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Women, self-harm and borderline personality disorder: a search for understanding

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For John and Hetty

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Abstract

Adopting a case study approach (Yin, 1984; Stake, 1995;) this study aims to explore the experiences of 'self-harm' by women who have been given a diagnosis of 'borderline personality disorder' (BPD) within one area of a Mental Health NHS Trust. By taking a material-discursive-intrapsychic approach (Ussher, 1999; 2000) this research explores the accounts that have been constructed around 'self-harm' and 'BPD' by mental health professionals working with women and women themselves. This research looks at the ways in which 'self-harm' and the diagnosis of 'BPD' are operationalised by professionals and the implications arising from these constructions and discourses when delivering services to women. The study also explores the narrative accounts of women who access the mental health care arena in relation to their experiences of 'self-harm' and 'BPD', and in particular how they have constructed and experienced such responses in their everyday lives.

The process of data gathering for this project was organised in two phases. In the first phase of data gathering eight mental health professionals participated in conversational interviews (Nichols, 1991; Conrad and Schober, 1998). These professionals worked for the Mental Health NHS Trust and each of them aimed to provide care, support and treatment for individuals accessing mental health services. The second phase of the research involved the participation of four women, living in the locality of the NHS Trust, in lengthy narrative interviews (Reissman, 1993). Data analysis for phase one drew upon the guidelines developed by Willig (1999; 2001) and for phase two Reissman's (1993) thematic narrative analysis and Langellier's (1989) personal narrative guided the analytical process.

Unlike previous research that has explored 'self-harm' and 'BPD' the present study draws upon social constructionism, critical realism and post-modern thinking. This approach has made it possible for an alternate way of considering 'self-harm' and 'BPD'. Individual women at material, discursive and intrapsychic levels experience this phenomenon. It's meaning to women, and to the mental health care professionals, has to be understood in relation to the specific historical and cultural contexts in which both are positioned and the dominant cultural discourses that exist at these times. By drawing upon a critical realist epistemological standpoint and adopting a material-discursive-intrapsychic analysis the present study has been able to incorporate these different layers of the women's subjective experience, and the different types of expert knowledge about 'self-harm' and 'BPD', into one framework. The present study has been able to explore 'self-harm' and 'BPD', both as discursive constructs and a set of symptoms experienced by individual women.

Contents

Chapter 1

'Self-harm' and 'Borderline Personality Disorder': How are they constructed in the Literature?

Overview

This chapter explores and reviews the research and literature in relation to the definition of 'self-harm' and the diagnosis of 'Borderline Personality Disorder' (hereafter referred to as 'BPD'). It aims to offer a historically and culturally situated account of the ways in which these phenomena have developed over time. In order to demonstrate this, the chapter opens by briefly outlining the principles that will guide the reader through the chapter by reflecting the broadly post-modern framework of the research. The chapter then locates 'self-harm' as a historical issue exploring its changing conceptualisation over time and the impact of this on women's current treatment interventions. In the second half of the chapter I will explore the development of 'BPD' within mental health and the recent identification and re-conceptualisation of this diagnosis as a mental health care issue. Finally, this chapter concludes with an examination of the literature that appears to position 'BPD' as a woman's mental health issue.

A move away from positivism

The first step is informed by critical theory, and questions what Gottschalk (2000) refers to as, '...the ideological biases of modern 'mind' sciences...' (p.22). Mental illness since the seventeenth century has been dominated by a realist/positivist epistemology and this approach has traditionally sought to locate the roots and causes of mental disorder in

individual biology (Ussher, 2000). According to Gottschalk (2000) such reductions are ideologically motivated and are thus neither neutral nor innocent. Further, such explanations tend to reproduce a certain worldview about the mind, about society, and about their interrelationships (Gottschalk, 2000). Furthermore, by failing to recognise, acknowledge and critically address the historical and cultural context in which individuals live, such accounts of human behaviour endorse the notion that the existing social order is 'sane', and that 'normal' (i.e. accepted, conforming) social psychological dispositions are indeed healthy (Gottschalk, 2000). The first step thus consists of questioning and challenging these ideas.

The post-modern movement

Following on, the second step, which guides this chapter, has its grounding in a broadly post-modern perspective and the concept of the 'self' in relation to this position will be discussed. Postmodernism emerged in the West from about the 1950s onwards and characteristically it means different things to different people. According to Lewis (2000) the three most common usages are:

1. post-modern art, literature, or architecture which refers to creative works that break from the modernist heritage,

2. post-modern culture which refers to the recent explosion in world cultures of mass media and transnational capitalism, and

3. post-modern theory that refers to the recent philosophical critiques of Enlightenment philosophy.

<div align="right">(Lewis, p.75, 2000)</div>

The focus in this chapter is on the third use and the work of post-modern philosophers and theorists, such as Jacques Derrida (1973), Michel Foucault (1965; 1979) and Jean-Francois Lyotard (1984) who have questioned the foundations of modernity and challenged the notion of a fixed meaning and a unified subjectivity (Weedon, 1987). As Gergen (1991) observes, the dominant modern view specified that the 'self' was a finite, rational, self-motivated and a predictable entity that is consistent with itself and others across time and contexts (see also Bauman 1996; Hall, 1996). The 'self' for modern theorists was therefore 'solid' and 'stable' (Gottschalk, 2000). In post-modern thought, however, this position is rejected as obsolete and ideological (Gottschalk, 2000; Gergen, 1996; Frosh, 1991; Weedon, 1987). The 'self' from the post-modern perspective is 'fluid' and 'liminal' (Gergen, 1991; Kvale, 1992) and it is a continuous process (Gergen 1996) that is constituted through the multiple relationships in which individuals participate (Gottschalk, 2000). Within this theoretical domain language is central, as it is the mechanism by which constructs in wider society are defined, characterised and internalised in socially specific ways (Scott, 1994).

Weedon (1987) asserts that language is the common factor in the analysis of social organisation, social meaning, power and individual consciousness, and this is how one makes sense and meaning of one's world (Doering, 1992). From this perspective, power is not identical to knowledge. They are mutually dependent upon one another, with power generating knowledge and knowledge initiating power (Arslanian-Engoren,

2002). Dickson (1990) contends that because knowledge is socially constructed, inherently transient and closely associated with power, individuals with power are able to control and regulate what constitutes the essence of experience and an individual's subsequent understanding of the event (Arslanian-Engoren, 2002). According to Alcoff (1995) an individual's perception of 'self' is therefore constructed, shaped and mediated by social discourse and cultural practices, not by individual motivations and intentions (Arslanian-Engoren, 2002).

The level of the individual

It must be noted that there are several authors that, although they recognise and acknowledge this epistemological framework, do not adhere totally to the suggestion that a sense of one's self is only constructed through language (Ussher, 1997, 2000; Bhasker, 1989; Pilgrim and Rogers, 1997). A brief comment will now be made to this theoretical stance because although critical thinking and an examination of the discourses and discursive practices that exist within society are important it is also necessary, according to Ussher (1991; 2000), to operate on the level of the individual. This is the third guiding principle of this chapter.

Ussher (1991; 2000) asserts that the language that individuals use has a personal meaning for them as well as having historical and contextual meanings. Ussher (1991; 2000) believes that individuals have a 'reality' that is real to them and is a part of their everyday experience, and that this requires acknowledgement. Language does not only represent the dominant discourse currently upheld within society, words can be a medium through which insight is gained into the life-world of individuals. Ussher (2000) cites the work of Bhaskar (1989) to give credence to her theoretical framework. Bhaskar

(1989), who adheres to a 'critical realist' stance, affirms the existence of 'reality' but at the same time recognises that its representations are characterised and mediated by culture, language and political interests (Pilgrim and Rogers, 1997). Thus, both the physical and psychological aspects of experience are acknowledged but are also positioned within discourse and the historical or cultural context in which individuals live (Ussher, 2000). According to Ussher (2000) 'experience' is a product of a symbiotic relationship between material, discursive, and intrapsychic[1] factors and she asserts that they cannot be considered without each other. The most radical premise in this approach is the acceptance of the legitimacy of the 'voice' and 'views' of the individual (Bhaskar, 1989; Pilgrim and Rogers, 1997) explicitly acknowledging 'subjectivity'.

A critical approach, the ideas of postmodernism and individual experience therefore inform this thesis. In the first part, an analysis of the clinical literature on the subject of self-harming behaviour will be provided. An effort will be made to highlight, through this historical review, how there has been a move in how such behaviour has been conceptualised and treated, and how women who exhibit such behaviour have been portrayed. In the second part, the historical developments that have resulted in the 'construction' of 'BPD' will be examined. The history of the meanings of the 'borderline' concept in psychiatry will also be explored which will illustrate how this diagnostic category, over the last century, has become feminised.

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[1] Intrapsychic factors are those which operate at the level of the individual and the psychological (See chapter 6 for further discussion).

'Self-harm': a definitional approach

According to Tantam and Whittaker (1992) there is no generally agreed terminology for the notion of 'self-harm'. For example, it has been referred to as self-injury, self-mutilation, deliberate self-harm, self-attack (Simpson, 1976; Morgan, 1979; Smith, Cox and Saradjian, 1998; Favazza, 1998), self-poisoning, intentional self-harm, non-fatal suicidal behaviour and self-inflicted violence (Kreiman, 1977; Walsh and Rosen, 1988; Briere, 1996; NICE, 2004). An explicit definition of 'self-harm' has been put forward by the World Health Organisation (WHO) on 'Parasuicide' (1993) and this states that it is,

> '...an act with non-fatal outcome, in which an individual deliberately initiates a non-habitual behaviour that, without intervention from others will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes which the subject desired via the actual or expected physical consequences.' (p.8)

A much shorter definition than the one adopted by the WHO (1993) is put forward in the draft guidelines of the National Institute of Clinical Excellence (NICE) (2004) on 'Self-Harm' according to this document it is, '...self-poisoning or self-injury, irrespective of the apparent purpose of the act.' (p.15) Other authors have characterised it as actions taken by an individual, which are deliberate, intentional and are of a socially unacceptable nature. For example, Feldman (1988) asserts 'self-harm' is, '...actions taken by a person causing intentional damage to a part of ones own body without conscious intent to die.' (p.35) Favazza and Conterio (1988) uphold a similar view and consider the behaviour to be,

'...a deliberate destruction or alteration of body tissue without conscious suicidal intent and if habitual may best be thought as a purposeful, if morbid, act of self-help.' (p.40)

Several feminist writers (Burstow, 1992; Arnold, 1995; Chipchase and Liebling, 1996; Pembroke; 1994) have described the contrasting definitions of 'self-harm' and argue that they all fail to wholly define the problem. They argue that 'self-harm' is a strategy that is used to cope with 'unbearable' experiences, particularly by women, and that many notions of 'self-harm' do not take this into account. The reason for this, they state, is because of the dominant and taken-for-granted assumptions of medical psychiatry that exist within society that base the reasons for 'self-harm' within biology. In 2000 Pembroke presented an explicit description of 'self-harm' that was offered by a woman for whom it was an integral part of her life,

> *'Self-harm is a direct, candid relationship and dialogue with powerful feelings, life circumstances and extra-ordinary perceptions. When our ability to cope, our capacity for living is stretched to the limit and our self-worth collapses, self-injury becomes necessary. Not a whim, not a wild impulse or wilful deliberate act. Simply necessary.' (p 22)*

There is therefore a divergence in both the literature and the health care field in the way that 'self-harm' is defined. However, the majority of the definitions do tend to concentrate upon, and highlight, physical forms of 'self-harm', for example, self-poisoning, cutting (Bongar, Peterson, Golann and Harridan, 1990; Langbehn and Pfohl, 1993), burning and interference with wound healing (Favazza and Conterio, 1988). On reflection, it might be argued that these definitions are limited when trying to understand

why women 'self-harm'. According to feminist writers (Burstow, 1992; Arnold, 1995; Chipchase and Liebling, 1996; Pembroke, 1994; Shaw, 2002) approaches need to begin with the women's perceptions, views and accounts of 'self-harm' and how these may be linked to their individual life experiences and position in the broader social structure. Shaw (2002) argues that,

'self-harm is a complex phenomenon with multiple meanings, which take on nuances of new meaning with individual women, as a woman self-injures over time, and with cultural transitions.' (p.209)

In light of the evidence presented it would seem that self-harming behaviour may be appropriately situated within the context of the socio-economic and political structure so that the critical events in women's lives that preceded their involvement in self-harming behaviour can be examined and explored.

Incidence and prevalence of 'self-harm'

Research shows that many acts of 'self-harm' do not come to the attention of healthcare services (NICE, 2004) and hospital attendance rates do not reflect the 'true' extent of the problem (Hawton, Rodham, Evans and Weatherall, 2002; Melzer, Harrington, Goodma, Jenkins and Brugha, 2002b). This is because many incidents of 'self-harm' are treated at home (Arnold, 1995). According to a survey of 76 women performed for the Bristol Crisis Service for Women in 1994/95, 74% had begun self-injuring during childhood or adolescence (0-19yrs) and 69% had been inflicting injuries on themselves for more than five years (Arnold, 1995). Further, a study conducted in Ontario in the early 1970s by Johnson, Frankie and Ferrence investigated incidents of 'self-harm' over 12 months in

nursing homes, general practices and hospitals. This piece of research showed that there was an annual rate of 730 occurrences of 'self-harm' per 100,000 population, committed by 559 individuals per 100,000 population, but they hypothesised that the 'true' rate was 1433 episodes per 100,000 (cited in Tantam and Whittaker, 1992).

In 1998 a report by the Department of Health highlighted that the rate of self-harming had increased so significantly in the United Kingdom (UK) that there was an estimated 400 cases per 100,000 population. This is higher than other recorded rates in Europe (NHS Centre for Reviews and Dissemination, 1998). To further support this, in 2002 a national interview study was conducted in the UK and the research showed that between 4.6% and 6.6% of individuals have self-harmed (Melzer, Lader, Corbin, Singleton, Jenkins and Brugha, 2002a; NICE, 2004). Overall, from this study, and other published research (Kreitman and Foster, 1991; Yeo, 1993) it has been estimated that at least 1 in 600 people 'self-harm' to such an extent that they need hospital admission and/or treatment (Tantum and Whitaker, 1992).

Self-harming, once begun, also tends to be repeated (Favazza, 1987; Favazza and Conterio, 1988) and it has been estimated that approximately one-quarter of all the people who attend a general hospital following an episode of 'self-harm' will die by committing suicide in the following year (Owens and House, 1994). This is between 50 and 100 times greater than the rate of suicide in the general population (Hawton *et al*, 2002; Owens, Horrocks and House, 2002).

Gender and 'self-harm'

'Self-harm' is reported as one of the top five causes of acute medical admission for women and men in the United Kingdom (Hawton and Fagg, 1992; NHS Centre for Reviews and Dissemination, 1998). However, many authors have noted that women are more likely to 'self-harm' than men (Pao, 1969; Simpson, 1976; Cross, 1993; Favazza, 1987) and studies suggest that rates are 2-3 times higher for women than for men (Hawton, Fagg and Simkin, 1997; Department of Health, 2002). When accessing service provision to receive support and treatment more women than men are shown to access mental health services for self-harming behaviour (Bird and Faulkner, 2000; Department of Health, 2001).

Research (Cookson; 1977; Horrocks, House and Owens, 2002; Department of Health, 2002; Burrows, 1992; Smith, Cox and Saradjian, 1998) suggests that women who 'self-harm' have described a wide range of behaviours that they have used to cause harm to their bodies. According to the Bristol Crisis Service for Women 90% of a sample of female self-harmers had cut themselves and a third had inflicted blows or scalded themselves (Arnold, 1995). Further, overdosing, burning with cigarettes or caustic agents, self-strangulation, inserting/ingesting sharp or other harmful objects (Cookson; 1977; Horrocks, House and Owens, 2002; Department of Health, 2002), stabbing, scratching or scraping their skin, gnawing at flesh, biting, picking at wounds, pulling hair out and banging their head against something (Burrows, 1992; Smith, Cox and Saradjian, 1998) have also been highlighted as ways that women harm themselves. It must also be noted that 'self-harm' can also include many behaviours that are culturally and socially acceptable and which in turn can result in self-inflicted physical or psychological damage (NICE, 2004), such as smoking, excessive alcohol consumption,

drug use, over eating or dieting (Favazza, De Rosear and Conterio, 1989; Lacey, 1993; NICE, 2004). In addition, 'self-harm' can happen as part of a religious practice, as a form of political or social protest (NICE, 2004) or as an act of 'body enhancement' (Babiker and Arnold, 1997; Walsh and Rosen, 1988). Thus it might be argued that there is a divergence in both the literature and the health care field in the way that 'self-harm' might be defined within wider society.

Tracing the changing conceptualisations of women's 'self-harm'

Clinical encounters with 'self-harm': 1900 to the 1940s

Within the clinical literature Emerson (1913-1914) makes the first explicit contribution with regard to 'self-harm' in 1913 with a case study of Miss A. This account by Emerson reveals an approach to understanding self-harming behaviour grounded in *her* subjective experience (Shaw, 2002), a 'reality' which is real to her (Ussher, 2000). In this case, Miss A. relates her self-harming behaviour to a number of personal factors such as the nightmares of incest she experienced and distress over past romantic relationships. Emerson emphasises Freudian concepts, a psychodynamic perspective, to understand her self-harming behaviour. He suggests that cutting represents the tension between Miss A's difficulty in bearing psychic pain and anger as a result of the abuse she suffered (Emerson, 1913-1914).

