselves, which implies that their attention was drawn towards an –undefined- 'object'.

The complexity of the declensions of emotions and feelings highlighted by the narrative is in contrast to their common portrayal in the clinical self-harm literature where they are often reduced to single entities, e.g. 'anger', which can then be quantified and measured but are rarely described. This then leads to the suggestion of treatment with a problem solving approach, such as behavioural therapies. Their aim is to deal with emotional issues (Rayner, Allen, & Johnson, 2005; Rayner & Warner, 2003) by challenging the person to change their thinking process (Walsh, 2007; Walsh, 2006). This is another instance of how the biomedical model fails the person who self-wounds by focusing on the 'outside' (the 'behaviour', how a person responds to a situation as problem) rather than on the 'inside of the box' (the reasons why someone responds in the way that they do, the meaning).

For some participants, these feelings seemed to remain in the background until an event of some sort (e.g. a message not returned) brought them to their more immediate attention. As Damasio (2000) put it, "Sometimes we become keenly aware of them [*background feelings*] and we can attend to them specifically . . . In one way or another, however, background feelings help define our mental state and colour our lives" (p. 286).

5.2   The first episode as turn in the self-wounding narrative

5.2.1   The first episode is a unique experience

The narratives indicate that something happens at the first episode that later transforms the initial experience into a response practice to emotional pain.

An unexpected and surprising effect

Participants sometimes clearly sought pain from the first episode. More precisely, they say they "wanted to hurt", sometimes "desperately", by way of punishment for their behaviour, or hoping to be able to use physical pain as a tangible proof of the invisible inner pain. However, most experienced something which they say they did not expect, which was the release of tension and release of emotions and feelings. Although they did not actually talk of surprise qua surprise, there is clearly a 'ah-ha' or surprise moment. The effect was palpable through the language used by these people who were distressed to the limit of their emotional endurance: "unwinding of the self", "deflating", "big sighs", "strange" [in context meaning unexpected], "great, phyorr↑", "having control", "did feel good", "release of emotional stress", "felt good", "breathing out" etc.

The first episode kicks off an incidental learning process about something they did not expect (relief and release), nor consciously seek or plan. The fact that there was no intent to learn also contributed to the surprise effect. The strength of the surprise effect and of the effect of self-wounding meant that it is highly plausible that the participants paid enough attention to the experience for the encoding process to have an enduring quality. They used this new factual knowledge (relief and release) to successfully recapture the experience at subsequent episodes, which often happened very soon after.

There is no evidence that these participants even thought beforehand about self-wounding more than this particular one time. Self-wounding was about responding to an overwhelmingly emotional situation which they could not cope with any longer (apart from Kate for whom self-wounding was a means of switching back to reality). This refutes the argument of "premeditation" (Rodham, Hawton, & Evans, 2004, p. 80).

Considering the finding that something unique happens at first episode, confirmation was sought from the literature. This proved as frustrating a process as the initial
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literature searches on first times/episodes. It was only during the very last stages of this study that some kind of a breakthrough occurred. Upon a suggestion by Professor David Chalmers[1] (2010), who encouraged me, my attention was drawn to the theory of "one-shot learning", even if (in short) it is focused on subjects being the recipients of usually one experience, (often visual, although it can also be linguistic, etc.) while looking at how they are able to learn from that one time. Nevertheless this theory, in exploring how a brain subjected to high stimulus learns, presents interesting arguments. According to Liwanag and Becker, "Our brains have an extraordinarily large capacity to store and recognize complex elements after only one or a very few exposures to each item."(1997, p. 442). Thus, it is highly plausible that the first episode creates such high stimuli in the brain that a learning/encoding (memory) process starts at the very point a decision to self-wound is made. In this 'model', at the 'ah-ah' moment, participants were acutely aware of the phenomenal quality of the experience (as reflected by their own descriptions/designations in the narratives) and particularly attended to it, precisely because of the unexpected/surprise effect.

Through this first experience, participants also came to understand (conceptualise) self-wounding as "relief" and "release". Furthermore, it seems that the combination of the sensory (seeing the cut and the blood) and emotional (relief and release) experiences that take place within the first episode are important elements for the development/construction (cognitive process of this combined information) of the practice for all of the participants (except David who only self-wounded once). According to Chalmers, "Many of our experiences appear to pass without our forming any beliefs about them"(2003, p. 16). In this case, they clearly did. Chalmers also states that, "This sort of concept formation can occur with visual experiences . . . but it can equally occur with all sorts of other experiences: auditory and other perceptual experiences, bodily sensations, emotional experiences, and so on."(2003, p. 16). It seems clear that this quality (high stimulation) was such that it was able to override other cognitive processes, in particular intention in the shape of suicide attempt. Lauren is a good example of this as she hedged her bets until she started cutting and, as she did so, realised that self-wounding met her needs and rejected suicide.

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[1] Professor David Chalmers is a world renowned expert on consciousness and the mind.

Thus it could be argued that the first episode of self-wounding represents a developmental timing of critical emotional and cognitive importance, making it a unique experience. This emotional and cognitive experience creates a turning point in the participants' narratives and is a narrative in itself. However, if at present encoding mechanisms go a long way to explaining the functional aspects that lead to the first episode, leaving such an impression (literally) within participants that becomes constructed possibly within the episodic and autobiographical memory, and is then consolidated through further episodes, we are still missing another, phenomenological dimension, that would explore the qualia of the experience. This is referred to in the literature by what Chalmers and other materialists call the "hard problem" [2] of consciousness which would potentially help us understand why certain decisions are made in relation to experiencing self-wounding for the first time.

5.2.2   Transfer of emotional pain into physical pain

The discovery of release and relief was the first effect. The second, transfer of emotional pain into physical pain was often connected to the first effect. Some participants experienced physical pain afterwards while others did not. There was a conceptual transfer from emotional pain into physical pain which was felt to be easier to cope with, clearly expressed in the narratives. This is consistent with the literature, "Participants also reported that DSH externalized emotional pain, thereby making the pain more tangible, less abstract, and easier to understand"(Chapman, Gratz, & Brown, 2006, p. 380).

The evocative language used in connection to the experiences of surprise and transfer, such as "wanting to hurt", is an echo of the linguistic associations between the physical and social pain highlighted by MacDonald and Leary (2005, p. 206). The idea of a transfer of experiences designates a transformation in the narrative and the self-wounding map, from the inside to the outside; perhaps from the invisible to the (more) tangible.

5.2.3   Suicidal intent

At the very moment of self-wounding for the first time, only one participant was still unsure of their intentions. These changed as they started to experience the effects of

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[2] What is consciousness: http://thebrain.mcgill.ca/flash/a/a_12/a_12_p/a_12_p_con/a_12_p_con.html

self-wounding which cleared any remaining feelings of ambivalence; they then knew they did not want to kill themselves. This is consistent with Suyemoto's finding (1998) and Pembroke's argument (1994) that people self-injure to prevent themselves from committing suicide.

5.3 Subsequent episodes as second turn in the self-wounding narratives

All but one participant continued to self-wound beyond what had become the 'first time'. At subsequent episodes, the narrative took not one but several turns in so far that the participants did not just settle into self-wounding but experimented with it. Their narratives are journeys where participants engaged in self-wounding for a second then subsequent episodes usually quite quickly after the 'surprise' effect of the first episode. Participants said they self-wounded "quite a lot" in this initial period until self-wounding became more established mostly as a response to emotional pain. As time went on, some participants represented self-wounding as a coping strategy that acquired an addictive quality which often became an event of its own, detached from the original source of anxiety and emotional pain.

5.3.1 Coping

At subsequent episodes, the most common shared narrative in the participants' accounts is the representation of self-wounding as a regulatory coping mechanism, (re-)establishing a sense of emotional equilibrium, even if this period is sometimes of short duration. The literature confirms that self-injury, of which self-wounding is an aspect, does have an affect regulation function (Chapman et al., 2006; Gratz, 2003; Klonsky, 2007, 2009; Knock & Prinstein, 2004; Laye-Gindhu & Schonert-Reichl, 2005). However, because it has not so far looked at the first episode, the literature does not show how or when after the first episode self-wounding acquires this affect-regulating function. Most of the literature concerned with frequency only focuses on what it sees as "temporary relief" (Chapman et al., 2006, p. 379) which only serves to reinforce and strengthen the practice, "making this behavior considerably more likely when the individual experiences similar conditions in the future" (ibid). This fails to see the value of temporary relief as better than no relief at all, as illustrated in the narratives.

Some of the coping functions co-occurred or overlapped (Klonsky, 2009), (to punish one self and to get relief and release from the negative affects they described :

anxiety, isolation, self-hatred, anger, frustration, etc.) although the affect regulation function dominated in the narratives. This is consistent with the findings from the literature which report similar functions of self-wounding (Gratz, 2003; Gratz et al., 2002). However most studies have only looked at the effects of self-injury in terms of factors that might worsen the 'behaviour'. They have rarely attempted to conceptualise these effects and functions for those who engage in the practice. This is due to the use of prescriptive questioning, directing, and therefore limiting the choice and type of answers from participants. Polk & Liss (2009) is one of the rare studies which sought the meaning that participants attached to the effects of self-injury without being prompted or asked to choose from a list. The result is a much more free-flowing picture of co-occurrences and of fluidity of the experience.