Menniger (1935; 1938) provided the first systematic and most widely cited discussion of 'self-harm'. He still maintained a psychodynamic explanation and asserted that in all cases 'self-mutilation' symbolises a struggle between the life instinct and the death instinct whereby a compromise is 'struck' between 'instinctive' and 'repressing forces'

(1935, p. 450). As such, self-harming behaviour is 'an attempt at self-healing, or at least self-preservation' (1935, p. 450). He put forward treatment recommendations and these consisted of a holistic approach, which involved psychoanalytic psychotherapy, attention to family dynamics and the social environment. According to Shaw (2002) both Menniger (1935) and Emerson (1913-1914) conceive self-harming behaviour as a *meaningful phenomenon* that presents in 'normal' individuals in society. This is highlighted in Emerson's example of Miss A whom he describes as '...completely amenable, showing excellent judgment...' (1913-1914, p. 42) Furthermore, those who 'self-harm' are described in both pieces of research as complex, fully human, and possessed of subjectivity (Shaw, 2002). Thus, the level of the individual, and their reality of this experience seem to be acknowledged and taken into account here.

During this period however there was a contrasting approach put forward by Dabrowski (1937). In this research he differentiates between 'self-mutilation' in states of 'neuropathic dramatization and hysteria' (1937, p. 16), 'feelings of inferiority, guilt, or the need to be in the spotlight' (1937, p. 22), and he also stated that 'self-mutilation' was due to a 'lack of mental balance' (1937, p. 29). From this perspective, and the choice of language that is being used here, individuals who self-harm may seem to be being portrayed as lacking 'rationality', and as having a 'mental problem' or 'disorder'. In effect Dabrowski (1937) appears to be 'individualising' and according to Shaw (2002) assigning pejorative characteristics to those who self-harm. Similarly to Dabrowski (1937), Ackerman and Chidester, in 1936, analysed self-harming behaviour in adolescents; they stated that to hurt themselves was either a need to punish themselves for having sexual fantasies or a ploy for attention and sympathy. In light of the evidence presented here, and the language used by both Dabrowski (1937) and Ackerman and Chidester (1936) it would appear that from their perspective women who engage in self-

harming behaviour are portrayed quite 'negatively', are observed to be 'mentally imbalanced' and there seems little recognition of women and materialism.

After Menninger's work in the 1930s the literature in the area is scarce and the few publications and accounts that are given tend to be in relation to learning disabilities and other psychological disorders. According to Shaw (2002) the study of 'self-harm' became incorporated into the suicide literature and was not explored or investigated by the health care profession or academics. She accounts for this absence of publications in the area by claiming that what was actually investigated in this period was exclusively self-poisoning, which is the deliberate ingestion or inhalation of substances (Horrocks, House and Owens, 2002; Camidge, Wood and Bateman, 2003) not 'self-harm' (Kreitman, 1977; Pierce, 1977; Hawton and Catalan, 1987).

Clinical debate and 'self-harm' from the 1960s to the mid-1970s

After the early clinical literature it was not until the 1960s and mid 1970s that publications (Lester, 1972; Siomopoulos, 1974) began to emerge that highlighted the issue of self-harming behaviour by women in psychiatric institutions and in accident and emergency rooms. Once again the psychoanalytic framework was utilised, as a way of understanding the behaviour but now there was also an acknowledgement that relationships and the environmental context (Podvoll, 1969) may play a 'causal' role in self-harming behaviour. Research started to suggest that women were self-harming because they were unable to voice their feelings and experiences surrounding a loss in their interpersonal relations; and feeling increasingly numb as a result of this, they would harm themselves '...as a means of achieving reintegration and repersonalisation' (Simpson, 1976, p. 432). This behaviour was therefore seen as 'adaptive' (Novotny, 1972, p. 510) and 'tension-relieving' (Rosenthal, Rinzler, Wallsh, and Klausner, 1972).

For the first time, self-harm, according to Podvoll (1969), was being framed in a '...larger cultural context...as a dramatic expression of those patterns which are felt to be intolerable within the self.' (1969, p. 219)

Treatment of 'self-harm' during this period centred on psychodynamic therapy where the aim was to understand the women's self-harming behaviour and the meaning they attributed to this (Graff and Mallin, 1967). The use of medication was discouraged and staff were encouraged to build trusting relationships with the women voicing their responses to the women's behaviour; be it positive or negative feelings. The literature highlighted during this time that professionals had a mixture of feelings ranging from fear and anger, to feelings of helplessness and wishes to save the women. Mental health professionals during this period were encouraged to engage in honest and trusting relationships with women who self-harmed and sought assistance and support from their service. As a result, this may involve the views, opinions and responses of the psychiatric staff as being both positive and negative and the evidence in the literature has highlighted women being responded to punitively (Crabtree, 1967; Ballinger, 1971; Kroll, 1978).

Clinical descriptions of 'self-harm' since the 1980s

Since the mid-1980s there has been a growth in the literature trying to understand and explain self-harming behaviour. The psychodynamic approach continued to offer a rationale for self-harming behaviour based upon earlier conceptualisations, but there were also significant contemporary developments based on diagnostic classifications and an increased emphasis on the impact of trauma.

The first development in the conceptualisation of self-harming behaviour entails constructing the behaviour as a 'syndrome of impulse dysregulation' (Shaw, 2002;

28

Favazza and Rosenthal, 1993; Favaro and Santonastaso, 1998 cited in Shaw, 2002, p. 198). In this explanation the behaviour is viewed as 'addictive'. Interpersonal and environmental factors are de-emphasised and the cause is located within individual women and their inability to resist self-destructive impulses (Shaw, 2002, p. 198).

The second contemporary development was in relation to how self-harming behaviour may be a 'coping strategy' for trauma. There is a wealth of literature that highlights the role of childhood sexual and physical abuses, neglect and other manifestations of trauma in self-harming behaviour. This view advocates that individual women attempt to manage feelings of powerlessness, helplessness and intrusive memories of what happened to them by punishing their own body (Shapiro, 1987; Miller, 1994).

Lastly, the third contemporary development has its basis in neurobiological research and this highlights that self-harming behaviour has physiological antecedents and consequences, which cause the self-harming. As a result the individual woman finds it especially difficult to stop her self-harming behaviour (Stanley, Winchel, Molcho, Simeon and Stanley, 1992; Haines, Williams, Brain, and Wilson, 1995).

The contemporary developments in conceptualising 'self-harm', although different from the earlier literature at the turn of the century do share some commonalties. According to Shaw (2002) there is agreement in the literature that 'self-harm' is a response to psychological distress and the act not only provides relief but a sense of control for the individual (Favazza, 1996).

Current treatment for 'self-harm'

The research that has been presented in this review suggests that there has been a move in the way that 'self-harm' has been conceptualised particularly the identification of biological factors (Shaw, 2002) and the recognition of the consequences of trauma (Shapiro, 1987; Miller, 1994). Authors such as Shaw (2002) have asserted that it would seem likely that there would be a move in the health arena to more sympathetic treatments and portrayals of women who 'self-harm'. However, with regards to the current psychological, pharmacological and psychosocial interventions for the management of 'self-harm' today there are very few NHS services and specific intervention programmes that are for women who 'self-harm' (NICE, 2004). The treatments that are offered tend to be for both women and men despite the evidence that more women than men 'self-harm'.

Generic treatment interventions for 'self-harm'

The treatments and interventions, which are currently available in the NHS, fall into three broad categories: psychological therapies, pharmacological therapies and psychosocial interventions, each of which has a somewhat different rationale for their use. In 2004 NICE published guidelines on 'Self-Harm' and within this they had undertaken a review of the current clinical practice for people who self-harmed. The guidelines highlight that the provision of treatments for people who have self-harmed was highly variable. The document states that about 50% of individuals who have self-harmed and attend an emergency department do not wait for, or are not offered, a psychosocial assessment, and therefore receive no treatment for the problems that may have led them to 'self-harm' (Bennewith, Stocks, Gunnell, Peters, Evans and Sharp, 2002; Kapur et al., 1998; Horrocks et al., 2002). Further, for those people who received a psychosocial

assessment, the services and interventions that are offered were again highly variable (NICE, 2004).

In the conclusion of the review the NICE (2004) guidelines argue that '...the evidence-base for the treatments of self-harm is extremely limited.' (p.173) as there is a lack of comparative studies (Feldman, 1988) and most studies that have been conducted are small, making generalisation problematic. The guidelines published by NICE in 2004 therefore focused primarily upon the link between 'self-harm' and suicide in women and men and may be of particular benefit to Accident and Emergency Departments.

In terms of treatment in the mental health services, the evidence suggests that there has been a move, in particular, from psychodynamic therapy to medication and short-term approaches (Grob, 1994: Shorter, 1997). Today, current treatment models in mental health focus on predominantly symptom removal (Conn and Lion, 1983; Roy and Linnoila, 1990), written treatment contracts (O'Brien, Caldwell and Transeau, 1985), cognitive-behavioural techniques (Linehan, 1987; Wood *et al*, 2001), medication and short-term approaches (Grob, 1994; Shorter, 1997).

Overall, the evidence and research presented would seem to suggest that there has therefore been a shift in the treatment of women who 'self-harm'. There has been a move from supporting women in a holistic and engaged fashion, with a focus on mean-making (Menniger, 1935; Emerson, 1913-1914) and the clinician-patient relationship (Shaw, 2002), to one that is characterised by disengagement with women who 'self-harm'. It would seem from the evidence (Walsh and Rosen, 1985; Rosen and Walsh, 1989) that the women service users are held responsible for the spread of 'self-harm' and according to Shaw (2002),

'...the roles culture, social structures, hospital environments, relationships and clinicians may play in fostering conditions conducive to 'self-injury have been omitted from current discourse.' (p.199)

Furthermore Shaw (2002) argues that psychological approaches, that facilitate the exploration and understanding of a woman's *world*, are in a large part given lip service comparative to other treatment approaches. Current discourse, particularly in mental health, frames the behaviour of women who 'self-harm' as 'treatment resistant' (Valente, 1991; Department of Health, 2002), 'a management problem', 'attention-seeking' and 'manipulative' (Feldman, 1988; Arnold, 1995; Department of Health, 2002). It would seem from the current review that the health care profession might have lost sight of the widely supported conceptualisation of 'self-harm' *'...as primarily an attempt to reduce symptoms of psychological distress'* (Shaw, 2002, p.200).

Today, in the NHS there are only a few known examples of services that work in partnership with women to minimise the risk of 'self-harm' with clearly defined policies and protocols, for example, Rampton Women's Service, Crisis Recovery (Residential) Unit, Bethlem Royal Hospital, Kent and a range of residential community based settings provided by the Mental Health Care Group in Denbighshire (Department of Health, 2003). The Department of Health (2003) therefore argues that more services and interventions are required and need to be developed that will effectively assess, support and work in partnership with women who 'self-harm' – primarily as a coping mechanism or survival strategy – in inpatient and community mental health services.

The development of 'borderline personality disorder' in psychiatry

The chapter now turns to the notion of 'BPD' primarily because women who self-harm are commonly diagnosed with this label by mental health services (Casey, 1992; Brodsky, Cloitre and Dulit, 1995; Department of Health, 2002).

Foucault (1965) argues in *Madness and Civilisation* that the difference between sanity and madness was constructed in the eighteenth century with the creation of the rigid distinction between 'reason' and 'unreason', and the incarceration of the mad in the specialised setting of the asylum (Foucault, 1965). However, the rigid distinction between reason and madness in the early nineteenth century was blurred, as physicians began to recognise that some service users who retained their powers of reason, appeared at the same time to be highly disturbed or showed emotional anguish (Wirth-Cauchon, 2001). The French psychiatrist, Philippe Pinel termed this "manie sans delire", mania without delirium and believed that it was characterised by unexplained outbursts of rage and violence, in the absence of impaired intellectual function or delusion (Castillo, 2000). Further, in 1835 the British doctor James Prichard formulated a new term called "moral insanity" for this unknown phenomenon and defined it as,

> '...a morbid perversion of the natural feelings, affections, inclinations, temper, habits, moral dispositions and natural impulses...without any insane illusion or hallucination' (cited in Mack, 1975, p. 45).

A range of further classifications and definitions were put forward throughout this period, for example, "moral imbecility" and "moral deficiency". According to Wirth-Cauchon

(2001) in order to deal with this ambiguous territory between reason and unreason, early psychiatrists started to use the metaphor of the 'borderland'. Henry Maudsley in 1847 wrote,

'...many persons who, without being insane, exhibit peculiarities of thought, feeling, and character which render them unlike ordinary beings and make them objects of remark among their fellows' (Maudsley, 1847, in Showalter, 1985, p.105).

These 'peculiarities', that Maudsley describes, were thought to be due to an individual's lack of control that was in turn related to their position in Victorian society. Physicians therefore placed emphasis on the lower classes and looked for individuals who transgressed social codes as being the signs of potential madness (Showalter, 1985). Thus, as Mack (1975) identifies,

'The concept of moral insanity enabled European and American psychiatrists to consider a vast group of patients and disorders that they had not previously considered as falling within their purview.' (p.3)

The interest of psychiatry in the concept of 'moral insanity' continued into the early twentieth century with the investigations into 'psychopathic states'. By 1905, Kraepelin had introduced the category of 'Psychopathic Personality'. He put forward that this type of personality fell into seven types – excitable, unstable, eccentric, liars, swindlers, anti-social and quarrelsome. Lunbeck (1994) points out that although the new category of 'psychopathy' may be useful it was also '...dangerously indeterminate' (p.65) as it incarcerated individuals '...so various, so numerous...so elusive that some wondered

whether it referred to anything at all.' (p.65) The classification of psychopathy was extended further in 1923 by the German psychiatrist Schneider to include ten sub-classifications, incorporating a much wider meaning regarding personality abnormalities of all types (Castillo, 2000).

In relation to 'BPD', the next stage in the development of the concept in the literature occurred within psychoanalysis in North America. It is suggested that the analyst Adolph Stern first used the term in 1938 in order to give a categorisation to a specific set of pathological criteria. He began to describe patients who appeared more disturbed than the 'neurotics' that were 'suitable' for psychoanalysis, yet did not show signs of outright 'psychosis', placing them as Stern wrote, on '...the border line between neurosis and psychosis' (1938, p.467).

It was felt by Stern that these patients appeared to be more severely disturbed than those who were enduring neurotic symptoms, yet they could not be classified as psychotic. Stern went on to argue that such patients showed evidence of conflicts to do with the earliest acquisition of a self. They withdrew from the outside world and turned it upon themselves. This group of individuals, according to Stern (1938), suffered from insecurity and anxiety, feelings of inferiority, hypersensitivity and had negative reactions to therapy. Overall, Stern asserted that the 'borderline' was a condition, which he felt, embodied both neurotic and psychotic features within the same individual.

The term 'borderline' did not come into wide use until 1953, when Robert Knight (1953) discussed the 'borderline state'. He wrote that this disorder could result from a combination of a number of factors that included trauma, disturbed relationships, and current stressors in the individual's life (Becker, 1997). During this period, the term

began to take on a more specialised clinical meaning and was viewed as a distinct character or personality type rather than meaning a descriptive location between categories (Wirth-Cauchon, 2001). Due to these discussions in the 1950s further debates began to develop in relation to the usefulness of this new concept of 'the borderline'. Some analysts questioned whether 'BPD' actually existed whilst others asserted that it was a 'wastebasket' term (Rangell, 1955).

During the 1960s there were further developments of the category as a discrete entity in its own right and the connections of the borderline condition with schizophrenia began to diminish. The key feature in the literature was that the 'borderline' individual lacked a stable *self* or a clear sense of *identity* and the roots of this disorder were seen to be in early childhood/early infancy. A diversity of treatment approaches continued to proliferate and by the late 1970s there were major discrepancies in the different psychoanalytic and psychiatric models for treating the individual with a 'borderline personality'.

'Borderline personality disorder' as an 'official' diagnosis

Within contemporary psychiatric discourse, the diagnosis of 'BPD' did not acquire official definition until 1980 when it appeared in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), which is published by the American Psychiatric Association (American Psychiatric Association, 1980). The DSM has a set of codes that are used to diagnose individuals with mental health problems. For the first time, the 'borderline' category became included in the official psychiatric nomenclature and it no longer had its basis in psychoanalytic formulations (Wirth-Cauchon, 2001). It became

one of the six new personality disorders included in the 1980 edition: avoidant, dependent, narcissistic, schizoid, borderline, and schizotypal personalities.

The criterion for 'BPD' was based upon a study of over eight hundred individuals who had been given this diagnosis. A factor analysis was conducted on the symptoms that they voiced and the main criterion identified was instability 'in sense of identity, interpersonal relationships, impulse control, and mood and affect regulation' (Spitzer, Williams and Skodol, 1980, p.162).

Today, 'BPD' is classified as a severe personality disorder and is described by the DSM-IV (American Psychiatric Association, 1992) as:

'A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked inpulsivity beginning by early adulthood and present in a variety of contexts.' (p. 654)

This pattern is indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.
2. A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.

4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.

5. Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour.

6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).

7. Chronic feelings of emptiness.

8. Inappropriate intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).

9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

(Becker, 1997, p. 7)

The ICD 10 Classification of Mental Illness (World Health Organisation, 1994), which is a further tool used by psychiatrists to diagnose individuals, also suggests that those who experience this disorder will present with emotional instability. They will experience unclear or disturbed perceptions of self-image, coupled with chronic feelings of emptiness. It is noted that many sufferers will have a tendency to become involved in unstable or volatile relationships that may cause repeated emotional crisis. There is also a strong inclination to make excessive efforts to avoid real or perceived abandonment, which may manifest itself by threats of suicide or actual self-harm (Becker, 1997).

In recent decades, the validity of 'BPD' as a diagnostic entity in the DSM and ICD has been the subject of several studies (Sanislow, Grilo and Morey, 2002; Koenigsberg, Harvey and Mitropoulou, 2002). A key study by Farmer and Chapman (2002 cited in Trull, Steph and Durrett, 2003) that investigated the reliability of the 'BPD' diagnosis and

criteria, found that individuals who were screened for personality disorder features could be rated reliably. Other research however has begun to question and query the psychiatric view of this disorder and the medical and biological assumptions that underpin this stance. Aronson (1985) maintains that while there has been an array of systematic longitudinal studies performed the data has generally yielded interpretations and impressions rather than inter-rater reliability and statistical significance. Further, Zanarini (1991) found the DSM-III criteria to be over inclusive and lacking in specificity. Interestingly, Millon (1996) strongly argues that the 'borderline' label is used when a clinician is uncertain about a diagnosis.

Incidence and prevalence of 'borderline personality disorder'

'BPD' is the most prevalently diagnosed personality disorder in both medical and psychiatric settings (American Psychiatric Association, 1992; Skodol, Gunderson, and Pfohi, 2002). According to researchers Gunderson and Zanarini (1997) it accounts for 15% to 25% of all reported psychiatric illness within mental health. It has been estimated that there are 10% in outpatient settings, 15-20% in inpatient settings, and approximately 1-2% in the general population (Skodol et al, 2002). With regard to gender, those who are described as having 'borderline' personalities are predominantly women (Castaneda and Franco, 1985; Gibson, 1991; Gunderson and Zanarini, 1997; Swartz, Blazer, George and Winfield, 1990). According to Nehls (1999) of those receiving the label of 'BPD' 70-77% are female and many of these women may harm or threaten to harm themselves by engaging in self-harming behaviour. Gunderson (1984) states that 'self-harm' is unarguably the behaviour that is most readily recognised as 'borderline', even though, and this is important, this behaviour is by no means restricted to the "borderline" service user (Favazza, 1987; Becker, 1997). Furthermore, Gibson in 1991 from an overview of the issues of gender and BPD, profiled the typical borderline

service user as 'an 18-30 year old white female inpatient' (p.147) (Gibson in Wirth-Cauchon, 2001). Women therefore seem to outnumber men in this diagnostic category. So why is this happening? What is the relationship of gender in the delineation of the 'BPD' diagnosis? Why do women come to be the majority of those diagnosed with 'BPD'? An attempt will be made in the final part of this chapter to explore how the borderline concept has become associated with women and femininity.

The feminisation of 'borderline personality disorder'

In the early literature, which was predominantly psychoanalytic in orientation, the individuals who were described as having the BPD diagnosis were both men and women. No distinction was highlighted between cases in terms of gender. However, from the 1940s onwards women are predominately portrayed in the literature as having the symptoms of 'BPD'. Michael Stone (1986) cites an article written by Helen Deutsch in 1942 that he purports, 'laid the foundation for contemporary psychoanalytic formulations of the borderline.' (p. 48)

Deutsch describes women patients who appear to exhibit a superficiality and inner emptiness of their personalities. They appear to be 'normal' according to Deutsch but when examined closely they lack warmth or depth. These patients, '...do not belong among the commonly accepted forms of neurosis and they are too well adjusted to reality to be called psychotic.' (p. 90)

Others went on further to describe several cases, once again mainly women (Hoch and Polatin, 1949; Chessick, 1966), who showed a deeper level of anxiety and a wider variety of symptoms than the neurotic individual. By the late 1970s and the early 1980s,

the majority of cases discussed in the clinical literature were women (Ross, 1976; Chessick, 1982). When the diagnosis appeared in the DSM in 1980, the predominance of women was explicitly acknowledged in the definition, '...the disorder is more commonly diagnosed in women' (American Psychiatric Association, 1980, p.347).

The issue of feminisation, according to feminist writers (Showalter, 1985; Becker, 1997; Wirth-Cauchon, 2001), is a complex one. Prior to Dana Becker's comprehensive clinical study of women and 'BPD' in 1997, this gender specificity has rarely been discussed in the literature. Wirth-Cauchon (2001) argues that the construct of 'BPD' has changed over time in the direction of '...stereotypically defined feminine traits...' (p.66). Becker (1997) sees the feminisation of the 'borderline' category as having occurred through a process similar to that of hysteria, which has been conceptually related to women's sexual organs. She has compared the symptomatology of both of these supposed disorders. For both hysteria and 'BPD', the range and type of symptoms has expanded over time, so that it can be applied to more and more women for various illnesses. Like hysteria, 'BPD', according to Becker (1997) is a '...catchall or wastebasket category, a flexible diagnosis for a variety of stereotypically female behaviours.' (p.70) Becker further argues that the diagnosis of 'BPD' '...over the last two decades has been feminised in its very meaning.' (p.60) She provides evidence that shows how descriptions of 'BPD' symptoms have moved away from 'schizophrenic-like features' and towards features that stress emotions or affects such as, '...rage, depression, self-destructiveness (including suicidality), feelings of emptiness and emotional lability.' (p. 60)

Becker notes that what is interesting in this shift is that the features of 'BPD' have moved towards more feminine ones, towards emotions rather than more 'masculine' features. Thus, according to Becker's analysis, the placing of 'BPD' in the DSM in 1980 not only

marked the medicalisation of the diagnosis but also made it specifically a feminised diagnosis by emphasising feminine traits. Overall, Becker argues that, '…the diagnosis has been "feminised" and that it has become the new 'female malady' for the late twentieth century.' (p.24)

Another feminist writer in this area is Mary Jimenez (1997) and she notes that during the 1970s and 1980s, interest in hysteria declined and women were no longer being given this label for their apparent disorders. According to Jimenez 'BPD' emanated as a contemporary alternative because of the changes in gender roles in society and she further argues that the diagnosis of 'BPD',

'…represents new cultural norms for feminine behaviour in reaction to women's assertiveness and anger, norms that then translate into psychiatric definitions of mental pathology.' (p.162)

The diagnosis of 'BPD' she asserts '…delimits appropriate behaviour for women, and many of the criteria are stereotypically feminine.' (p.163) In order to support this point Jimenez cites a 1990 study (Sprock, Blashfield and Smith, 1990) that found that the majority of the criterion for 'BPD' was judged by health care professionals to be 'feminine qualities' apart from anger that was perceived as a masculine characteristic.

'BPD' is therefore a complex category, which describes a markedly diverse range of symptoms and according to feminist writers is applied to an increasingly large number of women who display what is constructed in wider society as disturbed or excessive behaviour. The changing meaning and uses of the 'BPD' diagnosis can be traced

through psychiatric discourse so much so that Becker (1997) writes, '...the originator of the term would likely not recognise it in its present form.' (xxiii)

According to Wirth-Cauchon (2001) the analysis of Becker (1997) and Jimenez (1997) provides a useful framework for considering the meanings that have developed towards the 'BPD' diagnosis since its emergence from the 1960s. The evidence has shown that over time the category has been feminised and it has been argued that it is the contemporary successor to hysteria. Becker's (1997) work in particular highlights the similarities between hysteria and 'BPD' and that, like hysteria, the diagnosis of 'BPD' '...is a 'label' or 'category' that is used for the troublesome female service user.' (p.68)

Despite this critical analysis there appears to be a lack of attention to gender in the literature on 'BPD'. Feminist analysis of women's emotional distress in this area seems to have illustrated that women's mental health needs, be they biological or psychological in origin, have become pathologised as unstable when they are judged against the rational norm.

Summary

In this chapter there has been an exploration and a review of the literature in relation to the definition of 'self-harm' and the diagnosis of 'BPD' and how both of these seem to have become constructed by psychiatry over time. Clinical discourse on 'self-harm' and 'BPD', current conceptualisations of 'self-harm' and 'BPD', treatment approaches and portrayals of these behaviour's, have real implications for women when they express their emotional distress. It would seem from the research and literature that 'self-harm' and 'BPD' may continue to remain poorly understood with few helpful treatment

43

approaches being available in mental health until women are given a 'voice' and allowed to express their own individual life experiences. It would seem that there needs to be a shift from positivism/realism to a critical approach that encompasses the *discursive, material* and *individual* aspects of experience all at the same time. This standpoint will be discussed in more detail in the proceeding chapter.

Chapter 2

Developing a theoretical approach

Overview

Building on the previous chapter the aim of this section is to outline the theoretical approach underpinning this research and to reveal my own ontological and epistemological stance within it. Throughout the chapter I endeavour to provide the reader with a reflexive account of the tensions and contradictions that I explored and negotiated my way through to develop my theoretical stance for the research. The present chapter begins reflexively with an account of how the research began and continues throughout to explore the steps that I took to reach the decision to apply Foucauldian discourse analysis (Parker, 1992; Willig, 1999; 2000) to phase one of the research and a Material-Discursive-Intrapsychic approach (Ussher, 1999; 2000; 2002) to phase two.

Reflexive pause – how the research project developed

The initial idea for the research project arose from my experience when I was studying to be a mental health nurse at Bradford University in the mid-1990s. Throughout this three-year training period I had the opportunity to meet many women who had been given the diagnosis of 'BPD'. Due to being a student nurse I had more time and opportunities than the qualified members of nursing staff to sit down and speak to the women who had been admitted to the various mental health units. For much of the time in my third year of training I worked on a one to one basis with women who self-harmed and had been

given a diagnosis of 'BPD' and I talked and listened to them about their everyday life experiences. Through listening to these accounts, and the discussions that I had with the staff whilst on the various placements, it seemed to me that both the professionals, and the women themselves, felt that they were being 'problematic' and 'disruptive' to the everyday running of the health care establishment. It appeared to me that little attention was being given to the 'fact' that most of these women had had traumatic past histories which had often involved childhood sexual and physical abuses and neglect. Sexual and/or physical abuse is one of the predisposing factors that have been largely ignored by researchers until recently (Whalen, 2004). One notable exception is Shapiro's 1987 article focusing on the connections between self-blame in incest victims and self-harm. According to Shapiro, sexual abuse survivors often blame themselves for the abuse, and thus, as adults they harm themselves physically as punishment for their "bad" behaviour. They perpetuate the cycle of abuse, and may express feelings of intense rage turned upon themselves. Survivors often cannot imagine themselves as lovable human beings. They also cannot physically strike out at the abuser, which leads to striking out at themselves. Van der Kolk, Perry, and Herman (1991) found that sexual abuse victims were the most likely of all respondents to cut themselves. The earlier the abuse began, the more severe the self-harming became.

Another factor that not only caught my interest and attention was that in most cases the women had engaged in self-harming behaviour. When the incidents of 'self-harm' occurred on the unit the mental health professionals, more often than not, arranged for the physical care to be organised and undertaken for the 'self-harm'. However, from my perspective, there appeared to be very little discussion with the women about 'why' they had harmed themselves. Professionals did not appear, to me at that time, to be interested in listening to the women's accounts of this experience.

From reflecting upon these experiences and through reading the literature and research that had already attempted to explore parts of this phenomenon a series of questions about this area started to go through my thoughts, for example, why do individual women harm themselves? Why do more women than men receive this diagnosis? What are the experiences of these individual women? All of this therefore impacted upon the choice and focus of the present study. In 2001, whilst working as a researcher at The University of Huddersfield, I found myself with the opportunity to undertake research in this area, and with the help of two academics at the University I approached the University Research Committee with a proposal for the research in 2002. After an interview the Committee accepted the proposal and offered me a studentship for three years to undertake a piece of research entitled, *'A phenomenological study of self-harm: women's personal perspectives and perceived support needs'*. The study at that time aimed to:

- investigate current service provision for women who self-harm in one area of a Mental Health NHS Trust.
- explore, in depth, the subjective experiences of women who self-harm and have a diagnosis of borderline personality disorder, and
- develop a descriptive and theoretical understanding of women's experiences of self-harm and the 'meaning' that they attribute to this behaviour.

Originally it was expected that these aims would develop into a conceptual framework that would allow an understanding of the complex interplay between health care policies, mental health practice and experience in relation to 'BPD', 'self-harm' and the mental health service response. However, as I engaged in the research and explored the differing theoretical frameworks and positions in the first 18 months of the PhD, it became

increasingly clear that these would change as I developed my skills and knowledge as a reflexive and critical researcher (Denzin and Lincoln, 2000).

Formulating the research project

At the time when I prepared the initial proposal for the research there seemed to be a large body of literature about 'BPD' that reported and focused upon the aetiology, treatment, and outcome of 'BPD' (Adler, 1993; Paris, 1994; Stone, 1990; Zanarini, 1997). What appeared absent from the abundant literature on 'BPD' were the voices of those who had been diagnosed with this psychiatric disorder. There seemed to be little research conducted and published about the women themselves. Nehls (1999) argues that describing an experience from the perspective of someone who actually lives it provides an additional and, in some cases, alternative view of the phenomenon. This has been demonstrated in research focusing on the experiences of individuals with various problems including depression (Karp, 1996; Moore, 1997; Schreiber, 1996), schizophrenia (Dzurec, 1994) chronic mental illness (Hayne and Yonge, 1997), and incest (DiPalma, 1994; Draucker and Petrovic, 1996; Kondora, 1993). Thus, it seemed imperative to me that more needed to be known and understood about the experiences of women who live with the diagnosis of 'BPD', as this appeared to be a neglected area (Nehls, 1999; Miller, 1994).

To further support the formulation of this research project the Government in 2002 published the document *'Women's Mental Health: Into the Mainstream'*. This document argued that there needed to be a better understanding at local service level to assess and manage women who had been given a diagnosis of BPD. The Department of Health (2002) also acknowledged within this document that treating this group of service

users as a 'nuisance' or using labels, such as 'personality disorder', to exclude them from health care had led to a poor and patchy provision of services throughout the country. Thus, according to the Government more awareness and understanding across mental health service settings was required. It was suggested that women's needs, experiences and choices should be listened to and taken into account so that services could be developed that were sensitive to their needs (Department of Health, 2002).

It was therefore my experiences as a mental health practitioner, and the literature which I gathered when I was preparing the initial proposal for the research, that provided me with the motivation to emphasise the experiences of women with this diagnosis rather than the psychiatric nomenclature. Further, I aspired to encourage researchers, clinicians and educators to view women who had been given the diagnosis of 'BPD' not as objects of knowledge but, instead, as authors of knowledge from whom others have something to learn (Caputo, 1993).

Searching for a theoretical base

Following on from my initial examination of the research literature into this area, the first theoretical approach that I explored was phenomenological psychology (Leonard, 1994; Moustakas, 1994; Giorgi, 1995). The preference for this perspective was affected in part by the literature I had already reviewed, which highlighted that to date the majority of research on 'BPD' and 'self-harm' had been undertaken in the positivist tradition. Ussher and Nicholson (1992) argue that this approach is limited because although it has generated knowledge about the prevalence of these disorders and the relative effectiveness of various treatments it is limited in its ability to further understand the personal issues surrounding the diagnosis. They assert that the experiences and

accounts of the women themselves need to be explored and examined so that an insider's view can be given of the phenomena. Further, Nehls (1997) asserted that mental health research had not considered what the diagnosis of 'BPD' meant to the women themselves nor what it meant to live with the diagnosis of 'BPD' for the women. In this regard, I thought that a phenomenological perspective would best facilitate the specific aims of the research.

Considering phenomenology

The phenomenological approach within psychology arose out of dissatisfaction with the explanations of behaviour in psychoanalytic or behaviourist terms, which see humans as driven by unconscious inner motivational forces *or* by their external environmental conditions (Atkinson, 1987). The phenomenological approach, as discussed by Edmund Husserl (Barkway, 2001), proposes a return to the lived world, the world of experience, which as he sees is the starting point of all science (Sadala and Adorno, 2002). According to Smith (1995) this approach is concerned with an individual's subjective account of reality, and the aim is to capture the meaning of a particular experience from an individual's point of view. Phenomenology therefore pursues not only the sense people make of things but what they are making sense of (Crotty, 1996). By doing this, I would be working with the description of the phenomenon and focusing on searching for its *essence*. The *essence* is the very nature of what is being questioned; it is that which gives the phenomena its unique character (Moustakas, 1994). Hence, adopting a phenomenological approach, I believed, would allow me to listen to women so that their accounts could be voiced and knowledge be produced that would aim to improve women's lives (Eichler, 1986). Furthermore, phenomenology I believed might allow me to discover and draw out the experiential meanings of responding to women who 'self-

harm' and whom those professionals working in mental health service provision have diagnosed with 'BPD'.