Sometimes self-wounding made self-conscious emotions worse (Lloyd-Richardson, Perrine, Dierker, & Kelley, 2007), for instance transforming a feeling of guilt at not being able to cope into guilt at having given in to the practice. In particular, some participants were affected by how self-wounding did or had the potential to affect others, such as close family or friends.

Rituals, like elements of magic, had a duo protective self-controlling and coping function in the narratives of those participants who had integrated them in their self-wounding practice. Sometimes they seemed to have other protective properties, for instance by giving options (keeping blades just like some former smokers keep cigarettes) which was a form of retaining control. Rituals, as private acts, had a prime subjective meaning to them (Le Breton, 2003). However, participants also said they were aware that it was only the self-control rituals offered was only perceived control. They talked of the ambivalence of this effect and how the need to perform the ritual sometimes became as important as the act of self-wounding itself.

5.3.2   Clearly making the difference between self-wounding and suicide

Narratives at subsequent episodes confirmed that participants continued to make a clear difference in their mind between self-wounding and suicide attempt. They were very clear about the degree of intent and the type of motivation involved in both instances. This was often expressed in terms of "wanting to hurt", "to feel pain", "wanting emotional pain to go away", and so forth. Only one participant toyed with

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the idea of further testing himself a few times but always knew that his choices were directing him towards living rather than dying. This confirms the survivor self-harm literature which clearly states that "Suicide is final. Self-harm is a release from emotional pain and a struggle for survival" (Pembroke, 1994, p. 22) or the anthropology literature "Physical [self] attacks are the opposite of suicide" (Le Breton, 2003, p. 56)[3].

5.3.3   Gaining or regaining control

Gaining or regaining a sense of control was one of the most important functions and effects of self-wounding reported in the narratives. Control in the narratives was at least as much about what was happening in their lives as about self-control and the regulatory effect of emotions. The participants were individuals who experienced little or no control over events. They also lacked control over people who exerted control over them in one way or another, at times to the point of inducing fear, anger, frustration, loneliness and self-hatred in themselves. This appears in some of the self-harm literature, although most studies have totally ignored (re)gaining control over one's own life as a function (Klonsky, 2007, 2009; Klonsky & Glenn, 2009). This may again be a consequence of methodology.

Control is sometimes used as a protective means in an aggressive situation (MacDonald & Leary, 2005), for instance when individuals feel ignored or excluded, which resonates with most participants' accounts. However, the outcome of 'control' also often depended on the context(uality) of individual self-wounding narratives whereby the term 'control' itself was sometimes used in conflicting ways. When the narratives are located within the confines of the psychiatric ward, they reflect a need for control of the person's individual agency. However, from the perspective of mental health services, control is depicted as the containment of individual agency through the imposition of its own set of rules, from the very moment of admission when the person is submitted to a process similar to that of prison inmates (Le Breton, 2003) (searches, certain personal objects removed, being assigned a bed or a room and a psychiatric identity etc).In the narratives, when mental health services impose 'no-self-harm contracts' or threaten an individual with discharge from hospital or sectioning if

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[33] "Les atteintes corporelles sont à l'inverse du suicide"

they continue to self-wound, mental health services actively increase the level of emotional tension.

Through such forms of control, psychiatry institutionalises how it expects the person to behave and conform, which is a very "classicist" or "rationalist" (Curt, 1994) understanding and appreciation of control. Semantically, Frank tells us that "Control and chaos exist at opposite ends of a continuum"(1995, p. 100). It also confirms the self-harmer as a sick person who should be controlled. "This sick role is a modernist narrative of social control" (Frank, 1995, p. 81). This is what the social order expects. For Borg and colleagues, "The implications of the sick role for user involvement [*in their own care*] are to accept, rather than challenge the imbalance of power between professional experts and service user" (2009, p. 289). Cresswell (2005b), citing Peter Campbell, also reminds us that the survivor movement views the psychiatric social order, in particular the way it operates, as "'that ostensibly helping system'" (Campbell, 1992, p.117 cited in Cresswell, 2005a, p. 271), pointing to the contradictions of a system that should, but does not, help. This form of control is also akin to what Borg refers to as "microagressions" (2009, p. 290), whereby individuals are constantly subjected to accumulative and hostile forms of aggression (here being watched, being moved, being ignored, being threatened etc.) pushing individuals to the brink and over. Roberts (2010) goes further still and says that patients in the psychiatric system are effectively invited to be educated by, meaning surrender, to the dominant discourse, "thereby fully participating in the inhibition of their own existential possibilities and in the negation of their own active involvement in mental health services"(2010, p. 292). In the narratives, this resulted in conflicting discourses, whereby someone could be at the same time threatened with discharge and sectioning (Johnstone, 1997) when they challenged the lack of emotional support they felt they were entitled to, or when they did not resign themselves to being compliant patients to the dominant social order. The self-wounding of participants on the ward reflects a dialogical duality between loss of control and desperate attempts at gaining or regaining it in spite of being controlled. The decision not to be compliant was an act of defiance.

The psychiatric discourse focuses on the outside of the box (the behaviour) while Jim's discourse focuses on the inside of the box (the inner chaos, the self and agency). This conflict bears consequences,

> To deny a chaos story is to deny the person telling this story, and people who are being denied cannot be cared for. People whose reality is denied can remain recipients of treatments and services, but they cannot be participants in empathic relations of care. (Frank, 1995, p. 109)

The irony is that mental health services' control approach created more emotional chaos (less control) leading one participant to self-wound for the first time, and the other to increase their self-wound. The narrative accounts support the evidence against insisting on contracts (Strong, 1998, p. 172) and in the *Bristol Survey* "Many women reported being subjected to distressing 'behavioural' attempts to control their self-injury, such as ignoring it or threatening to discharge them. Several reported having been excluded from services they wished to use because of their self-injury" (Bristol Crisis Services for Women, 1995, p. 19). There is a school of thought that supports these contracts and other so-called prevention methods (including "thought-stopping", (Favazza, 1996, p. 312) arguing that by preventing a person from self-harming, they will change their behaviour (Favazza, 1996). However, many professionals have come to recognise that such measures are counterproductive and unhelpful, "Asking individuals to give up self-injury when it is their best emotion regulation technique can be both unrealistic and invalidating. Clients may view efforts to contract for safety as an implicit form of condemnation."(Walsh, 2007, p. 1061).

Marc Rufer, a German medical practitioner says, "What is happening is a typical psychiatric vicious circle: in the end, symptoms caused by coercive measures confirm the diagnosis for the psychiatrist and retrospectively justify the exercise of violence"(2007, p. 388). Foucault, in *Psychiatric Power* (2003), stated that power can never be considered in isolation. It exists because it permeates different means of communication, is sustained by mutual agreements, differences in potentials and in shifts, and so on. Therefore, not being in control is at the opposite end of this. Individuals lose control in the asylum because they have no allies, because their position, their views, their identity, their agency have been isolated. Isolated, the individual patient is weak and vulnerable to the discourse of the institution. Psychiatric patients are not free subjects in the Foucauldian sense and are thus unable to enter

such power relations where they could stand their ground. This is possibly because they are the only patients within health services who, since the first Lunacy Act of the 1840s, can be forced to receive treatment without consent. This puts them in a default position of submission to the power of the psychiatric institution. The hospital narratives showed that the participants had no power and no means of exerting power. Self-wounding gave them at least the feeling of regaining power and therefore control.

The association between control and self-wounding also manifested itself in the choice participants made about revealing its existence to others and how others reacted to seeing the wounds and scars. For Jamie, Mary and Jane, as words were missing or failed, wounds and scars were a means to prove to others how much pain they were in. In the study, bandages served as proxies for wounds and scars, sub-texts of the suffering. The literature interprets this in widely different ways (Warm, Murray, & Fox, 2003). Sometimes the literature is neutral and does not place any judgement, moral or otherwise on this function (Lloyd-Richardson et al., 2007), whereas in other cases, it clearly points an accusatory finger (Favazza, 1989). For Nock & Prinstein, this is an illustration of the "social-positive reinforcement" function of self-injury (2004, p. 886); their stance is negative and refers to attention seeking and manipulative behaviour, usually of teenagers, which was clearly not the case here.

The body location of where individuals self-wounded served different purposes such as being a means of deflecting criticism from friends and colleagues or as a defiant gesture against any future potential assailant. Overall, however, most participants chose not to show their scars. Most of the literature does not explore the meaning of hiding the external marks of self-wounding. It talks about self-harm (and derivative terms) as being "secret", "private", "secretive" only as a counter-argument to self-harm being depicted as an attention seeking, manipulative practice (Nock & Prinstein, 2004). Only the sociological and anthropological literature has taken an interest by focusing on the skin as the framework of reference for our relationship to the world (Le Breton, 2003).

In the study some of the narratives highlighted the need for participants to keep self-wounding private because it was something that belonged to them, because it was

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part of them and because it was an experience that gave them back a sense of empowerment and control in their lives. Allowing scars to be visible potentially meant questions being asked, possibly lending themselves to potential criticism, and the sullying of their experience, including by those who are meant to be caring (health staff, friends etc.), therefore debasing their suffering, something which is often confirmed in the literature (Le Breton, 2003; Pembroke, 1994).

The issue of pain and its control presented different aspects in the narratives. After a while, some participants reported not feeling the same level of physical release they had initially or previously experienced. They had to cut deeper or seek other methods to reach the same level of release again (Favazza, 1996). The control over the depth, amount, type or frequency of self-wounding is something that participants said was important to them. Often it was about being able to manage the wounds themselves rather than having to seek medical help (self-wounding is private) and because they did not want to talk about it to others for fear of their negative reactions (Le Breton, 2003; Pembroke, 1994).

Self-wounding sometimes meant tolerating very high levels of physical pain. The normal function of physical pain is to protect or alert to danger. In self-wounding, this function is abandoned (Le Breton, 2003). For Le Breton, this is about "harming oneself to feel less suffering, to halt a flow of stifling suffering. The individual takes control over their body. The cut is a . . . symbolic means of restoring agency" (p. 94)[4]. In the narratives, participants who felt in control of the experience, as with self-wounding, were able to tolerate physical pain over time and/or to high levels. In other words, self-wounding pain is better (because it can chosen and mastered) than suffering (which is about the intolerable and always imposes itself).

5.4 Emotions and autobiographical memories

At subsequent episodes, it was found that emotions and feelings played a part in the construction of autobiographical (narrative) memories,

> Levine and Burgess (1997) have argued that the valence of emotions does
> matter for memory: they argue that the specific emotion will influence not

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[4] « Le fait de se faire mal pour avoir moins mal, de juguler un flux de souffrance qui étouffe. L'individu reprend contrôle de son corps. L'incision est une . . . modalité symbolique qui restitue l'initiative à l'individu »

just how much is remembered but also what within the event is remembered. In their view, emotions enhance memory for information that is 'functionally relevant' to the emotional state and what information that will vary from one emotion to the other. (Riessberg & Heuer, 2004, p. 5)

According to Arntz and colleagues (2005) "emotion specifically promotes perceptual memory, probably by better encoding of perceptual aspects of emotional experiences" (2005, p. 19). They suggest that this "might be related to the prominent position of perceptual memories in traumatic memory, manifest in intrusions, nightmares and reliving experiences" (ibid). Intrusive memories cued by external events could quickly trigger the evocation of painful events and their related emotions (Berntsen & Rubin, 2002; Conway & Pleydell-Pearce, 2000), leading participants to self-wound.

There is also evidence of a strong link between autobiographical memory and the construction of the self (Conway & Pleydell-Pearce, 2000). Liz tells how she has been battling throughout her life with her sense of self, starting in her teenage years by projecting a negative outcome (the enforcement of self-fulfilling prophecies). This is an example of self-schemas which, "when activated, generate 'possible selves' that is, selves, either feared or desired, that an individual might become" (Markus & Nurius cited in Conway & Pleydell-Pearce, 2000, p. 266). Here autobiographical memories show that they can contribute to the build up of emotional turmoil and ensuing self-wounding.

5.5   How a narrative approach offers a better understanding of the first episode of self-wounding

5.5.1   Not "on the way to language": When language fails or is failed

For Heidegger,

> Man speaks. We speak when we are and we speak in our dreams. We are always speaking, even when we do not utter a single word aloud, but merely listen or read, and even when we are not particularly listening or speaking but attending to some work or taking a test, we are continually speaking in one way or another. (1971, p. 187)

Through this statement, Heidegger acknowledges the power of language as vehicle of discourse. For him, speech was the externalisation of internal psychological movements as representations of human activity, either symbolic or conceptual. Such

movements are a reflection of our thoughts' own 'movements' which makes language, speech, a fluid experience, constantly in movement, undergoing transformations .

Self-wounding can be construed as a form of language reflected through the fluidity (movement) of the narratives, apparent through their construction, their turning points, and through the expression(s) of self-wounding itself. The narratives in the sample serve to show that language does indeed matter; it matters all the more when it fails. When language as words, as vehicle and a means of projection of thoughts, emotions and feelings do not come; when language is not allowed; when language is stifled; when language is ignored, that would "express emotions and thus symbolically keep suffering away"[5] (Le Breton, 2003, p. 77), something else happens, that is outside discourse (Frosh, 1999) precisely because discourse, language are not able to meet that particular challenge. This something else is "extra discursive and unnameable" (ibid, p. 383) but takes shape as self-wounding. Self-wounding suddenly affords an impossibly reasonable notion, a paradoxical solution and allows a different kind of language that symbolically focuses on and appeases another wound, another pain, supported by the skin, bringing together the inner and the outer selves in one locus, as with Jane. Self-wounding thus became (literally) embodied text, allowing participants to make sense of what was happening to them; the body, the skin were the main loci, the textual framework of self-wounding.

5.6   The quality of narratives prior to, at first and subsequent episodes

The narrative highlighted the presence of the "Spring" (tension reduction) and the "Switch" (impulsivity) pathways as defined by Huband and Tantam (2004).Their function was to give the narratives a general direction. In parallel, Frank's model (1995) maps the pathways by focusing on the self and the movement inside and around the narratives.

5.6.1   The Spring and Switch Pathways

The "Spring" pathway, the most prominent, illustrated a narrative of inner struggles with increasingly strong feelings and emotions which often had nowhere to go until they became too strong to be contained, and could only be released through the act of

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[5] "dire l'émotion ressentie et donc à tenir, symboliquement la souffrance à distance"

self-wounding. Its prominence serves to show the importance of such feelings and emotions in the mapping self-wounding in terms of effect, affect and regulation.

The "Switch" pathway was only represented in one narrative, which illustrated a story of apparent dissociation followed by abrupt reconnection to the world through the medium of unconscious self-wounding. Apparent dissociation as she does state that looking back she had been aware of tensions building up. Her case raises the question of how (and why) such individuals are constructed as 'Switch-es' rather than "Spring-s" and how she differs - or not- from other 'Switch-es' in crisis situations. Her narrative also suggests that there may not be clear-cut boundaries between the two pathways.

5.6.2   Narrative landscapes as loci of being and movement

Frank's reference to Holocaust stories incidentally offers an interesting parallel with self-wounding narrative landscapes, "The story traces the edges of the wound that can only be told around. Words suggest its rawness, but that wound is so much of the body, its insults, agonies, and losses, that words nearly fail"(1995, p. 98). In the study, this would be as much about the landscape of self-wounding (the wounds and scars, their location) as about the locus of (failed) expression. It also hinted at the fact that each narrative had its own unique textual and contextual landscape, steered by turning points and shifts, following a course that was anything but linear or causal, taking on different, erratic forms. Often, the thought processes that led up to the decision to self-wound at first episode highlighted a chaotic inner emotional journey and landscape, a "locus of being"[6] (White K., 1987, p. 73) where the participant struggled, and juggled complex interactions between events, emotions and feelings.

There was much narrative "wreckage"(Frank, 1995) in the "locus of being" of the participants when events took place which wrecked the course of their lives. This took place mostly prior to the first episode through (different forms of) abuse, social isolation, rejection, grief, instances of rape, and so forth. There were also fragments of "restitution" narratives. Crossley (2001) talks about individuals who, traumatised by life events, manage to rebuild their lives. One of the main ways in which they do this is by implicitly rebuilding images of self and world, which enables them to make sense of their trauma and helps explain the meaning and purpose of events to themselves. This

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[6] "localité de l'être"

process of rebuilding enables traumatised individuals to restore some sense of order (however rudimentary) to their lives.

Self-wounding allowed them to create a sense of reality that had meaning for them. For Liz, it was an evocative "unwinding of the self" which slowly empowered her to rebuild an image of her self and its relationship in the world.

Frank (1995), makes a similar point with "restitution" narratives (where the patient does get better, sometimes against all odds, sometimes before the illness has had a chance of having a negative impact), and the "restorable body" (p. 84). Applied to the study, this would translate as the 'restorable mind', although one should be wary of any kind of expectation of conformity to norms of behaviour. Some participants had moved on, in different degrees, from their earlier locality of being to a different and more positive (to them) locus, and created a space where a future has become possible and tenable, is somewhat restored. Some had stopped self-wounding. Some were still struggling with it but were making what was for them good progress. Others were in places where the present still largely dominated their lives, connected to different territories of memories, experiences, thoughts and emotions. For them, any "restitution" narrative was still somewhere in an unknown future, which sometimes came closer to them.

There are also fragments of "quest" narratives whereby individuals "have been given something by the experience, usually some insight that must be passed on to others"(Frank, 1995, p. 118), and moving it beyond their own lived experience. In their account, Liz, Peter and Jamie have identified gaps which their 'quest' hopes to fill or challenge. It is about something that did not but should have happened for them. In common is the idea of listening to someone's pain: as a confused teenager, as a man, as an abused child.

There are also what I would call 'paradox' narratives running through the participants' accounts, more particularly at subsequent episodes. The paradox pertains to the seeming contradictions (often arising from ambivalence) in the agency of some of the participants towards self-wounding. Why would someone want to self-wound or continue to self-wound, sometimes using painful methods as a means of having control over their lives, despite sometimes ambivalent feelings towards the act or

practice itself? Ambivalence too about how much control self-wounding really afforded some of the participants who sometimes felt compelled to self-wound; ambivalence about the feeling of guilt that came with self-wounding. This ambivalence is well documented (Spandler & Batsleer, 2000). The paradox itself is often picked up in the literature as a contributing factor for the negative attitudes (incomprehension and rejection, sometimes disgust) practitioners and others express towards self-harmers (Babiker& Arnold, 1997; Johnstone, 1997; McAllister, 2003, NICE, 2004, Pembroke, 1996). Kleinman (1988) actually argues that the biomedical model has an instinctive distrust of inconsistencies and tensions, preferring linear constructs.