Problems with phenomenology

However, it became clear as the literature review progressed that adopting this approach was increasingly problematic and, as Willig (2001) notes, the phenomenological method does suffer from several conceptual and practical limitations. The first she asserts concerns the role of language. When data is collected from this perspective no matter which data gathering technique is utilised the accounts that are given by participants are in the form of 'words'. Language is therefore the vehicle by which the experiences of the participants are communicated to the researcher. Willig (2001) asserts that phenomenological research therefore '...must assume that language provides participants with the necessary tools to capture that experience.' (p.63) However, it could be argued that language constructs, rather than describes reality (Willig, 2001). From this point of view, the 'talk' that has been gained in the research does not constitute the means by which the participants express how they think or feel about something. Rather it is the language that prescribes what they can think and feel about things that they encounter in their everyday lives (Willig, 2001).

A further limitation of the phenomenological approach is that because it puts such an emphasis on subjective experience it can lead to an under consideration of the wider material factors which shape that experience. For example, Ussher (2000) talks of materiality or material factors as existing at corporeal, societal, or institutional levels. This would include biological processes, economic factors, issues of social class, gender, ethnicity, power relationships and the way individuals are treated by institutions in society such as social services or mental health professions (Ussher, 1991).

Hammersley (1995) points out that phenomenology treats the individual accounts of phenomena by participants as adequate and unproblematic, rather than as one aspect of a wider, multifaceted explanation that gave rise to these experiences. This lack of consideration given to the socio-political realm by the phenomenological approach therefore succumbs to what Burman and Parker (1993) call a 'backslide into empiricist notions of truth' (p. 256). By searching for the essential structures of an experience it does not fully interrogate or situate those structures in terms of the sociopolitical realm. In relation to women's mental health, where the medical profession is still dominant and reductionist models of research and practice are still maintained (Pilgrim, 1990), it became clear that it may be useful to focus beyond the individual to the historical and political role of the 'mental sciences' (Ussher, 1991). According to Rose (1990) these '...play a key role in providing the vocabulary, the information and the regulatory techniques for the government of individuals' (p 121).

The 'turn' to discourse

The first encounter that I had with discursive psychology was when I attended one of the Wednesday meeting sessions that my supervisors organised for their PhD students. These supportive meetings occurred every week and it was a time where my peers and myself could present for debate and discussion the various philosophical, methodological and theoretical issues that we were currently dealing with in our PhD studies. One of my peers was adopting a Foucauldian approach to her research studies and she presented this in one of the Wednesday meeting sessions. This meeting marked a turning point in my theoretical journey as I then began to explore for myself what adopting a discursive approach might enable within my research. I found the approach extremely interesting, as it seemed to provide me with the opportunity to explore how women's mental health had been constructed historically within mental

health services. In addition, it appeared to let me explore how these constructions were operationalised by policy makers and health care professionals. I therefore engaged in reading journal articles and books that were situated within a Foucauldian discursive approach. From my exploration of this area I found that it would be possible to examine the impact of power and individual, organisational and wider social practices from the different positions from which 'self-harm' and 'BPD' could be viewed (Gergen, 1999). In the next section of this chapter I will offer an account of the Foucauldian discursive approach that I have adopted for the first phase of the research.

Foucault, the subject, power and knowledge

According to Michel Foucault, the French philosopher and historian, the term 'subject' has two different but interconnected meanings. Firstly, human beings are said to be 'made subjects' in the sense that they are 'made *subject to*'; in particular, human beings are said to be made subject to others by 'control and dependence' (Foucault, 1982, p. 212). Secondly, human beings are said to be 'made subjects' in the sense that their 'subjective identity', who or what they understand themselves to be, is 'made' or produced by being 'tied' to a specific identity through a 'conscience or self-knowledge' (Foucault, 1982, p. 212). These two aspects of Foucault's 'subject', however, are not distinct and independent. The manner in which a human being is made subject to control and dependence and the manner in which a human being is 'tied' to a specific identity through a conscience or self-knowledge constitute two aspects of a single, dynamic process. A key feature of this process is, for Foucault, power.

Power, he proposes, is commonly understood either in terms of legal power or the power of the state (Foucault, 1982), and is characterised as being prohibitive and repressive (Foucault, 1996). In *Discipline and Punish* (Foucault, 1991) he provided an analysis of

disciplinary power through the example of the Panopticon. In the 18th century the English philosopher, Jeremy Bentham, created plans for a new type of prison that he referred to as the Panopticon (Foucault, 1991). This has a central observation tower encircled by an annular building divided into individual cells; this allows the 'supervisor' in the central tower, to continuously observe each prisoner within their cell. The prisoners, each partitioned within their individual cells, are unable to come into contact with other prisoners and are unable to see the supervisor in the tower; each prisoner according to Foucault '...is seen, but does not see' (Foucault, 1991, p. 200). Panopticon therefore creates and maintains a 'power relation' (Foucault, 1991, p. 201). This account of power by Foucault signals the transformation throughout the 18th and 19th centuries of the manner in which power was exercised. In contrast to a cruel, restrictive and sovereign power, the Panopticon is illustrative of the emergence of a more efficient, effective and productive form of power; a power that Foucault refers to as 'Panopticism' (Foucault, 1991, p. 208). For example, if service users believe that they are being persistently monitored and observed, Roberts (2005) argues, they will regulate their own behaviour in accordance with the rules, standards and values promoted by psychiatry and mental health care.

With the emergence of Panopticism Foucault argued that it was not only restricted to prisons, but that it began to be employed throughout the whole of society. Significantly, according to Foucault, Panopticism has not only led to the formation of a 'disciplinary society' (Foucault, 1991, p. 209), but it has enabled the emergence of new forms of knowledge. For example, in *Madness and Civilisation* (1965) Foucault highlights the way in which madness emerged as a distinct subject-domain in the eighteenth century. In his account, he illustrates how madness became explicitly constructed as a *subject* of scientific knowledge at a particular historical conjuncture, in relation to which a variety of

social technologies began to proliferate. According to Foucault, the discursive construction of 'madness' as susceptible to understanding by reason had the effect of removing it from the realm of the family or the community and into the realm of regulation and control by the state. Within this sphere the dominant knowledge is that of medicine, which it is argued has become endowed with the power to '…control individual bodies and populations' (Gastaldo, 1997, p. 114). Scientific medicine saw the body as a set of component parts, each with discrete functions, whose workings could be explained on purely mechanical grounds. Disease was now seen in terms of uni-causal biological explanations resulting from a defect in the biochemical processes taking place within the human body. Disease could be precisely and objectively identified (Jewson, 1976). The individual body became the target of a 'ubiquitous and calculating gaze' (Foucault, 1977) that aimed to regulate conduct by surveillance and prevention. The role of the doctor is one of active expert, and the role of the patient is one of a passive non-expert who must comply by being subjected to medical investigations and treatment.

Thus, for Foucault, power and knowledge are therefore indivisible and rather than speaking of power or knowledge as single, independent concepts, he introduced the concept of *'power-knowledge'* (Foucault, 1991, p. 98-99) to reflect their mutually constitutive relationship.

Psychiatric power and the production of the psychiatric subject

Roberts (2005) asserts that Foucault's account of Panopticism enables an appreciation of a more refined and subtle form of power functioning within psychiatry and mental health care. He argues that an inpatient unit in a mental health hospital, for example, can be understood as employing an array of Panoptic approaches. For example, there are differing levels of service user observations, record keeping, risk assessment, the

evaluation of 'nursing interventions and techniques' and reviews by the multi-disciplinary teams. All of these can be understood as examples of Panopticism. Roberts (2005) argues that such interventions which are conceptualised as elements of 'care' in society can be reconceptualised, within a Foucauldian analysis, as interventions whose effect is to produce and sustain within a service user *'...a state of conscious and permanent visibility...'* (Foucault, 1991, p.201).

Furthermore, in accordance with Foucault's (1991) account of Panopticism it is not a single individual that watches and monitors, the power relation is *'disindividualised'* (p.202) and there will be several people monitoring, for example, doctors, nurses, community psychiatric nurses, social workers, psychologists, and occupational therapists. Thus, in line with Foucauldian analysis, any member of the service users' 'mental health team' can retain within the service user '...a state of conscious and permanent visibility...' (Foucault, 1991, p.201). Furthermore, Roberts (2005) purports that the Panoptic power of psychiatry can move beyond the boundaries of the psychiatric unit and can be evident in the community, for example, the family and friends of the service user may further watch and monitor them. Therefore, in line with Foucault's concept of Panoptic power, it is a form of power that seeks to permeate every part of a service users' life and to give '...a permanent account of individual's behaviour' (Foucault, 1991, p.214). Thus, with regard to this research, women may be seen as 'self-harmers' or 'personality disordered' rather than an individual woman who is attempting to cope with traumatic issues or difficulties in her life presently.

Psychiatric knowledge and discourse

It would seem from the discussion presented so far that mental health care is built upon, and is informed by a 'body' of psychiatric knowledge (Roberts, 2005). Thus, Foucault

suggests that such bodies of knowledge are fundamental to the manner in which individuals are 'made subjects'; therefore in order to understand the role played by such knowledge it is necessary first of all to outline his analysis of how such knowledge developed.

In *The Birth of the Clinic: An Archaeology of Medical Perception* (1973), Foucault traces the development of the medical profession, and specifically the institution of the medical clinic or hospital. He highlights that there was an epistemic shift in medical practice that radically and conceptually transformed the diseased body into a discursive site. Foucault demonstrates that this transition of medical knowledge did not arise in isolation from the social, cultural and political events of its time. It was, instead, intimately entwined within them. In order to illuminate this point Foucault refers to such bodies of knowledge as 'discourse' (Slattery, 2003). Consequently, psychiatric discourses are, according to a Foucauldian perspective, to be understood as the historical manifestations of '...a range of institutions, economic requirements, and political issues of social regulation...' (Foucault cited in Rabinow, 1991, p. 51). Thus, the concept of 'madness', for example, that is central to psychiatric discourses, emerged as a result of the eighteenth and nineteenth centuries' Enlightenment notions of civil society, rationality, and the agental-yet abstract individual (Morgan, 1998). During this period, the 'body' became remade and was deemed in need of medical protection and support (Foucault, 1980). Medicine was given primary authority to oversee all aspects of this new entity (Foucault, 1980). Specifically,

> '...medicine, as a general technique of health even more than as a service to the
>
> sick or an art of cures, assumes an increasingly important place in the

administrative system and the machinery of power, a role which is constantly widened and strengthened throughout the eighteenth century...'(p.176)

To these ends Foucault asserts that as doctors gained an increasing surplus of power, sickness, illness and madness changed from being conceptualised as *dwellers in* to *conditions of* the human body. Disease could therefore be viewed by the clinical gaze, which allowed the doctors to know entirely the individual and their disease, thereby producing a rational language through which the doctor can relate his findings (Foucault, 1973). With this historical shift, a precise focus was created for medical discourse. This discourse allowed the medical profession to view all disease and ill health in physiological terms and processes, for example, due to organic abnormalities, hormones or neurotransmitters. Thus, Foucault highlights through his analysis of this period that the concept of 'mental illness' emerged at a certain historical point, and that it was inextricably bound to the political concerns, norms and values of that culture and society (Foucault, 1991).

Roberts (2005) suggests that the discourses, which are used within psychiatry and its practices, can therefore be seen to produce a person's 'subjective identity'. These discourses and practices serve to transform and confine who or what an individual understands themselves to be and, importantly, who or what others conceive them to be. A key element in this process is *diagnosis.* This technique allows the medical profession to identify, classify and categorise certain thoughts, feelings and behaviours as constitutive of 'mental illness'. Further the power of psychiatric diagnoses and categorisations are such that they may cover an individual's identity. For example, Laing (1960), who was highly critical of the notion of 'schizophrenia' within mental health argued that,

'To give a person a diagnosis of schizophrenia is not to give a person one identity amongst others; instead, it is to suggest that a person 'is' schizophrenic, that schizophrenia determines the very 'being' of that person'. (p.34)

Furthermore, when an individual is diagnosed as having a mental health issue they are also subject to a variety of presumptions that are analogous with that concept. For example, if the concept of 'schizophrenia' is considered, there is still an enormous investment within psychiatry to investigate the biological basis of schizophrenia (Moncrieff, 1997). Drugs variously termed 'major tranquillisers', 'neuroleptics' or 'antipsychotics' continue to be considered the most appropriate treatment for schizophrenia (Kendell, 1996).

Foucault's analysis has therefore illustrated how psychiatric knowledge or discourses may be inextricably linked to psychiatric power, and how psychiatric power-knowledge relations may be central to the way in which individuals are constructed as 'psychiatric subjects' (Roberts, 2005). A number of key issues therefore emerge as crucial within this approach, and are fundamental to this research. Of prime importance for this point of view is language and its role in the constitution of social and psychological life (Parker, 1992). This approach takes a critical stance towards taken-for-granted knowledge and acknowledges cultural and historical specificity (Ussher, 2000). It also holds the position that *all* knowledge is sustained by social practices (Burr, 1995). According to Ussher (2000) this approach challenges the realist/positivist assumptions of traditional biomedical and psychological research, arguing that the very meanings of 'mental health' and 'mental illness' are constructed within practice, language, relationships, and roles (p.216).

This research is therefore interested in exploring and identifying the way that language mediates, or shapes, the complex relationship between the self and the social world (Foucault, 1979). The significance of language in framing an individual's experience is therefore seen as crucial in attempting to understand the way in which 'self-harm' and 'BPD' are constructed by health care professionals and subsequently responded to in terms of support and treatment. A Foucauldian approach does not assume to know the truth or reality of an individual's life, but does try to explore the way in which individual actions may be constituted through social processes.

By analysing the discursive processes that shape values and beliefs about women who 'self-harm' and have been given a diagnosis of 'BPD' a critical understanding of how women's emotional distress is responded to may be developed. If consideration is given to the way that discourses shape how individuals think and act in the social world then their political nature in terms of power and knowledge relations may be seen. To give an example, Shaw (2002) in her historical review of white, middle-class women's self-injury behaviour in North America and Britain highlighted the remarkable shift in how this behaviour has been conceptualised and treated. Shaw asserts that the current discourse frames the behaviour as 'attention seeking' (Hartman, 1996), 'treatment resistant' (Valente, 1991) and a management problem (Feldman, 1988; Allen, 1995). This discourse apportions blame to the individual, the self-harm becomes individualised as the woman's problem and she is held 'responsible' for getting on with things. There are assumptions here about the individual's responsibility for controlling and managing private emotions in order to achieve an ideal way of being, that in neo-liberal societies figures as the rational, autonomous, self-managing individual (Rose, 1999).

A Foucauldian perspective and analysis may therefore provide an important alternative to the dominant medical and psychological understandings of responding towards a group of women who 'self-harm' and have been given the diagnosis of 'BPD'.

Discourse and the loss of subjectivity

However, it must be acknowledged that this position does have a number of limitations at an ontological level, and the most significant one for this research is with regard to the conception of the subject and its potential for understanding, exploring and theorising subjectivity (Henriques, Hollway, Unwin, Venn and Walkerdine, 1984). This limitation is significant because a key aim in this study is to explore and understand women's lived experiences.

According to Cosgrove (2000) the Foucauldian perspective maintains that meanings are given through language rather than discovered, and the meanings that are available, to a large extent, are dependent on the discourses that are dominant at that particular time and place. With this focus on language Kvale (1996) asserts that this approach therefore implies a '...decentralisation of the subject' (p.36). The identity of an individual is not a 'natural' category of being, and as Cosgrove (2000) asserts 'it does not 'have' an ontological status' (p.249). Rather, the sense of one's self or subjectivity from this point of view is *produced* within discourse (Hollway, 1989). And so as Burr (1995) points out, the very things that we tend to assume exist prior to and apart from language – such as 'identity' – are actually constituted by and through language (Cosgrove, 2000).

The problem with this part of Foucault's approach is that although it illustrates the fractured, fragmented and changeable position of subjectivity, it does not help to fully explain why individuals have a '...sense of coherence and constancy about

themselves...' (Cosgrove, 2000, p. 253). Further, Cosgrove (2000) argues it 'falters on being able to accept, much less explain, the experience that one in some sense has (a self or identity)...' (p. 253). Furthermore, it fails to fully explain and '...theorise agency as an aspect of subjectivity' (Cosgrove, 2000, p. 258), it therefore cannot fully address or provide information on how, why and in what ways certain individuals in society, for example, women, may be able to resist dominant discourses. Lather (1992) identifies this dilemma as the 'rethinking of agency within the context of the unknowable' (p.104).