But then, self-wounding <u>is</u> the (impossible) paradox. It comes into being at first episode in the shape of the realisation that it is a twofold event: the act of self-wounding itself and the effect of surprise of feeling release and relief rather than pain. The paradox is experienced as a better option than the alternative (being unable to cope any longer). A wound is created that offers an incidental experience that helps feel better, regain a sense of emotional equilibrium and peace, even power and control, even if temporary, as a means of exorcising the emotional pain. The wound, in effect, is the ultimate map of the narrative.

5.6.3   Turns in the narrative

Turns in the narrative were catalyst elements which shifted the direction of narratives prior to and/or after the first episode. The first episode was itself a turn, particularly in learning terms.

Turns had the power to contribute to the wrecking of an individual's narrative or to affirm an already existing narrative. Their power rested in their capacity to halt the movement of a narrative, before changing its course, often dramatically. They were rarely unconnected pieces to the individual's life although they could be, as in Jane's case (the first turning point being an assault by a stranger at a party). They also had the power to produce forward movement due to the arrival of new, nurturing elements (new partners, better family relationships, better self-understanding...). Through them a wreckage narrative could become a "restitution" (or "restorative") narrative.

These different narratives 'talk' about movement; 'are' movement, are in movement, directed by the thoughts, emotions and feelings that feed and connect them. As such

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they are the tectonics of the textuality (Curt, 1994) of self-wounding. This takes place within each chronological sequence and across the chronological order, with the first episode as the primary turning point of the self-wounding narrative itself- either side of which other turning points take place that move the stories in one direction or another.

The narratives recounted by the participants do not really fit the 'beginning, middle, end' emplotment format, mostly due to the overwhelming amount of personal narrative wrecking taking place. They are 'unfitting' stories. This may also illustrate why self-wounding narratives are so hard to hear, because they are so full of narrative wreckage and seeming incoherence (apparent ambivalence and contradictions) which is the paradoxical epitome of self-wounding.

Being once more empowered also sometimes happened thanks to the supporting cast of 'third parties'. They were usually the first people prepared to listen and not judge. Bartholomew and Horowitz (1991) tell us that

> Epstein (1980) argues that compelling emotional experiences that are inconsistent with existing models are required to change them. Such experiences are likely to arise within emotionally significant relationships, such as those with a spouse or therapist. (p. 242)

The arrival of a new partner or of a more responsive mental health professional created opportunities for change, for better self-awareness, for nurturing and, therefore, the possibility of a future.

CHAPTER SIX: REFLECTIONS AND CONCLUSIONS

I start with some reflections and limitations to the study and offer a reflexive account of the impact of working as a survivor researcher. I then assess the main findings of the study and look at the implications for future research and for NHS practice.

6.1   Reflections and Limitations to the study

A methodological choice was made which aimed to reconstruct the narratives from the relative 'chaos' of the interview data. This aim was to turn the exchanges between researcher and participants into 'coherent' narratives, full of memory(-ies) and manageable affect. The chronological order was respected following the pathways

leading up to the first episode of self-wounding. The challenge however was to ensure that the landscape of chaos, movement, turns, emotions, feelings and dysphoria still came through for these renderings to fully become narratives and not "simple reconstructions of the calculations made by the agents of the action" (Ricoeur, 1984, p. 229). Thus, whereas the original interview narratives were about story breaking, this reconstruction process allowed story making.

My aim was to highlight transformation through the different periods prior to, at first episode and at subsequent episode, following Clandinin and Rosiek's definition of narratives as "the form of representation that describes human experience as it unfolds through time." (2007, p. 40). I am aware that this piece can only be a tentative representation (Clandinin & Rosiek, 2007). Therefore the emphasis has been on highlighting the narrative shifts and turns, following Huband and Tantam's pathways (2004) and Frank's model (1995).

It seemed that some participants used the original interview as an opportunity to make sense of their experience as a therapeutic space (Josselson & Lieblich, 1999) and then reflected this back to the researchers at the follow up interviews. It could be construed that some participants used the space (physical and psychological), the opportunity and the interviewers to construct forms of quest narratives, as an unconscious sounding board to the accounts of their reality and of their emotional cognition. This was sometimes clear in the way that for instance Mary produced a meta-analysis of her thoughts (in particular), how Tim and Peter engaged with the process, or Kate insisted to be interviewed.

There was something about settling into the interviews and, for some, taking their time to see if they could trust the person asking the questions and this particular space (physical and psychological). This was reflected for instance in the way they cautiously qualified certain events to start with and, as the interview progressed, moved to a more affirmative (more daring?) choice of language, more open about the true quality of an event (e.g. its effect on themselves or others) or something else. It is possible that there came a point in the interview when they started to be less aware of the unnaturalness of the situation and to trust the researcher more. As a researcher, I had to be mindful of the sensitivity of this particular engagement as this relation is based

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on trust and respect. Josselson calls this an "explicit and implicit contract" (Josselson, 2007, p. 539) between both parties which results in the degree of "openness and self-disclosure the participant felt was warranted and appropriate under the relational circumstances she/he experienced" (Josselson, 2007, p. 539).

This study was originally designed as an exploratory qualitative study for the NHS. When the study was developed for the University in parallel to the NHS project, I felt trapped by the quantitative (but still called 'qualitative' by academia) approach which was encouraged. Although it was a perfectly suitable strategy for the NHS contract, I intuitively felt it was ontologically and epistemologically inappropriate with regard to the stories. Negotiating a change of methodology was a difficult process. I also had to learn quickly about narrative inquiry and its context, and to think about designing a methodology which could work with what had come out of the NHS project. The eventual late shift to a more narrative approach, while taking into account a number of constraints (time etc.), was aimed at addressing at least some of the issues of the original basic thematic methodology. The approach was therefore a pragmatic compromise with a view to achieving a richer account of the phenomenon.

Working as a survivor researcher

The inspiration for this project had stemmed out of my very poor personal experience of self-wounding at the hands of the NHS and out of frustration at the way clinical research deals with the subject. My choice to do this piece of research, as a survivor researcher, has a 'quest narrative' dimension in itself: a blend of a need to promote a different message about the experience of self-wounding to those health professionals who have a textbook approach to self-wounding and fail to understand the 'pain inside-outside', too deeply fixed on a suicide ideation perspective, and a personal transformative journey through research.

I feel my experience had a positive impact on the subject overall. I was able to explore a subject which, from a user perspective, is so evidently crucial and yet remains ignored by clinical research. I was also able to fight at first from the NHS, then from the University, for different issues that had ontological and epistemological importance to me: a more experiential approach to the stories and a more ethical recruitment strategy for the participants. For example it was important to recognise the needs of

men within the wider gender awareness issues. This meant providing men with a choice of interviewer gender. Giving such specific thought to this issue revealed that my own assumptions, that men may might prefer to be interviewed by men, was incorrect; they actually preferred to be interviewed by women. It shows that spending the effort to think reflexively can uncover important information for future research – it is not just an exercise done to be politically correct. Finally, I was also able to support survivor testimonies into the world of academia in a more narrative fashion than is usual for the subject matter which, in itself, is a political act.

In addition, the fact that both my colleague and I are survivor researchers with experience of self-wounding seemed to help greatly with the collection of this highly sensitive data. This is about a certain balance of power that is not so much redressed between the researcher and the participant as at least tilted a bit more in their favour. I am aware that, even though participants knew of our experience, we were still primarily seen as people collecting data with a certain level of power over the process. This made me, us, very humble towards the participants and the whole process.

It is said that there is a danger of identification with the participant and their story, meaning that the researcher is then unable to remain 'objective' in their work. However, this objectivity which transforms what is being studied into an object, unconnected from the researcher, and research in a supposedly neutral activity belongs to quantitative and positivist qualitative methodologies (Clandinin, 2007). As a qualitative researcher, I refute this stance. I believe that a degree of identification is necessary as part of the relational process that needs to take place to make the research meaningful. As user/survivor researchers, we often share with our participants experiences of receiving similar treatments and of going through similar care pathways. These are common elements which form the foundation of an unwritten bond between service users and survivors. This echoes Clandinin, "What fundamentally distinguishes the narrative turn from 'scientific' objectivity is understanding that knowing other people and their interactions is always a relational process that ultimately involves caring for, curiosity, interest, passion and change" (2007, p. 29). We may then share similar experiences of psychological distress; in this case, self-wounding. Such at least partial insight gives user/survivor researchers an unusual and rich opportunity to explore and map the experiences of the participants
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which many academic researchers without direct experience of the subject do not share. It does not follow that user/survivor researchers are totally immersed in the 'emotional shoes' of the participants or to the point that they forget that they are researchers engaged in a particular (peculiar?) process. It does not follow either that as a survivor researcher engaged in this study I ignored the occasional ambivalent feelings that took place in the landscape of the interviews when for instance there were difficult issues or points I found difficult to agree with. I dealt with them by talking with my colleague and during supervision. In this study, I hope that my empathy, care, curiosity, passion, strive for change and integrity as a researcher are apparent.

Given the opportunity I would create a proper narrative inquiry design, one that would have a flexible enough framework to respond adequately to the voice of the stories rather than try to make the stories as 'data' fit within it. I would also ensure that I have continuity of supervision, which was not the case unfortunately.

Working on the study and reflecting on this type of work has been a very positive experience during which I have learnt a lot as a researcher and I have been able to use some of this knowledge in other projects, in particular a study on cancer advocacy, and in my political writings.

6.2   Main findings

The first episode is unique

If one considers the theory of "one shot learning" and, linked to it, the notion of encoding and conceptualisation of new knowledge for an individual, whereby new factual knowledge (relief from tension and release of emotions and feelings is learnt incidentally) and gets imprinted successfully thanks to a combination of high stimulus (powerful emotions and feelings) and strong attention paid to the experience (due to both the high emotions and positive effects of self-wounding), then the idea of the first episode is confirmed as not only an important experience but also a unique enhanced event in between a 'before' (pathways leading up to the first episode) and an 'after' (subsequent episodes).

The study showed that from an unexpected outcome, a process was started. It also showed that not only subsequent episodes were, unlike the first episode, often the

result of conscious choice, (though not "premeditation"), they were at first an attempt at recapturing the surprise (and successful) effect of the first episode before they took on a new function, mostly that of a regulatory coping mechanism. Later, self-wounding sometimes became an event of its own, its meaning and motives being detached from the original or earlier episodes.

While most of self-harm research uses data based on subsequent episodes, where practice is already established, this study contributes new knowledge to the field by attempting to highlight a learning model at first episode showing the importance of high stimulus and attention paid to the experience with the extensive support of narratives (and experiential evidence).

The importance of being in control

The study showed that one other significant finding was the importance of being in control of one's life. Most of the participants had little or no control over what happened to them prior to the first episode of self-wounding. The study showed that, paradoxically, the first episode allowed participants to start gaining or regaining control or a feeling of being in control. When everything else was out of control in the participants' lives, when language failed, their body was still theirs; they could use it to script and voice that 'silent scream', in their own language. Where agency had institutionally been taken away from participants, as within mental health settings, the issue of regaining control through self-wounding was no longer just about the self but about exposing a repressive and aggressive system.

Self-wounding is not about suicide

The study also confirmed that at first episode, self-wounding was not about a desire to die or a suicide attempt; this was also true at subsequent episodes. Even though some participants did have suicidal feelings at times, their self-wounding practice clearly revealed a determination to remain in control of the act, precisely because of the reported positive and protective effects it had for them.

Role of narratives in providing a better understanding

Although this was not a full narrative study but, by necessity of circumstance, a compromise, it still showed that narratives, in particular their quality, had an important part in furthering our understanding of the first and subsequent episodes of self-wounding.

Narratives served to show that language in particular does matter, all the more when it failed or was failed by external factors (social isolation, not being kept informed etc.). More precisely, when language was somehow denied while participants could no longer silence their emotions or distress, self-wounding suddenly afforded an impossibly reasonable, paradoxical solution.

Narratives were also important in highlighting the individuality and the complexity of the subjective processes at work for each of the participants, something that is often lost or diluted in much of the self-harm literature. In particular, the quality of narratives, their movement through the interactions between thoughts, emotions, feelings and mental states, wove and mapped journeys and landscapes of textuality and contextuality which were as important as the actions themselves. Often this happened against a backdrop of challenging life events and, for some, the often contradictory or punishing discourse of mental health services. Those maps were sometimes chaotic, full of hurdles and apparent contradictions or ambivalences. Upon closer exploration, these ambivalences and contradictions were in fact the paradoxical reflections of the often impossible choices participants were faced with. Sometimes these were caused by the very people supposed to be helping (such as health professionals and that "ostensibly helping system").

The narratives showed that no journey of self-wounding is linear or 'neatly causal'; nor is life. On the contrary, in the study the narratives were at the mercy of unpredictable challenges and only moved forward when supportive and non-judgmental elements entered the scene (e.g. new partners).

Each narrative was singular and idiosyncratic in its own right, pointing to the need for self-wounding to be treated in a genuinely flexible, imaginative and individual way by truly empathetic and well trained professionals who enable individuals to regain control and agency.

6.3   Suggestions for further research

Further exploration of first experiences of self-wounding, from a 'hard problem'

consciousness of the mind perspective

Such a study would move away from the functional aspects of memory and learning, and explore the qualia of the first episode. The methodology would use first person accounts and could ask the question "What does self-wounding for the first time mean?" looking to offer a more phenomenological understanding of the experience. It would move the attention away from the object onto the first person subject. By getting an insight into how individuals experience the first episode, a better understanding of the consciousness choices they make over any others could be uncovered, and so might a different perspective of the paradox of self-wounding.

Male self-wounding: masculinity issues

The study hinted that these issues seemed to have been critical in the construction and build up of the emotional states of the male participants prior to self-wounding. Such a study could explore the issue of attachment styles and self-wounding, when expressing the self is difficult or impossible especially in cases of social isolation and how failed attachment may become apparent as (though not equivalent to cause) risk-taking behaviours, ways of excusing/hiding self-wounding practice , coping with stress and pathways to self-wounding ("Spring" or "Switch").

The case of the "Switch" pathway

There was clear instances of ambiguity in the stories that could give rise to the following research question: Is there such a thing as a pure 'Switch? This would explore in more depth the phenomenology of the experience of the pathway.

6.4   Recommendations for health services

Pembroke (1994) and the Bristol Crisis Services for Women (1995) have already made highly valuable and still valid recommendations. A few more are offered here, partly drawn from the stories and from articles by the researcher (Donskoy, 2009a, 2009b). It is important that health professionals finally separate self-wounding from suicide ideation and understand that it is clearly about surviving extremely stressful situations.

It is important for individuals to be able to be enabled to regain a sense of agency in their lives. This cannot be achieved in coercive environments where risk is more important than trust and humanity.

Health professionals should receive proper skilled training in listening and hearing someone's distress, in other words in really taking an interest in the inside of the 'black box' as opposed to focusing only on the person's 'behaviour', symptoms and risk factors which detract from the story and authentic therapeutic work.

In the stories, stable, non judgmental, nurturing and supportive relationships often helped create new bonds with others (reference to an earned-secure style), life and humanity in general. They should be encouraged intelligently (not in a patronising fashion, knowing that these things may take a very long time to happen).
Finally, when offering support, it is important not to make presuppositions but to systematically offer a gender choice of therapists. This may be influenced by the person's own narrative, in particular when there is a history of abuse.

These recommendations are a reflection, from a survivor perspective, of the urgent need to support the salience of the first person, experiential voice, of all those who have experience of self-wounding.

INTERLUDE 3

EXCUSES THAT PEOPLE MAKE

Most of the websites that deal with self-harm have a self-help vocation, from a preventative to a more functional, educative perspective. The common aims are debunking the myths still surrounding self-harm and encouraging those concerned to seek help. The tone, content and presentation used differ according to the target age. Some of the websites also have light hearted spaces, such as this one:

- This is my excuse, hope you like: 'So I asked Brittany Spears for her autograph when she freaked an scratched me with her new nails, but calmed and said oops I did it again'
- Person: What are those marks on your arm? / Me: Oh my sister and I got into a fight... Who knew that forks could do that...
- I went swimming in a pool full of cheese-graters.
- I had sex with a hedgehog
- Just say: 'As it turns out, having unprotected sex with a porcupine is a bad idea', usually makes them leave
- Person: "What happened to your arms?" / Me: "Oh those, you see I got stuck at the grand opening of the new magnet shop in town. Shame they put it opposite a knife store." They look at you like a complete weirdo, might be because I'm laughing to much by then as well.
- Say your friend did it. i used it once and it worked the kid believed me.
- I was hanging out with Edward Scissorhands and he got a little too friendly.
- What you didn't see the little green men grab me wow you must be nuts": they will never bother to ask again.
- I fell out of a tree into a rose bush.

One comment:
> Before me and my girlfriend C. really knew one another we were in a big group of people and she asked me what happened to my arms and i told her to ask another time...when she asked i explained my story after the explanation she replied with "wow i seriously thought you fell out of a tree into a bush" i couldn't believe it she's also a very sheltered person though

Source: RecoverYourLife (RYL), http://www.recoveryourlife.com
(spelling/grammar left uncorrected)

EPILOGUE

The research question and the central theme of the thesis, the first episode of self-wounding, were grabbed from an open wound. The open wound of memories, frustration, trauma and hurt. My wound of wounds is not closed; its landscape remains embodied in different narratives: my personal journey, where it resurfaces every now and then; this piece of work as a form of Socratic enquiry, which had a striking beginning, a tumultuous middle and may or may not have an end. But it has not and cannot close until self-harm and self-wounding practice is not only truly better understood from a first person perspective but also until health services and the general public fully endorse the validity and credibility of this first person perspective.

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APPENDICES

APPENDIX 1

MANAGEMENT OF THE PROJECT UNDER THE NHS

Ethical approval for the NHS:

Ethical approval was sought and gained from the local NHS Research Ethic Committee (Bath LREC). The project was then signed off by the Avon and Wiltshire NHS Mental Health Trust's R&D Office.

University links and collaborations for the NHS:

Dr Jonathan Evans, Consultant Psychiatrist, Avon and Wiltshire Mental Health in Partnership NHS Trust (AWP) and Senior Lecturer in Psychiatry, Academic Division of Psychiatry, Bristol University.

Dr Simon Farrell, Senior Lecturer in Experimental Psychology [memory work) Bristol University.

Project Management for the NHS:

A steering group was constituted and was made up of:

- − Dr Rosie Jones, Coordinator Bristol Research Design Services (RDS, formerly known as Research and Development Support Unit);

- − Dr Jonathan Evans, Consultant Psychiatrist, AWP with an important record of self-harm research;

- − Two service users with personal experience of self-harm (one man, one woman).