In relation to women's mental health, Yardley (1996) maintains that in adopting a Foucauldian approach, or by putting forward the argument that 'mental illness' exists entirely at a discursive level there is a denial of the influence of biology or genetics. This diminishes the meaning ascribed to the body in general (Turner, 1984). Ussher (2000) asserts that this position is unacceptable, particularly when attempting to understand individual experiences, because it does not take into account the individual's own interpretation of 'mental illness' or psychological symptomatology. Further, she argues other material aspects of an individual's life may also be negated in a discursive analysis, for example, social class, economic factors and personal relationships. Furthermore, within this approach, '...the 'reality' of mental health problems may appear to be denied; madness can appear to be conceptualised as merely a social label or category.' (Ussher, 2000, p. 218)

Stoppard (1998) in her analysis of women's accounts of depression argues that although it is important to point to the socially constructed nature of women's mental health issues, at the same time it is important not to lose sight of the physical-embodied aspects of experiences currently labelled as depression. She puts forward that to ignore embodied aspects of depression, as currently defined within biomedicine, also means

foreclosing on knowledge about the range of bodily changes that may be experienced by women. Further, she asserts that if psychologists and social scientists are to start understanding mental health issues in women they must start from women's experiences, experiences that are at the same time, and always, both subjective and embodied. Research employing a Foucauldian approach, she suggests, needs to acknowledge that not only are subjective experiences and social actions open to discursive analysis, but that the material, as well, needs to be reconceived within a constructionist frame.

Finally, Ussher (2000) puts forward that there is an increasing number of women who seek treatment for mental health issues, as *they perceive* them to have a significant impact on their lives, and this is not taken into account by Foucault's critique of mental health. As Parlee (1989) notes,

> *'...what is strategically difficult for feminists, is that many women now derive genuine benefits in their personal lives from an ideology that functions to explain and obscure social contradictions in their lives and those of other women'. (cited in Ussher 2000, p.218)*

It would seem that engaging in a purely Foucauldian approach may clearly leave questions unanswered when attempting to understand the women's experiences in this research. Analysis from such a perspective may result in a 'disembodied' character and *'...deny the material reality...'* (Parlee, 1996) of the woman's individual experiences of 'BPD' and 'self-harm'. In my theoretical journey I therefore needed an epistemological approach that also had an appreciation of agency and an awareness of the histories or

the social and material structures that gave rise to the women's experiences (Willig, 2001).

Towards a theory of subjectivity - embodiment

The next step in my theoretical journey was therefore concerned with finding a way to study the relationship between discourse and the material embodied dimensions of human existence. In 1992, Emily Martin pronounced 'the end of the body' as we know it. In this statement she suggests that within both social scientific and humanistic inquiry debates were occurring about how 'the body' was organised and experienced. Rejections were being voiced about the understandings of the body as entirely and implicitly biological and that it was simply an object or a thing (Scott and Stam, 1996). These strands of theorising the body in psychology in a different manner have potential relevance here in my quest for understanding the experiences of 'BPD' and 'self-harm' in women.

The first set of approaches has grounding in the work of Rom Harre and stems from the book he published in 1991 entitled *Physical Being*. Harre takes the body as his primary focus and although he posits a material aspect of being he attenuates the concept of embodiment beyond this. He suggests that bodies are '...known from within' (p.14) and '....that one is uniquely identifiable with a particular body' (p. 19). Harre draws upon social constructionism in order to understand the body and human experience and argues that these two are both culturally significant and social constructed. For Harre, the body is a social phenomenon; a signifier of cultural meanings and a surface upon which cultural significance may be 'inscribed' (Scott and Stam, 1996). The body is therefore seen as '...a writing surface...' (p. 230) which is marked '...with social meaning through purposeful action and socialisation...' (p. 230).

Stoppard (1998) suggests that this 'inscription' can operate literally on the external body through the adoption of different 'fashions' governing appearance and style of dress. However, she also identifies that it can work through a variety of bodily practices which have the goal of 're-sizing' the body to conform to culturally coded notions of ideal physical form and shape (Stoppard, 1998). Bordo (1993) has illustrated this position in her analysis of the eating disorder 'anorexia nervosa'. In her reading of the body she illustrates how within Western society many women strive for the 'ideal female body', with its connotations of sexual attractiveness, self-control and social power. Many women she suggests internalise this ideal and objectify themselves with practices that physically alter their bodies or make them unhealthy (Bordo, 1993). 'Anorexia', from this perspective, can therefore be understood as culturally produced through certain practices of femininity at the site of the female body (Stoppard, 1998). Thus, Harre and others who subscribe to this position consider one's experiences of body as a bounded unity that is defined by a 'rim of felt embodiment'. They conclude by highlighting that the experiential context influences this sense of corporeal being that exists in an individual's human experience (Scott and Stam, 1996).

Several authors (Ussher, 1989; Radley, 1991) are critical of this position and the 'objectification' of the body. Ussher draws upon the fact that there are splits between self and body and she highlights the way in which these are related to medical-scientific discourse. She suggests that,

'...during adolescence, the young woman first experiences a split between her body and her self; between her own experience and the archetype she is expected to emulate' (p.18)

Ussher claims that this split is reinforced with medical-scientific discourse, through,

> *'the medicalisation, renaming and general mystification of cyclical phenomena which have served to isolate women from their own experiences' (p46)*, thus preventing them *'...from integrating their bodies with their conceptualisations of self, and ultimately producing fragmented and split identities' (p. 133).*

Thus, according to Ussher, women's *own* accounts of their experiences need to be acknowledged. Similarly, Radley (1991) in *The Body and Social Psychology* claims that,

> *'...to become the object of the surgeon's attentions, the body had first to enter medical discourse deprived of its subjectivity' (p. 147): '...to know the body as ill requires that it be objectified for us in terms of the ends that we cannot reach, the work that we cannot do' (p. 148-149).*

However, in contrast to Ussher, Radley suggests that emphasising the thought and speech in an individual will not '...make the human body sensible' (p .12). Experiences of embodiment he believes must be identified in both phenomenological and social constructionist terms otherwise '...the lived body and experiences, of illness for instance, may not understood' (p.151).

Another possibility to theorising material being is offered by Lock (1993) and her use of the concept of 'local biology' to explain the disparities between Japanese pre-menopausal and North American Women. Lock collected data on these women using a

self-administered questionnaire and she found from the responses that Japanese women showed the lowest prevalence of hot flushes, depression and the intake of medication. With regard to hot flushes, however, Lock found that the Japanese women did not have a word for the concept, which had to be explained using different words. Lock's interpretation of these findings was that Japanese women do not think the same way about menopause as, for example, women in North America. The Japanese word for midlife transition, Konenki, has a social rather than biologic connotation. According to Lock, middle age in Japan is thought foremost as a social process; the biologic changes are generally viewed as playing a small part. Konenki is seen as 'luxury disease' suffered only by those women who have too little to do. Lock's concept of local biology derives from a standpoint on human embodiment grounded in the 'lived body', one that is '…simultaneously a physical and symbolic artefact…' (p.373), both naturally and culturally produced. Lock's position on the body therefore postulates interdependence between human biology and cultural processes. Thus, in order to understand women's experiences Lock asserts there needs to be an exploration of cultural beliefs and practices, as much as local biologies (Stoppard, 1998).

These views that focus on embodiment therefore move beyond what Sampson (1996) refers to as the 'object-body', that is, the body as perceived and studied from the outside (Willig, 2000). The focus on embodiment by theorists allows individuals to be no longer conceived as a 'silent' biomed body, in which notions of 'mind' are reduced to the language of sciences, these new approaches posit an individual in which mind informs the life-body, as an articulate 'mind-body' (Stoppard, 1998). However, Willig (2000) argues that a concern with 'embodiment' raises methodological questions. She argues that social constructionist research methods work with texts when attempting to understand an individual's experience of life. Texts can be generated through a range of

67

methods, for example, interviews, discussions and diaries. When these documents are analysed there is an exploration of the social construction through language. Willig (2000) suggests that once the body is conceptualised having an 'embodied character' and therefore a 'meaning producing device' other methods may be required to study embodiment that do not rely upon textual material alone. Thus, Willig claims, embodiment requires further elaboration and development.

Ussher (2000) supports the points that are raised by Willig and argues that the integration of material and discursive approaches are to be welcomed, yet, she argues, these do not go far enough, as the *intrapsychic* is often still left out. She suggests that this is because it might be seen as individualistic or reductionist, or not easily accessible to empirical investigation (Ussher, 2000). She argues that material, discursive and intrapsycic factors need to be considered together when attempting to understand women's experiences of life.

Developing a material-discursive intrapsychic approach

The value of obtaining the opinions of service users has long been recognised by the National Health Service (Thomson, 1988). However, traditional approaches to exploring the needs of service users have often focused upon measuring their satisfaction with the services they receive (Clearly *et al*, 1991; Bruster *et al*, 1994) rather than attempting to explore and understand the experiences of specific groups of service users (Cornwell, 1984). In this research, understanding the experiences of women needed to be considered in the context of the women's lives as a whole in order to illuminate their significance. In order to acknowledge the women's voices and experiences the next step that I took in my theoretical journey was towards a position where material, discursive, and intrapsychic aspects of experience could be examined. This standpoint which is put

forward by Ussher (1999; 2000) does not privilege one level of analysis above the other, all of these different levels of analysis and experience (Ussher, 1999), need to be taken into account when analysing women's lives. The next part of this chapter will give a brief outline of how a material-discursive-intrapsychic (MDI) model (Ussher 1999; 2000) may be used to explore the accounts of women.

The level of the discursive

According to Ussher (1997; 1999; 2000) within social psychology in Britain there has been a move towards the use of theories and methods that focus specifically on the role of language and its relation to cultural practices. These approaches draw upon principles from ethnomethodology (Garfinkel, 1967), poststructuralim (Foucault, 1965, 1979; Gergen 1991), and conversation analysis and linguistics (Potter and Wetherell, 1987). Ussher (1999) purports that to focus on the 'discursive' is to analyse the social and linguistic domains in society such as talk, visual representations, ideology, culture, and power (Ussher, 2000). With regard to the women's mental health the discursive construction of 'madness' and 'mental illness' is of most relevance, as well as the analysis of the '…relationship between representations of 'woman' and 'man' and the actual social roles adopted by individual women and men.' (Ussher, 2000, p.220).

The level of materiality

Ussher (1999) argues that the factors of materiality exist at a corporeal, a societal or an institutional level. For example, this would include biological factors associated with psychological symptomatology, material factors that institutionalise the diagnosis and treatment of mental illness in women and gender inequalities. Further, it would also include issues of social class which,

'...lead to expectations of 'normal behaviour for women...which are implicated in educational or employment opportunities available...as well as in the way individuals are treated by institutions such as social services or mental health professions.' (p.219)

Previous or current physical and/ or sexual abuse or bereavement is also a material event, as is family history, for example, the number of siblings, parental relationships, and issues such as parental divorce or separation from parents in childhood. Current family context is also part of this level of analysis, for example, whether and how children are present in the relationship, and the tangible consequences of being married (or not). There are therefore many material consequences of experiencing or being treated for mental health problems for women, in terms of physical and psychological effects. The social isolation which can be a consequence of mental illness, or which can act to exacerbate its effects is also partly a material issue.

The level of the intrapsychic

According to Ussher (2000) this is concerned with the factors that operate at the level of the individual and the psychological factors that '...are traditionally the central focus of psychological analyses of women's madness.' (Ussher, 2000, p.221). Analyses may therefore focus upon the ways that women blame themselves for problems in their life, and psychological explanations for why this is so. Ussher (1999) cites such factors as low self-esteem, the impact of previous abuse, shame and guilt. Further, analysis would include an examination of the psychological defences that the women may use, such as denial. Specifically, concern is centred on the way '...women often blame themselves, or their bodies, for problems that they experience.' (Ussher, 2000, p. 221)

From this perspective the three levels of experience are irretrievably interconnected and one cannot be understood without the other. This is illustrated in Figure one below:

Figure one   An example of a material-discursive-intrapsychic approach

MATERIAL FACTORS

- Social support, family relationships
- Structural positions and opportunities (income, accommodation, education)
- Physical or sexual abuse
- Physical effects of self-harming
- Access and treatment options offered by mental health services


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                    Self-harm
                      and
                      BPD
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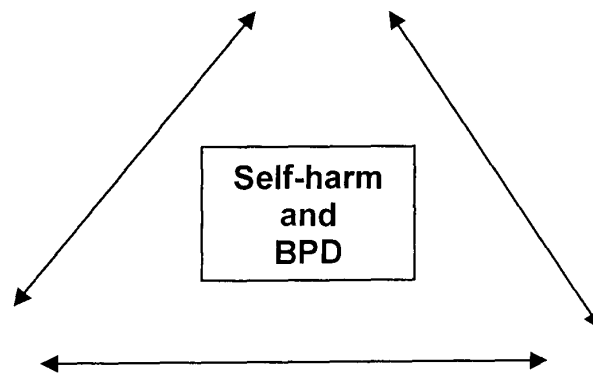
DISCURSIVE FACTORS
(discursive representations of)
- Madness/abnormality
- Self-harm
- BPD
- (Gendered) expressions of distress
- 'Sickness'/'illness'
- Femininity/masculinity

INTRAPSYCHIC FACTORS
- Impact of past experiences
- Self-esteem
- Ways of coping
- Psychological defences
- Current mood/well-being

Ussher (1999; 2000) has explored and conducted research using a MDI epistemological framework to inform a feminist analysis of the situation of women in relation to certain health issues.

In 2000 Ussher and several colleagues undertook an interview study with 120 British women who met the diagnostic criteria for 'pre-menstrual syndrome' (PMS) or 'Premenstrual Dysphoric Disorder' (PMDD), as it has become officially reified today in the DSM-IV (American Psychiatric Association, 1994). The women were participating in a study of PMDD treatment efficacy and narrative interviews were undertaken before and after treatment. The aim of the study was to examine women's subjective experience of premenstrual symptoms and the category of PMS, as this was the commonly used classification in Britain at that time. After the interviews were completed and transcribed they were analysed within a framework of thematic narrative analysis (Reissman, 1993). From the standpoint of a MDI model, the narrative accounts that the women gave posit that premenstrual symptoms are not static or fixed. They are the result from an interaction of *material* (e.g. changes in hormones or life stresses), *discursive* (e.g. cultural constructions of reproduction or femininity) and *intrapsychic* (e.g. expectations of self or reflective functioning) factors. These three levels produce changes in emotions, bodily sensations and behaviours, that come to be positioned as 'PMS' by the woman, her family, society or by a clinician (Ussher, 2002; 2003).

In agreement with Ussher (2000), this research accepts that 'BPD' and 'self-harm' are phenomena that are experienced by individual women at material, discursive and intrapsychic levels, and these notions cannot be disentangled from each other. This theoretical approach will be discussed in more detail in chapter 6.

Summary

What I have attempted to do in this chapter is to present the development of my theoretical position during this research project. I would like to emphasise to the reader that although this description may seem quite linear I often fell backwards and forwards to different positions when faced with theoretical contradictions and conflict. However, I hope that I have presented to the reader my theoretical considerations by reviewing the ways in which writers within psychology have attempted to understand this extremely interesting area.

The aims of the study

The aim of this study is therefore to explore and gain an understanding of the experiences of 'self-harm' by women who have been given a diagnosis of 'BPD'. This is a highly individualised process but at the same time is grounded in the social, cultural and material contexts of the women's lives. By listening to the women and exploring their experiences I aim to gain an understanding of their unique and individual experience of their professional lives and their encounters with the NHS (Department of Health, 2002). Specifically, the objectives of this study are:

1   To investigate the current service provision for women who 'self-harm' in one locality of a Mental Health NHS Trust.

2   To gain an understanding of the discourses and discursive practices through which 'self-harm' and the diagnosis of 'BPD' are constructed within one Mental Health NHS Trust.

3 To explore the discursive resources that health professionals draw upon when delivering services to women who 'self-harm' and who have been given a diagnosis of 'BPD', and how then that impacts upon women.

4 To explore how women narrate 'self-harm' and the diagnosis of 'BPD', and the part they play in their everyday lives.

Chapter 3

Methods: reflexivity and relinquishing control

Overview

The aim of this chapter is to outline the methodological approach and techniques employed within the research. The methodological discussions of the study have been divided into two separate chapters. This is due to the two differing processes that were used to collect the data. Firstly, the experiences and reflections that I engaged in during the first phase of the research subsequently informed the choice of strategies employed in the second phase. Secondly, during both phases of the research my theoretical positioning remained in a state of flux and as a result of this the collection of data in both phases began from a different theoretical foundation. This chapter is therefore structured to deal with the methodological approach concerning the data collection with the health care professionals. Chapter six deals with the specific methodological issues involved in collecting data with the women.

The chapter is therefore structured to provide an account of the development of a qualitative case study approach and the presentation of contextualising information about the Trust. It then moves on to detail the steps taken in collecting the data with the health care professionals. However, prior to embarking upon this account the reader is introduced initially to notions of reflexivity and my place as the researcher within the development of the study.

The 'reflexive turn' in the social sciences

Sullivan (2002) argues that in early mainstream and positivist accounts of research in psychology, the subjectivity of the researcher was thought to play no useful role. He maintains that the recording of the thoughts and emotions of researchers were of little benefit as the aim of the research process was to maintain objectivity and reduce the possible bias of the researcher. However, over the past two or three decades there has been increased recognition that the researcher's subjectivity is '...entangled in the lives of others' (Denzin, 1997, p 27) and that they '...are integral to the social world that they study' (Mauthner and Doucet, 2003, p 416). In qualitative research there is increased awareness that *'how* knowledge is acquired, organised, and interpreted is relevant to *what* the claims are' (Altheide and Johnson, 1994, p 486).