The group met twice during the life of the project and there were regular email contacts between the researchers and the members of the steering group who have also expressed a wish to continue supporting the project beyond its involvement stage with the NHS.

Ethical approval for the University of Bath

The project was further submitted to and gained ethical approval from the University of Bath's Ethics Committee.

APPENDIX 2: TOPIC GUIDE

Stress: 1st episode self-wounding
How old were you?
What happened?

Looking back now…..

- Did you reflect about having S-Wounded?
- Could you tell why you S-Wed?
- Did you seek or think about talking to somebody about it?
- Who to? How? When?
- Anything you think is relevant to your first experience of self-wounding?

Did you do it again?

- When? How? Where?
- Why?
- Was it different from the 1st time?

Did you experience a feeling of craving to do it again?

Thoughts and feelings after S-W

- How did you **feel** immediately afterwards? And then later?

- What were your **thoughts** immediately afterwards? And then later?

- Were you aware of other people's reactions if known/visible

Feelings associated with the pain:

- Positive, negative, guilt, punishment etc.
- Did you seek medical attention?
- Did you manage the wounds(s) yourself?

After

At first episode

Why did you choose that method?
Deliberate?
Opportunity?
Influenced by other people's (experience/ talk)
Gathered with a view to do something
Why one method over another?
Did you consider others?

Spring (Tension) /
Switch (Impulse)

Context:

What was going on in your life at the time?

What were you:

Thinking? Thoughts
Feeling?
Physically feeling?
Aware of mental state? (e.g. was in a dream, automatic pilot etc.)

Looking at immediately before

- Where and when did it happen the 1st time?
- How long did the episode last?
- How did it feel?:
  - Physically?
  - Emotionally?
- Any associations?: as with migraine: colours, smells, pictures…?
- Thoughts going through their heads
- Thoughts about what was going to/could happen as a consequence? (might die, might bleed to death?....: **this is to check suicidal intent)**
- Did they think about getting help?
- Was the S-W visible or hidden?

Experience of pain: physical and/or emotional

- Did you feel any at the time? or only afterwards or both?

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APPENDIX 3

Title of the study: **A Qualitative Study Exploring the Memories of
the Pathways Leading up to the First Episode
of Self-Wounding**

Screening Questionnaire

**We are aware that people self-wound for different reasons. This study
is only looking at people who did not intend to end their life when
they self-wounded.**

**The following questions will help you and us decide if this study
applies to you**.

Are you male?   ❑

Are you female?   ❑

Have you ever self-wounded? (for instance cut, burnt or injured yourself
physically in some way on purpose?)
Yes ❑   No ❑

Have you self-wounded once or more than once? (this is just to give us an
idea)
Yes ❑   No ❑

Did you first self-wound after the age of 13 years?
Yes ❑   No ❑

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Your name:

Your address:

....

....

....

....

Tel: ....

Email: ....

How would you prefer us to contact you in order to arrange the interview? (please tick box):

By post: ❑

By telephone?: ❑

By email?: ❑

What time of day is best for you?:

..

**Please return in the self-addressed envelope provided.
Thank you.**

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APPENDIX 4

Invitation to participate in research

Information sheet for service users

Dear Service User,

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the information below, and discuss it with others if you wish. You can ask me if there is anything that is not clear, or if you would like more information. The details of how to do this are given overleaf. Please take time to decide whether or not you wish to take part. Thank you for reading this.

> **Study title: A qualitative study exploring the memories of the pathways leading to the first episode of self-wounding.**

What is the purpose of the study?
We are Anne-Laure Donskoy and Rosemarie Stevens. We are both service users with personal experience of self harm and we have always been surprised that no one has apparently been interested in trying to understand what happens the first time that people self harm. In particular, we are interested in talking to people who self wound, that is people who cut, burn or otherwise physically injure themselves. We are not looking to talk to people who only overdose.
By talking to people about what they remember of their first episode of self-wounding we hope to understand how and why it happens. For this reason we have chosen the two year period up to the beginning of the study when memories are still reasonably clear in people's minds.

Why have I been invited?
You are invited to take part because:
- The clinical team thinks you have experience of self-harm.
Or
- You have responded to a flyer or an advert about taking part in a research project looking at self-harm.

We are interested in your first experience although it must not have occurred before your teenage years. It is hoped that 10 people in total, 5 men and 5 women, will agree to take part.

Do I have to take part?
No. It is entirely voluntary. You can decide whether or not you want to take part. If you do take part you will be given this information sheet to keep and be asked to sign a consent form. If you agree to take part you are still free to withdraw at any time and without having to give a reason. This is not part of your treatment or care and a decision to withdraw, or to not take part, will not affect the treatment or care that you receive from the team in any way.

What will happen to me if I agree to take part?
The study will take a year, but your involvement will consist of one or maybe two meetings only.

This will take the form of interview which will last up to an hour. You will be invited to talk freely about the first time that you self-wounded and what you remember. You will be given a choice of where the interview will take place, e.g. at home, at the offices of Bristol Mind or at a day hospital. It is possible that we may speak to you again towards the end of the study in order to share with you what we have found out and to get your comments. You will not have to answer questions you do not feel comfortable with. You will be able to take breaks or stop the interview at any time.

We would like to tape-record the interview so that we have a good record of what is said. However, we will ask your permission to do this at the start of the interview. If you feel uncomfortable about being tape recorded, we will make notes of what you tell us.

You will be interviewed by Anne-Laure and Rosemarie, the two lead researchers; but if you prefer, we will try and offer you a choice of gender of the interviewers. All interviewers on the project will be service users who will be properly trained in interview skills and techniques and who will be bound by confidentiality issues.

When we meet up for the interview, you will be asked to sign a consent form. This is to confirm that you are happy to be interviewed for the project.

There will be a payment of £10 for taking part in the interview.

Costs
You will be reimbursed for any reasonable travel expenses if the interview takes place away from your home.

What will happen to the information I give?
After the interview the audio-recording will be written onto paper, without any details which may identify you. All information we receive will be treated in strict confidence and no details that would identify anyone will be used. We may use the information from the interviews to write a report or give presentations about the findings of the research. It is hoped that the findings of the study will be

published in health journals, because they may be helpful to other mental health services. We may include the words people say, but we will not identify who said them.

What are the potential benefits of participating?
You may find that talking about your experiences is helpful and you will be helping to improve the understanding of self-wounding.

What are the possible disadvantages and risks of taking part?
It is possible that you might find that taking about your experiences might be a bit upsetting. The researchers will understand this and will try to support you as much as possible. You will be free to take a break or end the interview at any time.

Who is funding and approving the research?
This study has been funded by Avon and Wiltshire Mental Health in Partnership NHS Trust under the small grant scheme. Bath Research Ethics Committee has approved the study.

Who can I contact for more information?
Call the lead researcher Anne-Laure Donskoy on (0117) **980 0388**. Feel free to leave a message on the answer phone (the volume will be kept to mute for privacy), or email: ufm@bristolmind.org.uk. [Bristol Mind is providing practical support to this study].

What should I do if I want to take part?
If you were given this invitation to participate document by the Clinical Team, please fill in the short form called **"Screening Questionnaire"** and return it in the stamped addressed envelope provided within the next two weeks.

If you do not want to take part, you need not do anything.

What if there is a problem?
If you are unhappy about the way the interview was conducted, please contact the lead researcher Anne-Laure Donskoy (0117) **980 0388**, or:
Dr Tony Soteriou
Director of Research and Development
Avon and Wiltshire Mental Health in Partnership NHS Trust
Hillview Lodge
Combe Park
Bath BA1 3NG

Thank you for giving this invitation your consideration

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APPENDIX 5

Research Consent Form

Title of the study: **A Qualitative Study Exploring the Memories of the Pathways Leading up to the First Episode of Self-Wounding**

Name of the researchers: **Anne-Laure Donskoy and Rosemarie Stevens**

1. I confirm that I have read and understand the information sheet dated [Version 1 – December 2005] for the above study and have had the opportunity to ask questions

   Please put your initials in the box

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

   Please put your initials in the box

3. I agree to be audio-taped

   Please put your initials in the box

4. I agree to take part in the above study

   Please put your initials in the box

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Participant's name …………………………. **Date** …………….

Signature …………………………..

Researcher's name ………………………….. **Date** …………….

Signature …………………………….

Researcher's name ………………………….. **Date** ……………….

Signature ……………………………..

Copies to: **Participant**   ❑   **Researchers' file** ❑

APPENDIX 6: EXAMPLE OF FIRST ANALYSIS FRAMEWORK, AT FIRST EPISODE, NOT DETAILED (JANE)

The original document consisted of the first and subsequent episodes. Only the first episode is represented here. The key indicators are mostly grounded in the protocol and in the topic guide, or emerged during the coding and immersion processes.

Age at first episode	Background	Context	Emotions	Awareness of tension building up	Suicidal thoughts	Suicide attempt	Response/ Method	Effect		
								Pain	Release	Control
About 20	Young working professional "Stubborn, independent very strong person that gets on with things regardless of how bad they are"	Sexually assaulted at a party Followed by time off work Was staying at parents' house for a spell Unable to leave the house	Anger at person who assaulted her Hating self for letting someone do this to her Worthlessness Frustration Feeling overwhelmed: Distressed and Crying all the time	Yes, very Been toying with self-harming	No	No	Cut top of thigh with a blade	Very little Stingy	Yes During and after Release from stress and anger Felt good Almost felt relaxed	Not mentioned as an effect

APPENDIX 7: EXAMPLE OF SECOND ANALYSIS FRAMEWORK, AT FIRST EPISODE, DETAILED (JIM)

Pathway Participant Jim First episode

Age at first episode	Background	Context	Emotions	Awareness of tension building up	Suicidal thoughts	Suicide attempt	Response/ Method	Effect		
								Pain	Release	Control
37½	Mum alcoholic Father mentally ill (now deceased) Has had suicidal thoughts since age 8 Suicide attempt (hanging) age 12 Workaholic Likes to be in control Period closer to 1st episode: Poor physical health Stress Reckless behaviour	Hospital admission (Advanced suicide plan) Incident during home leave Readmission Broken promise Mechanical response to distress from staff	Anger at staff Frustration Abandonment Disempower- ment Loneliness Depression Feeling betrayed	Yes	No links to suicide plan that led to admission (Very clear ☺)	No (Would have chosen other method)	Taking control: "Sticking 2 fingers at system by cutting"	A little sore but no pain	Yes Euphoria Feeling numb after- wards	Yes Regai- ning and retai- ning control

Subsequent episodes

Age	Background	Context	Emotions	Awareness of tension building up	Suicidal thoughts	Suicide attempt	Response/ Method	Effect		
								Pain	Release	Control
37½	As above	Pursuing formal complaint against Mental Health services	Anger Frustration Disappointment/ Failure	Yes	No	No	Cutting: Stanley Knife Razor blades (ritual element) Thumping walls Hitting doors	Not really	Yes Euphoria (watching the blood) Numb-ness	Control
37½	As above	As above & Reading ward notes	Deep depression	Yes	Yes	Yes	Self-poisoning	N/A	N/A	N/A
38½-39½	As above	Pursuing formal complaint against Mental Health services	Anger Frustration Disappointment/ Failure	Yes Strong internal debate about cutting or nor cutting takes place Issue of retaining control	Yes	No	Cutting: Stanley Knife Razor blades Thumping walls Switch Hitting doors Switch	No (Anger re-directed)	Yes Euphoria (watching the blood) Numb-ness	Control

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Stops for about one year

Age	Background	Context	Emotions	Awareness of tension building up	Suicidal thoughts	Suicide attempt	Response/Method	Pain	Effect	
									Release	Control
39½- 41½	As above	Got a new job – Problems with hierarchy Doing a lot for other people	Frustration Feeling out of control of the situation	Yes	No	No	Learnt response Cutting	No	Yes	Yes

Stops for 6 months

| 42 | As above | Temporary position for a few months Very stressful week at work & Brief relationship failing | Deeper depression Anger Feeling out of control of the situation | Yes | No | No | Learnt response Cutting | Yes | No | No |

Stops age 42

Further detail JIM

Overall reflexion about JIM: Male, 45 at time of interview

JIM is a "Spring"

Background

There is a heavy legacy of thoughts and emotions, associated with the family background in particular. JIM talks mostly about his mother and how her alcohol abuse impacted on him as a child. His father is mostly absent from the conversation.

JIM's Pathway and location

Location here is an interesting aspect of this pathway. The first episode of self-wounding takes place on an in-patient ward. It adds a different dimension to the context surrounding the first episode. JIM is quite clear that the ward experience had been the trigger to his self-wounding.

JIM had had suicidal thoughts and an actual plan leading to hospital admission. Once on the ward, JIM describes himself as a *"model patient"* who got on well with staff, the medication kicked in fairly quickly and there was a dramatic and extremely rapid upturn in his mood. He was sent on home leave (although in hindsight, this rapid upturn (feeling euphoric) was abnormal, maybe an effect of the medication, and he thinks he should not have been allowed to leave the ward) while waiting, hoping, to be discharged through a planned Care Plan meeting. JIM does not get on with his mother and a phone conversation with her during those two days on leave caused a similarly rapid change in his mood, this time downwards. Back in hospital, instead of being discharged, JIM finds himself formally readmitted. This was the source of strong disappointment and frustration. Further to this, his room had been given to someone else which he experienced as a broken promise. JIM was then put on 15' obs (suicide watch). Adding to this, the new room which made him feels disoriented and claustrophobic. He felt staff were resentful of his readmission because he had appeared well only a few days before and was initially meant to be formally discharged on return from home leave. The staff's attitude overall was pragmatic and seemingly unconcerned. No one paid attention to him or his distress; if he did not eat, he was not encouraged to eat. The only thing the ward seemed proactive in was to encourage him to take his medication (psychiatric and for his

asthma). Only physical, practical nursing was offered, it was *"very much a mechanical thing"* and there was no direct input from medical staff; no doctors talked to him.

By the second part of the three week admission JIM had therefore accrued a lot of *"anger and frustration by the lack of progress" (getting worse rather than getting better), by "the lack of support from the mental health system"* (the pragmatic approach) and felt very disempowered. He was put on 15 minutes observation which was not being implemented regularly.

He has been thinking about cutting *"for a while, it was a deliberate decision".* In full view of the observation desk and despite the 15 minutes rule, JIM dismantled a safety razor, pull the blade out and cut, "Almost like taking two fingers at the staff". In fact there was a gap of 25 minutes when he wasn't observed by staff.

> *I supposed I was partly trying to show a weakness in the system, that I could take control, and if I wanted to harm myself I could*
> *I did not want to be caught and censored but I suppose I didn't care.*

Staff did not notice at the time; only a visiting friend did, the following day. Once it became known to staff (friend reported the act), a nurse cleaned and dressed the wound but no one asked him about his reasons for self-wounding, "It was almost like they didn't want to talk about it".

Suicide or self-harm?

There seems to have existed a long standing struggle in JIM's mind. JIM had harboured suicidal thoughts since the age of about eight and made one attempt age twelve (hanging) at a time his mother *"was drinking a lot". "Suicide was never far from my mind"*

Later on he says there was a *"confusion* (in his head) *between suicide and self-harm"* which had led to a period of reckless behaviour, leaving things to chance. This behaviour went on for about eight few years by his reckoning, *"I was not actively suicidal but not really, but taking a lot of risks... not caring".* (See below, section on losing control). Considering that JIM had been harbouring suicidal thoughts from a very early age, the balance of probability would have to be in favour of suicide rather than self-harm.

However JIM is quite clear, on that occasion, if had intended to kill himself, his method would have been very different; either hanging or self-poisoning, but not cutting. JIM knows how to kill himself, he has a good knowledge of what to do for a successful suicide whether by cutting or by self-poisoning. JIM also had awareness of self-harm through his work although this he says did not play a part and that *"it was not part of my thinking, not at all"*.

Feelings at first episode and expressing feelings

Anger (at staff, the weak system), frustration, disempowerment and abandonment. The experience on the ward is the key to his feelings and motivation for self-wounding.

JIM says that he talked about his feelings and thoughts of suicide to staff *"prolifically"* but they never proactively discussed them with him. They only acted on some of his comments about what he might do, about how he visualised hanging himself and would for instance take away the cord to his gown. He experienced this as a dismissal of his distress.

Control

Control is the dominant feature of JIM's pathway. It is very important to him. Rather than a means of compensating for something, with JIM control is about *"demonstrating that, unlike my mother or father"*, two people who had no control over their alcohol or mental illness and anger respectively, he has control and has made clear life style choices; and cites veganism as an example.

Control presents different aspects

⮌**Losing control**

There is a very big fear of losing control in JIM's life and his hospital admission comes as a test to his need to be in control.

Shortly prior to his hospital admission, JIM had been losing control over life events, his physical health had been poor (asthma, tiredness, insomnia and stress through overwork) and he experienced betrayal through a particular incident (client stole hubcaps off his brand new car).

JIM does not like emotions because emotions, in particular *"conscious emotions"*, mean *"losing control".* He hates his anger because it reminds him of his father and his own anger. When things become very intense, he says he experiences emotional shutdown.

JIM also describes a period of his life when he behaved in a reckless manner, putting himself in danger. This usually happened while cycling. JIM says he was not often aware of the danger he was putting himself in unless he was with someone as people would then comment about it to him.

> I wouldn't be actively suicidal but what I've be doing is taking a lot of risks"
> (for instance, stepping onto the road not paying attention to traffic.

He says that sometimes it is almost like he was trying to provoke a situation, for instance an argument with the driver of a car he had stepped in front of, trying to find an outlay, an opportunity to let his anger out. Leaving things to chance is also the exact opposite of being in control.

⊃ **Disempowerment:**

JIM does not like to feel or be disempowered but feels very disempowered on the ward:

⊃⊃ **Through lack of information his treatment**

> *"I felt very disempowered on the ward…the fact that I was getting given medication, very heavy duty medication, and no one actually told me what it was for",*

> *"I once found out my medication had been changed, and they decided to change it but they didn't tell me about it".*

⊃⊃ **Through lack of support**

Feeling of being abandoned on the ward without anyone to talk to or to communicate his distress to as staff did not seem to take any interest in him

> *"Yes, I mean it was very much like that, I was actually just laid facing the wall, but all the time, and if I said no, they said fine".*

JIM acknowledges there was a "game of brinkmanship" going on between him and staff.

⮌⮌ **Through feeling disoriented:** New room after return from home leave. Some stability in his environment was important and being moved to a different room proved destabilising for JIM.