Finlay (2002) maintains that the responses gained from participants in qualitative research are negotiated between the researcher and the researched. Research according to Finlay (2002) is therefore a '...a joint product of the participants, the researcher, and their relationship: It is co-constituted' (p.531). Thus, Finlay (2002) argues it is essential that qualitative researchers find ways to examine how subjective and inter-subjective factors influence their research. Reflexivity, it is argued, is one tool that allows researchers to do this (Finlay, 2002; Hertz, 1997).

'Doing' reflexivity in this research study

Reflexivity, it is argued, is the explicit location of the researcher in the research process (Finlay, 2002; Hertz, 1997). It involves a shift in the researcher's understanding of data collection from 'what I know and how I know it' to recognising how they actively construct knowledge with the research participants. Reflexivity therefore, according to Hertz

(1997), should permeate into all stages of the research process '...challenging us to be more fully conscious of the ideology, culture and politics of those we study and those we select as our audience' (p.viii). Thus, for Hertz (1997), the reflexive researcher '...does not simply report 'facts' or 'truths' but actively constructs interpretations of his or her experiences in the field and then questions how those interpretations came about' (p.viii). They constantly '...have an ongoing conversation about experience while simultaneously living in the moment' (p.viii).

Further, Reinharz (1997) argues that 'being a researcher' is only one aspect of the researcher's self in the field and she asserts that throughout the research process the researcher should explore the self or 'selves'. By analysing her field notes from her study of an Israeli Kibbutz, she was able to identify 20 'selves' that she organised into three major categories of 'research-based selves', 'situationally created selves' and 'brought selves'. Reinharz (1997) does not assert that the selves she has identified are by any means universal to all researchers. This does highlight that the researcher as well as the 'subjects' of research are not fixed entities, but rather that they are fluid and are dependent upon the time and context. Such an account is congruent with this research study as the researcher is seen as a product of social practices, that is, being constructed and defined by themselves and others, this concept forms the foundations of this research. Thus, each 'self' that is developed and created during fieldwork depends upon the time, research context, political perspective and historical experience of the researcher and those being researched (Reinharz, 1997).

Exploring [my] selves in the beginning

In line with the recommendations put forward by Hertz (1997) and Reinharz (1997) surrounding the need to explicitly locate the researcher, I believe that it is necessary to

highlight myself in this research and my relationship to the area of study. In figure two below I have attempted to highlight *[my]* selves in relation to the research at the beginning of the study. However, I am aware that a wide range of other 'selves' will be brought and created as I venture into the field I will therefore explore and discuss these at various points in the rest of the thesis.

[My] 'Selves' in the field		
• Research-based Selves • Being a researcher • Being sponsored	• Situationally-created Selves • Being a nurse • Being a psychologist • Being an academic	Brought Selves • Being a women • Being a mother
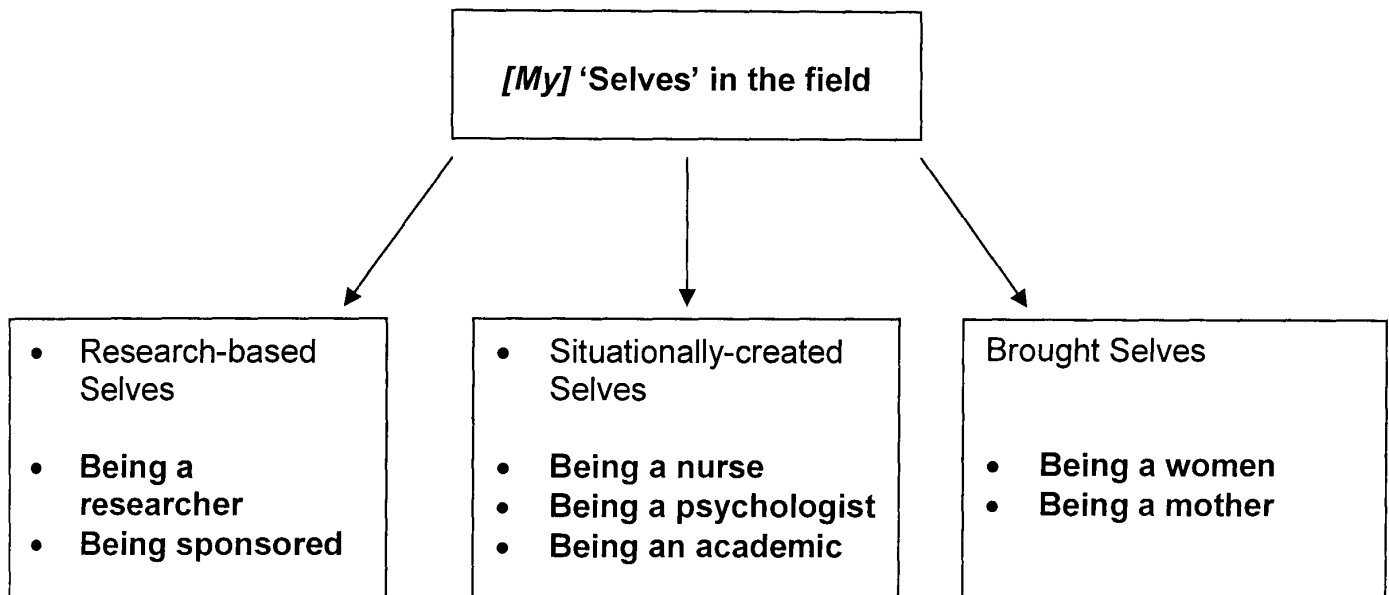
Figure two: Some variety of *[my]* selves at the beginning of the research study drawing upon Reinharz (1997)

Being a researcher, being sponsored: Reinharz (1997) states that when a researcher decides to enter into the field they have a desire and opportunity to study a particular setting. In my case, I wanted to explore, in-depth, the meaning that 'self-harm and the diagnosis of 'BPD' has for women within a NHS Trust in the North of England. I decided to do this because I suspected that the women would have unique and individualised accounts and experiences to share with me. This suspicion was based upon my previous experience working in the mental health care arena and the literature review that I had undertaken whilst working as a researcher at the University of Huddersfield. Further, in 2001, I found myself with the opportunity to undertake research in this area,

78

and with the help of two academics at the University I approached the University Research Committee with a proposal for the research. By the end of the summer in 2002 I received a letter from 'my sponsor' (Huddersfield University) stating that 'the project was approved' and I was therefore officially a 'researcher' being 'sponsored' to undertake the research study.

Being a nurse, being a psychologist: With regard to my professional and occupational background I am both a qualified psychiatric nurse and a psychologist, although I no longer practice as a nurse. However, I was aware that my 'professional status' might have an impact on the research relationship that I developed with the participants. Drawing upon feminist research methodology (Oakley, 1981; Reinharz, 1992) I was aware that I needed to eliminate or reduce power differentials between the interviewees and myself. Some feminists (Oakley, 1981) argue that the goal for the researcher should be to develop 'friendships' with the participants because otherwise the researcher will 'distance' themselves from the researched and this will result in their inscription as "other" (Reay, 1996). However, there are some other feminist writers (Cotterill, 1992; Phoenix, 1994) who identify that there are a number of drawbacks for the researcher in becoming an interviewee's friend. They argue that the interviewer-as-friend can be pulled into the interviewee's discursive universe in a way that hinders going beyond surface presentations and appearances (Huggins and Glebbeek, 2003). Furthermore, 'friendships' too can be exploitive and manipulative on both sides. I therefore decided that in the introductory letters that I would send to the potential participants I would include a statement, which stated that the study was a psychological exploration of women's mental health. I would also be 'honest' with participants and decided that if

they asked me about my professional background I would tell them anything that they wished to know.

Deciding to use a case study approach

As I have already discussed earlier in chapter 2 this research study was undertaken within a Mental Health NHS Trust in the North of England. In order that I could access mental health services and gain the accounts of both the health professionals and the women it was necessary for the Trust to be 'on board' with regard to the project as a whole. It was therefore mutually agreed that I would provide the Trust with a report at the end of the PhD that would provide them with knowledge of their own practices in relation to women's mental health. As a result of this I therefore decided to adopt a qualitative case study design (Yin, 1984; Stake, 1995) in my attempt to understand the discourses and discursive practices through which 'self-harm' and the diagnosis of 'BPD' are constructed within mental health.

The case study approach fits within the realm of qualitative research. Denzin (1989) outlines how qualitative researchers aim to get to the heart of social situation through what has been described as 'thick rich descriptions':

> *'It goes beyond mere fact and surface appearances. It presents detail, context, emotion and the webs of social relationships that join persons to one another. Thick description evokes emotionality and self-feelings. It inserts the sequence of events for the person or persons in question. In thick description, the voices, feelings, actions and meanings of interacting individuals are heard.' (p. 83)*

Qualitative methods therefore have the potential to explore interactions, conflicts and contradictions and there is a commitment to ground interpretations in the perceptions of those studied. Thus qualitative research and its associated techniques stress the importance of understanding and recognising the viewpoint and position of those being studied.

So, what constitutes a case study? Reinharz (1992) states that a case is a fully developed description of a single event, person, group or community. Stake (1995) takes a somewhat different definition of what a case study is and he begins his book *'The Art of Case Study Research'* with the following definition,

> *'A case study is expected to catch the complexity of a single case. A single leaf, even a single toothpick, has unique complexities –but rarely will we care enough to submit it to a case. We study a case when it in itself is of very special interest. We look for the detail of interactions within its contexts. Case study is the study of the particularity and complexity of a single case, coming to understand its activity within important circumstances.' (p. xi)*

Both Reinharz (1992) and Stake's (1995) descriptions appear consistent with the case for study within this research, since mental health services can be viewed as a group, and the 'interactions within this context' are the policy making, implementation, responding by professionals and the women's experience. Thus, case studies emphasise detailed contextual analysis of a limited number of events or conditions and their relationships and processes (Yin, 1994; Denscombe, 1998). It allows a phenomenon to be explored which is unique in some way and can be analysed in detail and depth. Furthermore, Yin (1994) asserts that the advantages of the case study

method are its applicability to real-life, contemporary, human situations and its public accessibility through written reports.

Drawing further upon the work of Stake (1995) I now wish to provide the reader with an account of my position in relation to using a case study approach. Stake classifies case study research into three types:

1. Intrinsic case study (where the interest is only in understanding the particulars of the case).

2. Instrumental case study (where the interest is in understanding something more general than the case).

3. Collective case study (where interest is in studying and comparing multiple cases in a single research study).

On reflecting on my own position in relation to the case study method, I believe that my aim is to be both *intrinsic* and *instrumental*. On an intrinsic level, I wished to attempt to explore in-depth the distinctive details of the case, specifically the discourses and discursive practices through which 'self-harm' and the diagnosis of 'BPD' are constructed within the Trust. In relation to the instrumental level, I wanted to attempt to theorise from and in relation to the case (Stake, 1995) so that knowledge may be produced which would aim to improve the mental health care experiences of women who 'self-harm' and have a diagnosis of 'BPD'. With regard to the collective type of case study this level was not applicable to the research study because I was not concerned with comparing it across differing NHS Trusts. Stake (1995) highlights that research barely ever fits into one of the three types that he has identified. It would seem

therefore that by utilising this in-depth approach it might allow the complex issue of 'self-harm' and the diagnosis of 'BPD' to be explored and understood in detail.

The Trust – contextual background for the 'case'

The NHS Trust where the research was undertaken was established three years ago and brought together the services from three previous organisations. It serves a population of approximately one million people over an area of approximately 600 square miles (Health Care Commission, 2004). The Trust was created from mental health and learning disability services and a regional forensic service. These services are organised into five localities due to the geographical size of the Trust and the metropolitan borough councils it crosses over.

The Trust provides specialist mental health services for all ages apart from children and adolescents. Learning disability services are provided by the Trust, however, by April 2006, most of these services will be provided and commissioned by local authorities. The forensic services are managed as a separate locality unit.

Due to the large geographical area that had been created by the 'new' Trust it was decided after consultation with professionals and the District Research Ethics Committee that the sample should involve only one of the five localities. The locality that was chosen had the largest variety of differing services for women with mental health problems to access in the whole geographical location of the Trust. By choosing this area it was felt that this might allow an alternative picture to be gained of the current adult mental health service provision that was available for the women to access.

Locality profile

The locality, which forms the case study for this research, extends over 350 square kilometers and it has a diverse range of city, rural and urban communities (Census, 2001). The resident population, as measured in the 2001 Census, stood at 315,172, of which 49% were male and 51% were female. According to the Census, the local population is primarily of white European origin (97.7%), with almost half of the remaining 2.3% being of Asian or Asian British origin (WMDC, 2003).

Deprivation

Deprivation for every ward and local authority in England is measured by the Indices of Deprivation. This tool, which is used by the Government, combines a number of indicators which cover a range of domains (income, employment, health deprivation and disability, education skills and training, housing and geographical access to services) into a single deprivation score (Carstairs, 1995). According to the 2004 Indices of Deprivation, the locality is ranked among the 50 most deprived local authority areas in terms of income and employment. Just under 50,000 people living in the area are classified as experiencing income deprivation and the locality as a whole falls within the top 5% of most employment deprived districts in England. Under the overall 2004 index of multiple deprivation, 31 of the locality's 209 super output areas fall within the 10% most deprived in England.

Local economy and employment

The locality had prospered for many years as an industrial centre of mining, engineering and textiles. These traditional industries after a difficult decline have given way to new growth in electronics, distribution and manufacture and a growing service sector. A

business survey undertaken by Dun and Bradstreet (2004) showed the locality to be one of the profitable places for business. Indeed, it is ranked in the top 30 as one of the most prosperous places for business out of 150 towns and cities in the UK and over 80 per cent of its companies are making a profit.

In 2003 there were 129,500 individuals employed at workplaces within the locality which was a 3.7% increase on the previous year (Annual Business Inquiry, 2003). The service industry, which employs 80% of the workforce, is the current key component of the local economy. Within this sector the distribution, hotels and restaurants are the largest broad industrial group (28.1%) closely followed by the Public administration, education and health sector (26%), as figure three below illustrates.

	Employee jobs In Locality	Locality (%)
Total employee jobs	129,500	
Full-time	87,000	67.2
Part-time	42,500	32.8
Manufacturing	18,300	14.2
Construction	6,500	5.0
Services	104,700	80.0
Distribution, hotels & restaurants	36,400	28.1
Transport & communication	14,500	11.2
Finance, IT, other business activities	13,000	10.5
Public admin, education & health	33,600	26.0
Other services	7,200	4.2

Figure three: Percentages of employee jobs in the locality, 2003

Despite the decline of local manufacturing industries in recent years, manufacturing is the third largest broad industrial group and employs 18,300 people, accounting for

14.2% of employees within the locality (Annual Business Inquiry, 2003). Lastly, the transport and communications sector has experienced the highest employment growth in recent years. Between 2000 and 2003, the number of individuals employed in this sector has increased by 52.6% and now accounts for 14,500 employees (Annual Business Inquiry, 2003).

Unemployment

Unemployment in the locality, year on year, has increased by 19.7% against 2.4% for Great Britain as a whole (NOMIS, 2005). According to official claimant count figures for June 2005, 4,409 living in the locality were out of work and claiming benefit (NOMIS, 2005).

Education and life long learning

Since 1995 the locality has shown significant progress in GCSE and in 2004 49.7% of pupils obtained five or more GCSE passes at grades A-C, up from 43.2% in 2000 (DfES, 2004). The rate of pupils obtaining more than five GCSEs (grades A-C) has increased by 13.1 percentage points since 1994 and is higher than the national trend (DfES, 2004). According to the Learning and Skills Council who undertook a skills survey of employers in the locality in 2003, 65% of the organisations in the area provided staff training in the past 12 months. However, the proportion differs markedly between sectors and smaller and larger businesses. Large organisations and the public sector are much more likely to encourage training.

In summarising, the locality has a diverse range of city, rural and urban communities. The local population is mainly of white European origin and some areas of the locality

have experienced higher levels of deprivation particularly in terms of income and unemployment. The locality prospered for many years as an industrial centre of mining, engineering and textiles. However, in recent years these traditional industries have given way to new growth in electronics, distribution and manufacture and a growing service sector. Lastly, although educational attainment is improving in the area the unemployment rate both short and long-term remains an area of concern too.

The organisation of mental health service provision within the locality

In 2003 the Government published *'Mainstreaming Gender and Women's Mental Health'* this document consists of implementation guidance for the NHS Trusts in the UK who planned and delivered mental health services. This guidance focused, to a large extent, on gender differences that were relevant to women because it acknowledged that in the past there were specific areas of women's mental health care that had been neglected by mental health services. The aim of this guidance was therefore to assist services in developing and delivering gender-sensitive and gender-specific services. Thus, there was a move in 2003 within mental health to extend women-only provision.

With regard to the locality in this study it was found that there were no women-only wards in the inpatient facilities nor were there any women-only day services. Women could only be admitted into the acute inpatient services and this service was for either sex. Thus, through the preliminary consultations that were undertaken with the service managers in the locality I decided, in consultation with the supervisory team, that eight mental health services would be approached and invited to participate in this phase of the study. Figure four below illustrates the eight services that were involved in the study.

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┌─────────────────┐   ┌─────────────┐   ┌─────────────┐   ┌─────────────┐
│ Primary   care  │   │ Assertive   │   │ Crisis      │   │ Forensic    │
│ mental   health │   │ outreach    │   │ resolution  │   │ service     │
│ service         │   │ team        │   │ service     │   │             │
└─────────────────┘   └─────────────┘   └─────────────┘   └─────────────┘
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┌──────────────────┐
│   The   │
│   Locality   │
└──────────────────┘

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┌─────────────────┐   ┌─────────────┐   ┌─────────────┐   ┌─────────────┐
│ Psychological   │   │ Acute in-   │   │ Community   │   │ Outpatient  │
│ therapies       │   │ patient unit│   │ mental      │   │ service     │
│                 │   │             │   │ health team │   │             │
└─────────────────┘   └─────────────┘   └─────────────┘   └─────────────┘
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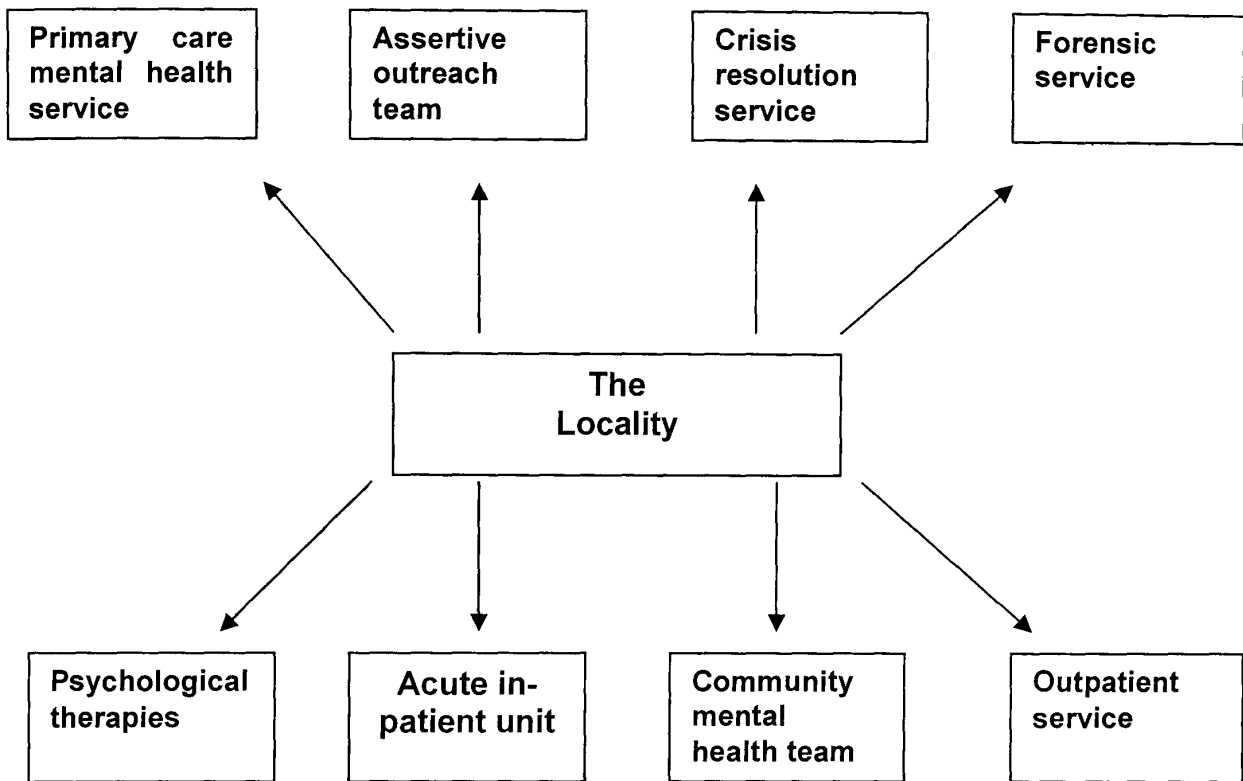
Figure four: The mental health services involved in the study.

- **Primary care mental health service:** This service delivered facilities at a general practice level, for adults with mild to moderate mental health problems. Adults of working age who required assessment of their mental health needs are eligible to access this service (Health Care Commission, 2004)

- **Assertive outreach team:** Assertive Outreach Teams, known also as 'assertive community treatment teams', provide intensive support for severely mentally ill people who are 'difficult to engage' in more traditional services. Clients will often have a forensic history and dual substance misuse and mental health problems. Care and support is offered in their homes or some other community setting, at times suited to them. Workers can be involved in direct delivery of practical

support, care co-ordination and advocacy as well as more traditional therapeutic input. The aim of the service is to maintain contact and increase engagement and compliance (Health Care Commission, 2004).

- **Crisis resolution service:** A crisis resolution team (sometimes called home treatment) provides intensive support for people in mental health crisis in their own home, or other suitable alternative such as a crisis house. The crisis resolution team will stay involved until the problem is resolved. It is designed to provide prompt and effective home treatment, including medication, in order to prevent hospital admissions and give support to informal carers. The service also acts as a 'gatekeeper' to other mental health services such as acute inpatient care. Adults of working age, 18-65, are eligible to access this service (Health Care Commission, 2004).

- **Acute in-patient unit:** The in-patient service is for adults who present with severe mental illness, mental health problems or a functional mental illness, which requires assessment and/or treatment. Individuals between the ages of 16-85 with mental health issues in crisis can access this service (Health Care Commission, 2004).

- **Forensic service**: Although the forensic service within the Trust was a separate locality unit, it was invited to be involved in the research as they had a 10-bedded single sexed ward for women. This service was a medium secure facility for women who had an offending history (Health Care Commission, 2004).

- **Psychological therapies:** The adult psychological therapy services offer outpatient psychological assessment, consultancy and therapy for a range of psychological problems, for example, anxiety and depression. Any adult of working age via a referral by a registered GP can access this service (Health Care Commission, 2004).

- **Community mental health team (CMHT):** The CMHT is a multidisciplinary team of professionals offering specialist assessment, treatment and care to adults who suffer from severe mental health problems in their own homes and the community. People aged 16 to 65 and who have been referred by their GP or other mental health professionals are eligible to access this service (Health Care Commission, 2004).

- **Outpatient service:** Psychiatric outpatient care is assessment, treatment and review provided in a clinic setting by doctors. This can include consultant psychiatrists and senior registrars, together with clinical assistants or other training grades acting under their supervisions. The service might be provided in a hospital, CMHT or primary care setting (Health Care Commission, 2004).

Data-gathering – an overview of the phases of data collection

The first step that I undertook towards gathering data for the study entailed gaining a contextualised understanding of 'self-harm' and 'BPD'. In order to do this I conducted a wide review of the information in this area. I found that the literature and research that I encountered highlighted an absence of the 'voices' of those who had been diagnosed with this psychiatric disorder. There seemed to be a large body of information about

'BPD' that reported and focused upon the aetiology, treatment, and outcome of 'BPD' (Adler, 1993; Paris, 1994; Stone, 1990; Zanarini, 1997) but there seemed to be little research undertaken and published with the women themselves. After becoming familiarised with the literature surrounding 'self-harm' and 'BPD' I began the process of data gathering for the thesis.

The process of data gathering involved two phases, adopting conversational interviews (Nichols, 1991) for phase one and in-depth narrative interviews (Reissman, 1993) for phase two. My intention at this particular point in the chapter is to provide the reader with a general overview of the two phases and their aims rather than an explanation for the choice of methods that were adopted.

Phase 1.   Conversational interviewing phase - in this first phase of the study, a series of conversational interviews were conducted with eight health care professionals, working at a various levels within the local mental health services of the Trust. The interviews aimed to explore and gain an understanding of the ways in which 'self-harm' and 'BPD' were constructed within services, and to identify the discourses employed by the mental health professionals when responding to this group of women. In addition, this phase of the research provided relevant contextual information about the range of services currently available to women when they may present for treatment/and or support.

Phase 2.   Narrative interviewing phase – during this second phase of the research four women were invited to participate in in-depth narrative interviews

(Reissman, 1993). These participants had a history of self-harming behaviour, had been given a diagnosis of 'BPD' by psychiatrists and had accessed the local mental health services that had been involved in phase one. Specifically, the data gathered during this phase of the research involved exploring their experiences of 'self-harm' and living with a diagnosis of 'BPD'.

Phase one: conversational interviews with the health care professionals

The research aims for the first phase of the research were:

- to explore the current service provision available to women who 'self-harm' within the locality.

- to gain an understanding of the discourses and discursive practices through which 'self-harm' and the diagnosis of 'BPD' are constructed within the locality.

- to explore the discursive resources that professionals draw upon when delivering services to the women.

In order to do this I needed to make contact with the health care professionals who were employed within the eight services. Thus, my early focus when I embarked upon the PhD in November 2002 was the development of these relationships.

Gaining research and ethical approval for phase one

In February 2001 the NHS introduced new guidelines regarding research and ethical approval. The new framework (Department of Health, 2001) stated that any research being carried out on NHS property or involving NHS employees required approval by the

District Research and Ethics Committee within which the research was being undertaken. I therefore had to approach the District Research and Development Committee (DRDC) and the District Research Ethics Committee (DREC), as I sought access to both health care professionals and service users within the NHS.

After careful consideration and discussion of the literature and information provided by the DRDC and the DREC committees it was decided that a phased approach to the research would be undertaken. This was decided because each phase of the study would inform the development of the next, and thus an application for both phases could not be made at the same time (Yin, 1994; Stake, 1995). A thorough application covering the whole of the research study but including only relevant paperwork for the first phase of the project was submitted for consideration to both committees in April 2003.

Negotiating access and developing relationships

According to Shulamit Reinharz (1992) the development of research relationships is important within research as they enable the development of an understanding of the context in which current services are provided. For me, this began with the Trust itself and a key aspect of this was the recruitment of a Consultant Clinical Psychologist onto the supervisory team for the PhD. This individual was also a practising clinician within the locality. This relationship I found offered key support in facilitating access to the managers of the eight services in the locality. Nevertheless, initially, I did not draw upon this relationship and I attempted to negotiate access on my own with the managers. However, I found that attempting to do this was extremely problematic. I received no replies from the first letters of invitation that I sent to the senior managers within each of the services despite follow-up telephone calls two weeks after to explain that I could attend a meeting at anytime on any day of their preference. On reflection, on this

particular point in the research process, I believe that I was quite naïve as a researcher as I assumed that as soon as the professionals received the information about the study they would be as interested and as keen to be involved as I was.

According to Hirsch (1995) access is sometimes easier for researchers who have existing links with those in power. In the case of this research I found this to be the case. After a meeting with my supervisor, who was also employed in the Trust, it was agreed that in the first instance he would make contact alone with the various operational managers within the locality to establish their initial thoughts and views about the research.

I agreed with my supervisor that this was probably the best way forward but at the same time I was extremely reluctant to do this, although I did not voice my reservations to him. My uncertainty was not with regard to his position within the Trust and his ability to gain access and establish rapport with the operational managers. It was more related with my own issue, at this point in the study, with regard to my research-based selves I was *being a controlling researcher*. I wished to 'control' and be involved with every aspect of the research process and yet this would be the first (of many) process where I would have to relinquish this control. I found this extremely difficult to do as I felt that if I did so I was losing *my* PhD. However, as a consequence of relinquishing some control of the study I found that within the space of a week a meeting was arranged with two of the operational managers in the locality, which both my supervisor and I attended.

Each of the managers was accountable for different services within the locality but both appeared keen and interested to be involved in the research process. The first meeting was with the operational manager who was responsible for the forensic unit within the

locality. This meeting appeared to go well and although he made a number of suggestions on how the research study may be changed to incorporate the women who 'self-harm' in the prison service he did provide me with the contact name of the manager on the women's ward of the forensic service. In the next meeting with the second operational manager the establishing of rapport and access was much easier and this seemed to be due to two factors. Firstly, my supervisor had had previous contact with her in relation to his daily clinical practice and so the rapport between the two of them as colleagues was already established. Secondly, it became evident through the course of the meeting that she was a previous acquaintance of my husband's (who is also a mental health practitioner) and had worked with him several years ago. Interestingly, I therefore had an 'insider status' at this point in the research process. Platzer and James (1997), suggest that this status of the researcher as an 'insider' can reduce the difficulties in research in terms of access and rapport with participants and therefore reduce the gaps that the researcher may have to overcome if they had an outsider status. By the end of this meeting it was agreed that she would inform four out of the eight service managers' of our meeting and provide them with my contact details if they wished to pursue the study further.

Negotiating access and establishing rapport was an ongoing process throughout the fieldwork and it involved multiple levels of 'gatekeepers' that included secretaries, personal assistants and other professionals. When I encountered 'new' gatekeepers I would send them a letter inviting them to be involved in the research and within these letters of invitation, I 'personalised' the research problem (Thomas, 1995) by making it clear that I was interested in *their* views and experiences.

Development of the conversational interviews

Deciding upon which interview approach to use in the study was an arduous and challenging process. Originally I had thought that the format for the interviews with the health care professionals would be quite structured. Frey and Oishi (1995) define a structured interview as a '...purposeful conversation in which one person asks prepared questions (interviewer) and another answers them (respondent)' (p.1). In this situation the interaction between the two individuals is kept to a minimum and each interview is conducted in exactly the same way. Nichols (1991) asserts that structured interviews assume that:

- there is a common vocabulary for all potential respondents,
- question formats have meaning to all, and
- the context of each question is obvious.

However, through discussion with my supervisory team and by reflecting on the information that needed to be gained for the research study it was thought that this method of interviewing might be too *inflexible*. This was primarily because the number of possible responses for the health care professionals may be quite restricted due to the structure of the questions, and it was felt that this may force them into giving responses which they believe I wanted to hear (Kirk and Miller, 1986). Upon further reflection at this point in the research process, I believe that in relation to my research-based selves this inflexibility was about me *'being a controlling researcher'*. I believe that the rigid and structured interview schedule that I originally developed was based once again on my wish to have *total control* of how the research developed. I wanted to make sure that I was gaining the information that 'I' thought I needed to gain from the

participants to meet the research aims. Once again there was a need for me to relinquish my control over the study otherwise the interviews would only gather a limited amount of information and there would be a lack of richness in the data (Richardson, 1996). I therefore developed another research self at this point in the study, which involved me *'being a flexible and adaptive researcher'* and realising that I could not control every aspect of the research process.

Furthermore, because of my theoretical stance, which had developed from a phenomenological approach and more towards a Foucauldian approach (Parker 1992; Willig, 1999) tensions were being created, since within a social constructionist framework, it is recognised that interviews are co-constructed events (Wertsch, 2001). Consequently any researcher working within this paradigm must be aware to try and avoid directing, controlling or seeking to impose upon the interview situation any 'realist' version of the phenomenon they are seeking to explore and uncover. Willig (2001) argues that the preparation and utilisation of a schedule in an interview serves to privilege the position and 'a priori' knowledge of the researcher and may therefore restrain what can be discussed or said by the participants. It was therefore imperative that how the interviewee frames and understands issues and events should be explored (Kvale, 1996).

Through this reflective process the initial structured interview format was altered tremendously and a *guide* was developed rather than a schedule (Kvale, 1996). It was hoped that this format would allow both the following research objectives to be met,

- to gain an understanding of the discourses and discursive practices through which 'self-harm' and the diagnosis of 'BPD' are constructed within this service.

- to explore the discursive resources that health professionals draw upon when delivering services to women.

The interview guide consisted of an outline of topics and issues to be covered (see appendix 1) which were informed by the research aims, the literature review and the research relationships that I had started to develop. I decided that a conversational interview format would be followed. Conversational interviews are defined by Nichols (1991) as interviews that allow '...fieldworkers to be free to deal with the topics of interest in any order and to phrase their questions as they think best' (p. 131). In this approach it is essential that the interviewer and participant *collaborate* and talk about the meaning of the questions until they are confident they adequately understand each other (Cicourel, 1973; Clark, 1992). The conversational technique is therefore 'flexible' and 'exploratory' as although the interviewer has an outline of topics or issues to be covered the wording and order of the questions can be varied as necessary to help participants understand questions (Mishler, 1986). This could involve defining concepts when participants specifically ask for clarification or when the interviewer judges that the participant might be confused or have misunderstood the question (Conrad and Schober, 1998).

According to Patton (1990) the participant may have more control over the conduct of the interview in that they are often allowed to discuss issues as they arise and not necessarily in an order predetermined by the interviewer. Thus, conversational interviewing can be seen as highly individualised and relevant to each individual (Patton, 1990). The flexibility of the questioning allows interviewers to glean the ways in which the research participants construct their social world (Richardson, 1996; Burgess, 1984),

and furthermore information or insights may be gained about a topic area that may not have been anticipated.