⮌**Losing freedom:**

The hospital admission came as a shock: *"I'd never been in a psychiatric unit before and suddenly feeling like a prisoner"*
For JIM the ward experience is one where he is controlled (medication, movements are restricted "I was told that I couldn't even go for a walk without somebody there", *"So there wasn't any help, it was basic they were keeping me contained".*

At subsequent episodes:

A further admission to hospital,

> *A lot of cuts, and I was actually admitted because I think that the cuts were getting very serious, and basically all my arm from the joint to my wrist was cut.*

JIM admits to "losing – not losing control but losing concern". One could argue that losing concern is a form of loss of control.

A suicide attempt is prompted by reading his medical notes (as part of a formal complaints process against the ward). JIM felt his self-wounding incident had not only been wrongly interpreted but the whole episode had also been dismissed "Cut himself on the ward, but this was not a serious attempt at suicide". The ward did not seem to make the difference between self-harm and suicide. *"They didn't ask me whether I was suicidal".*

Regaining control

⮌ Control through pride*:*

> *And also a bit of pride, the fact that I took control of things and it was two fingers to the nurses*

⊃ The situation JIM finds himself in makes him angry and frustrated *"it was a one time in my life when I felt out of control"*; deciding to self-wound allowed him to regain control

⊃ Self-wounding is attractive to JIM for the *"sense of control and the sense of power that it gives you".* This becomes especially true for him at subsequent episodes.

⊃ **At subsequent episodes**: There is a similarity (*"not a conscious thing"*) with his mother's drinking pattern (time of day and pathway/debate with self over cutting or not cutting): In JIM's instance, the pathway is about going through the motions rather than a process of emotional thoughts. On occasions when his mother managed not to drinking JIM would feel a sense of euphoria; if she did, he would be disappointed. However the similarity ends here. If he had self-wounded of an evening, he would feel shame the next morning and be very disappointed with himself, whereas his mother would feel or express no guilt, shame or remorse at having drunk the evening before.

Retaining control
Control over the act of self-wounding
"When I cut I feel in control"

JIM also has a very accurate knowledge of what will and will not cause damage (*"that's why I know how to cut my wrists"* and goes on to describe how cutting through tendons will lead to not being able "to grip the blade to cut your other wrist"; he is also aware of avoiding main arteries and tendons.

⊃ Control over the depth of cutting:

> *"I would never cut to the point where I needed stitches"*

> "because I didn't actually want anyone to know on the ward".

⊃ Control over the choice of method: JIM is in hospital so the choice of method is restricted to what is available. However he chooses to dismantle a safety razor, an instrument not normally meant to be taken apart. This emphasises the intention to go ahead with the act as this takes quite a bit of effort to accomplish.

⊃ About why he did not want anyone on the ward to know that he had self-wounded *"I wanted to keep it private"*.

At the same time there is an ambivalence in his feelings

> *"although I said it was control it may have also been a bit of a cry for help, you know like see my distress sort of thing"*

⊃ **At subsequent episodes:** While there is a similarity at a later stage with Mother's drinking pattern, JIM regains control after a particular self-wounding episode when he had a had a couple of glasses of wine and realised after while that he had been self-wounding without realising it.

> *"I decided then that I should stop drinking because I didn't want to – my mum was an alcoholic so I didn't ever want to go in her direction"*

⊃ **At subsequent episodes:** Self-wounding is still private: JIM is fairly self-conscious and sometimes holds his arm in such a way that they won't show

⊃ **At subsequent episodes:** the way that JIM keeps blades *("little stashes behind the sofa")* or hoards of medication in the house helps him keep in control of his need to self-wound, "It's more like I wanted to retain control, and if I do want to do it – it's like some people I think who give up smoking, will always keep a packet of cigarettes in the house".

⊃ **At subsequent episodes:** Overall, there is a lot of thinking going on with JIM. Is this a focus on mechanics rather than thoughts a way of avoiding thoughts and emotions?

Pain:

Hurt a lit bit, more soreness than actual pain.

Method:

⊃ **At first episode:**

Choice of method was determined by what was available, in this case a safety razor. Disposable razors are not meant to be dismantled; they take quite a bit of effort to take apart. Cut a few times but not deep enough to require stitches.

⮮ **Where:**

His arms

Subsequent episodes:

Feelings at subsequent episodes:

⮮ **Anger and frustration:**

Feeling out of control of the situation mostly. There would be a sudden rage, fed for instance by frustration at the set backs experienced with the complaints process.

⮮ **Guilt/shame:**

JIM would feel guilt and shame only the next morning if had not managed to resist self-wounding.

Looking back now: *"It got me through it. I've no regrets, no shame any more"*

⮮ **Role played by scars:** None. However he remembers not fixing the wall he had once so violently punched (outcome broken bone in his hand). He covered that hole with a poster. The hole served as a reminder of his emotions.

Self-narrative:

Although JIM spent a lot of time about self-wounding, there is no obvious presence of a self-critical narrative.

Triggers:

⮮ Follow-up from the complaint process started while in hospital

⮮ Reading his medical records issue

⮮ Loss of attachment: JIM cites the example of viewing two very intense episodes, back to back, of a science fiction series (X-Files). One was the end of a series and the other the final episode of the programme. The former was about one of the lead character losing her baby and he identified with her sense of loss. The latter represented the end of an era, of a long-standing programme. This is an individual who says lives emotionally a lot through watching fiction movies and for him these episodes made him experience a deep loss of attachment.

⮮ Having a bad week/stressful times

⮂ Arguments with the hierarchy at work

⮂ Problems with relationships

Method:

⮂ Razor blades:

There is a lot of control over the choice of method, cutting was always much more planned and thought about than other methods used.

There is no ritual element attached to this method: razor blades "cut better than blades from Stanley knives"; keeping blades used for self-wounding and keeping a stash of blades is about reminding him that he is in control; dismantling of razor was a one off in hospital; watching the blood is about comfort.

⮂ **Hitting door panels Switch and thumping walls: Switch:**

Less visible and less stigmatising. Much more as a result of sudden anger Treatment for associated injuries in A&E were easy to obtain while lying (DIY gone wrong, fall etc.) and brought commiserating comments from staff.

> There *"… would suddenly be a rage, and I'd suddenly lash out with my fists"*
> *"Just suddenly lash out, and anger and I'd hit the wall"*.

Hitting and thumping objects are clear representatives of the Switch pathway.

⮂ Where:

His arms

Pain:

Only the last cutting episode hurt quite a bit (which brought him to stop as it brought him no release, it had stopped working).

Thumping or hitting walls however hurt a lot whereas cutting barely did.

JIM describes himself as being a *"big baby, distressed by the sight of blood"* when it comes to pain and bleeding in ordinary circumstances. Yet he is able to cut and does not feel the pain from this act, despite inflicting a large number of cuts when he cut.

Release:

JIM experienced no pain at subsequent episodes, except for the final time, when it hurt and it did not work,. Otherwise:

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there wasn't any distress. It's like euphoric balls a slight numb feeling, like it was almost like I could see things happening, but I felt slightly outside of myself.

Frequency:

Once back home, cut quite a lot, quite often as a response to a disappointing letter as part of his formal complaint. He would get a down then cut. He remembers once cutting up to fifty times, which led to a hospital admission.

When:

⮱ At weekends (during brief period back at work) when there is a lot of empty time and feels lonely, then it becomes a ritual.

⮱ Parallel pattern between him and Mother's own drinking pattern: Early evening

Addiction/Craving:

Almost. To seeing the blood in particular: mesmerising. The way JIM describes the blood trickling down his arm feels like it is a comforting experience, something to look forward to; [he agrees]:

> *"Because I'd also cut in different directions, to watch the blood come down in different directions … Because if you look at it laterally, horizontally the blood tends*
>
> *to loop, and come down whereas if you come down that way, it tends to flow down the cut itself, till the cut ends. But when I cut laterally, because you can see on my arm I've got quite a lot of cuts going that way, and that way…"*

Telling/Showing:

⮱ **Telling:** *"I could just say oh I just damaged it".*

⮱ **Showing:**

> *"I do tend to sometimes sit in some environments with my arm facing downwards, because I only cut my arm in a certain area, and if someone looked closely they could see it, where I'd scarred. So I do tend to still wear some long sleeved shirts in some settings or I'd actually sometimes find I'd unconsciously got my wrist twisted slightly into my body, So that I'm not showing my cuts mainly because I don't want - I'm not ashamed of it, but sometimes I don't want people saying oh what's happened to your arm. I'm more than happy to talk about it, but not when I'm not prepared, when I'm not ready to talk about it, if someone just suddenly says what's happened to your arm, I don't particularly want to lie, but I don't particularly want to think I've got any reason that they should know about what's happened"*

Continuing or stopping?:

JIM stopped once but started again after a really bad week at work and a concurrent failing personal relationship. However the outcome was not as successful as before (no relief and it was painful) so JIM did not pursue self-wounding

Now JIM does not feel the need to self-wound, his life has changed a lot, it is more stable and he is a lot less distressed now.

This is an individual who has clearly spent a lot of time reflecting on the reasons for his self-wounding.

Sometimes, the thought crosses his mind, in particular when very stressed *"very briefly, little flashes".*

Post-Scriptum:

JIM is one of the two participants who were revisited as part of the validation process.

He was keen to highlight the fact that although he is currently experiencing a very similar situation, with loss of job, uncertainty about the future, bigger financial risk even, he has no desire to self-wound. This is partly, as mentioned above, due to the fact that he is a lot more emotionally secure than he has ever been.