Preparing and formulating the questions for the interview guide

In preparing for qualitative interviews Lofland and Lofland (1995) propose that researchers should ask themselves the question 'Just what about this thing is puzzling me?' (p.78) They suggest that this question can be applied to each of the research questions that have been generated or it may be a mechanism for generating some research questions. This question did stimulate and influence the initial thoughts that I had about the research as did the existing research and literature on 'self-harm' and 'BPD' when it was reviewed. Discussions with my supervisors, colleagues, friends and relatives also stimulated the puzzlement that was generated in the initial development of the interview guide.

Throughout this preliminary preparation of the topic areas I was also aware that the guide should not be so specific that alternative avenues of enquiry, which might arise during the collection of data, become closed off. Such premature closure, according to Kvale (1996), would be inconsistent with the process of qualitative research, with the focus on the view and experiences of the individuals who will be interviewed, and with the approaches of data analysis. A further question that Marshall and Rossman (1995) assert is that researchers should also ask is 'What do I need to know in order to answer each of the research questions I'm interested in?' (p. 25) This entails trying to gain an appreciation of what the research participant sees as significant and important in relation to each of the topic areas that developed. It was therefore equally important that the topic areas were covered that were needed to illuminate each of the research objectives, but at the same time also needed to be from the perspective of the research participants.

Once the interview guide had been completed and an outline of the topic areas and issues to be covered with the health care professionals were formulated it was important that I undertook a pilot interview.

The term pilot interview in social science research refers to the 'pre-testing' or 'trying out' of a particular research instrument (Baker 1994; De Vaus, 1993). Peat, Mellis, Williams and Xuan (2002) assert that pilot studies are a crucial element of a good study as they can provide valuable insights for the researcher. These interviews may identify potential practical problems in following the research procedure such as poor recording, participants can be asked for feedback to identify ambiguities and difficult questions and each question can be assessed to see if it gives an adequate range of responses (Van Teijlingen and Hundley, 2001). Hollway (1997) also argues that a major reason for the piloting in qualitative research is because '...the researcher lacks confidence or is a novice, particularly when using the interview technique' (p. 121). The pilot interview was undertaken with a Consultant Clinical Psychologist from the NHS Trust where the research study was being carried out. Once the pilot interview had been undertaken some of the topic areas were removed and others were revised in order to increase relevancy to the area. (see appendix 1 for a copy of the interview guide). Figure five overleaf illustrates the process that was followed for the formulation of the topic areas for the interview guide.

General
research
area → Specific
research
questions → Interview
topics → Formulate
topic
areas

Review/
revise
topic
areas

↓

Pilot guide

↓

Identify novel
Issues

↓

Revise topic
areas

Purpose of service
Understanding of 'self-harm'
Understanding of 'BPD'
Service provision/intervention

↓

Finalise guide
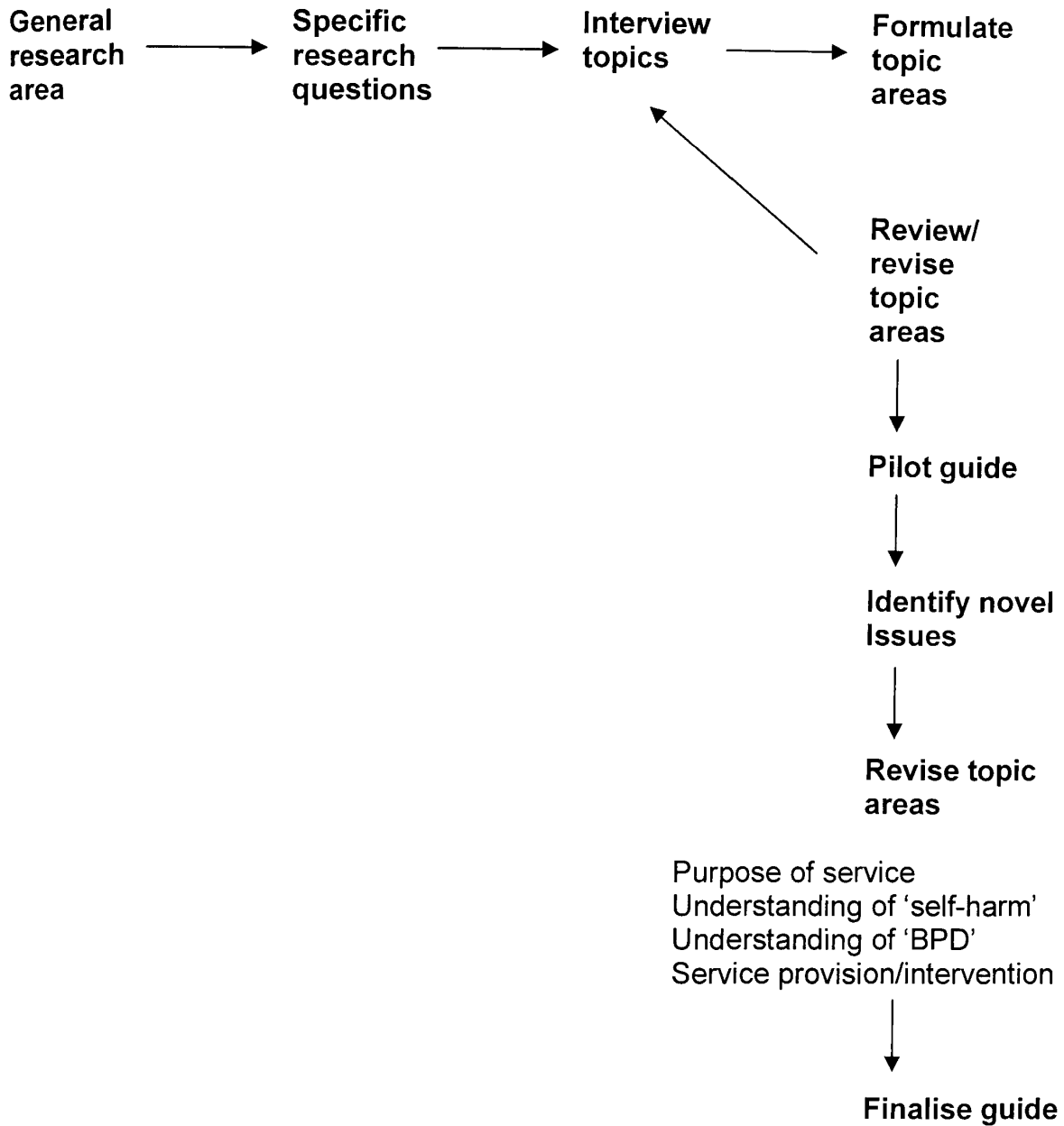
(Adapted from Richardson, 1996)

Figure five: The process for formulating the questions for the interview guide

Ethical considerations

In the next part of this chapter, I wish to discuss the ethical principles and issues that warranted identification and negotiation in phase one and two of data gathering for the research. These included issues of:

1) respect for human dignity
2) justice
3) beneficence
4) non-maleficence

The principle of respect for human dignity involves ensuring that an individual's consent to participate in research is informed and given freely. According to Roberts and Taylor (1998) within the research context, the researcher has an ethical obligation to disclose to all potential participants the purpose and nature of the research, as well as any potential benefits or risks. Further, no elements of the research must be concealed from the participants so that they are misled about the research (Minichiello, Sullivan, Greenwood and Axford, 1999). Participants, in turn, have a right to refuse to participate and to withdraw from the study at any time. In order to accommodate this issue and to ensure that the participant's consent was informed I developed an information sheet which outlined the aims of the research, why they had been invited to participate, what the research involved and what would happen to the information after their participation. Each of the participants who were invited to be involved in the research was sent an information sheet (see appendix 2) and once they had agreed to participate, before the interview commenced I once again went through their rights as participants.

The second ethical issue involved the principle of justice that refers to the right to confidentiality and anonymity (Roberts and Taylor, 1998). Confidentiality was maintained in the research by the removal of any reference to identifying information (British Psychological Society, 2000), prior to the audio recordings being transcribed by myself. The participants were also told that the tapes and the transcriptions would be kept in a locked drawer in my office at Huddersfield University, and electronic information would be kept on a password-protected computer in my office. Consequently, I was the only person who knew the identity of each of the research participants. With regard to protecting the anonymity of research participants, I assigned a pseudonym to each of the participants (Odendahl and Shaw, 2002). The pseudonyms chosen randomly had no connection with the participants' own names. I also sought to avoid the inclusion of any information or characteristics that might identify an individual participant in relation to their professional position because this may make them visible within their own organisation when the final report would be sent to the Trust on completion of the thesis.

The third ethical issue that is important for this research is the principle of beneficence. According to Roberts and Taylor (1998) this refers to *to "doing good"*, whereby the outcome of the research should benefit society or individuals. With regard to this research the individuals who may benefit from this research are arguably the women as they are being given an opportunity to tell their stories. The principle of non-maleficence is incorporated into beneficence, and means to *"do no harm"* (Beauchamp and Childress, 1994). With regard to this research I was extremely aware that for the women by telling their stories and talking about their personnel experiences that it may cause them distress and upset. To ensure that support was available in the event of such distress, the women would be able to speak to their key worker/professional after the

interview if they wished for further support. Thus, having prepared the interview guide, identified how the participants would be selected and made arrangements for the ethical issues that may arise in the research, the next step in my journey was to make contact and recruit the participants for the study.

Making contacts and recruiting participants

The sampling approach that I used in the study was *purposive,* which involves selecting a particular sample on purpose (Patton, 1990). This technique was chosen for the study because it would allow *key informants* to be chosen that were '....relevant to the research questions...' and will help '...to develop and test a theory or argument' (Mason, 1996, p.124). It was envisaged that the *key informants* would also have an understanding of the women. Further, because this phase was only related to the health care professionals' perspective in relation to women's mental health issues, and not the entire population, issues of representativeness were therefore less important (Polit and Beck, 2004). After two weeks the manager of each service made contact with me and suggested names of potential participants who had volunteered to be interviewed. I then contacted the key informants so that a convenient interview date and time could be arranged.

Interview preparation

Mason (1996) argues that when researchers are undertaking qualitative research methods it is important that preparation for the sessions has been undertaken in advance. I have already commented earlier upon the pilot interview that I undertook with a Consultant Clinical Psychologist from the NHS Trust and how the interview guide was slightly amended once this was completed. The next step of my preparation was

therefore to further familiarise myself with the interview guide and the questioning techniques that I planned to use in the interviews. I was aware that *'being a nurse'* in this part of the research process may have an impact on the interviews and I did not wish for the participants to assume that I always understood everything that they said to me. I was conscious prior to undertaking the interviews that I could possibly 'misinterpret' the participants' responses because of my previous 'insider' experience of *'being a nurse'*. I therefore practised such techniques as being *puzzled* and *confused* which would indicate to the participants that elaboration was needed. I also thought about how I might deliberately *contradict* what they said in an attempt to arouse further comments, however, I was aware that I needed to do this in an *encouraging* and *supportive* manner so that they would be enabled to carry on (Mason, 1996).

The next step was to prepare for how the data would be recorded. I thought about attempting to make notes in the interactions that I had with the professionals, as I believed that this might make them more relaxed and less nervous than having a taping device in the room. But I was worried that I may not capture exact phrases and statements made by the participants and I was also aware that I did not wish the note taking to interfere with the discussion. A pragmatic choice was therefore undertaken to use an audio-recording unit, despite its shortcomings in supplying a rather 'decontextualised' version of the interview (Kvale, 1996). In order to make up for this I also made field notes at the beginning and after each session to facilitate data analysis[6] (Morgan, 1988).

The final factor that I needed to consider in my preparation for the interviews was in relation to *[my]* selves. *Being a researcher* I was aware that I was extremely sensitive to the negative connotations that might be voiced by professionals in the study about the women. This was based upon both my previous experiences of *being a nurse* and *being a psychologist* as well as the research literature that indicated that this might happen. I therefore felt that I needed to reflect upon my biases, understandings, theories, beliefs, habitual modes of thought, and judgements (Kvale, 1996) when preparing for these interviews. I did find this difficult and hard to do but I was aware that it was important that I was sensitive to the intrusion of biases in the interview situation. In order to address this I therefore listed the ways in which my characteristics might bias me at research interviewing. I then wrote how I might counteract these biases. Through this exploration and reflection of these particular selves I identified that I might need to be supportive and non-judgemental in the interviews with the professionals.

Reflections on interviewing the professionals

During the interviews, a key problem was how much of my own knowledge on the subject area to disclose (Alder and Alder, 1987) because although I had attempted to prepare for this prior to the interviews I found that I tended to fluctuate between 'knowledgeability' and 'naivety' (Ball, 1994). In some cases, I had to 'show off' my previous knowledge of mental health, otherwise they tended to talk about this generally rather than focusing upon the issues of 'self-harm' and 'BPD'. I also felt at times that some participants were patronising me. For example, they would 'check out' my knowledge by trying to ask me about any of my previous experiences in the area. I

would carefully explain in these instances that I was there to obtain *their* personal reflections, views and experiences of the area.

During the interviews, I found at times that some of the professionals appeared 'cautious' about the responses that they were giving and often some would ask for reassurances regarding anonymity and confidentiality. On two occasions, when I had finished the interview and turned the tape off the professionals gave a big sigh of what appeared to be 'relief' but yet continued to talk about the area in what appeared more detail than when the tape had been on. In these cases, what they told me was not earth shattering – they had already voiced some of it earlier in the interview – but what was significant is that they believed it was too sensitive and did not want to risk that they could be caught saying it. I would like to note here that I did not use any of this information in the analysis that I present and discuss in chapter five. Similarly, during interviews, participants would make comments and then say, 'This is only for you'. They did however want to disclose this knowledge and information to me. Often, at the end of the interviews participants wanted to know if what they had said to me agreed or corresponded with what others had said. Comments such as 'How does this compare with what others have said?' and 'Is that what everyone else has been saying?' When asked these questions, I gave vague responses as I had given all participants assurances of confidentiality and anonymity.

Many of those interviewed expressed knowledge of research, methodology and the research process. In many instances, this had benefits for the research and interviews. For example, participants were amenable to being tape-recorded. Some of the professionals had experience of undertaking research, reading research, and in some

cases, conducting research. Comments such as 'When I was doing my MSc...' or 'I did some research myself a few years back' were frequent. In effect, the research process could not be mystified and my performance as a researcher was transparent. I was on display, exposed and therefore could be judged.

Summary

The aim of this chapter was to provide a contextual framework of 'self-harm' and 'BPD' mental health services within the locality. This detailed picture of the different services has allowed the reader to gain an understanding and an insight of where the data was obtained and where the professionals were based across the locality. The analysis of this data from the conversational interviews by the means of Foucauldian discourse analysis will enable a detailed mapping of the discourses through which 'self-harm' and 'BPD' is constructed within the localities services. Furthermore, it will allow for an understanding of subject positions made available to health professionals through their adoption or resistance of such discourses.

Chapter 4

Clinical talk: exploring the constructions of 'self-harm' and 'BPD' in the accounts of health care professionals

Overview

This chapter aims to provide the reader with a description of the process and method that was utilised in analysing the conversational interviews with the eight key informants from the first phase. Throughout the chapter I will present an interpretation of the transcripts and I aim to identify some of the constructions, discourses and discursive practices that health professionals draw upon when discussing the women.

The aim here is to give 'multiple perspectives' on the 'same' situations, and focus on how 'self-harm' and 'BPD' are constructed in their everyday clinical practice situations. This chapter therefore relates to both the second research objective *'to 'gain an understanding of the discourses and discursive practices through which 'self-harm' and the diagnosis of 'BPD' are constructed within this service'* and the third research objective which aims *'to explore the discursive resources that health professionals draw upon when delivering services to women'*.

Adopting a Foucauldian approach to data analysis

As I highlighted in chapter two the concern for this phase of the research is to identify the way that language mediates, or shapes, the complex relationship between the self and the social world (Foucault, 1979) and the impact of institutional environments and dominant discourses upon social phenomenon (Foucault, 1979). A Foucauldian approach does not presume to know the truth or reality of an individual's life, but does try to explore the way in which individual actions may be constituted through social processes. This study therefore follows Willig's (2001) six-stage guide to discourse analysis, which is consistent with the post-modern feminist position that underpins this research. Willig's (2001) approach offers the opportunity to explore the dominant discourses of women's mental health (Weedon, 1987). These dominant discourses in mental health, it might be argued, transfer and impact upon how health care professionals construct 'self-harm' and 'BPD' and subsequently respond in terms of support and treatment. It is believed that this exploration and identification of the constructions, discourses and discursive practices in this area might facilitate the feminist commitments to demystification and provoke change that benefits women (Weedon, 1987).

The analytical process

Willig (2001) provided the main rigorous approach that guided the analysis of the transcripts. The focus of the analysis was the identification of discursive constructions ('self-harm' and 'BPD') and the subject positions contained within them. I was therefore concerned with the discursive resources that the professionals drew on when they constructed particular versions of reality (Willig, 1999). The analytical process that I followed utilised the following steps:

Step 1

After each of the interviews I made brief notes that highlighted the interesting features of the interviews.

Step 2

During the transcription some of the extracts were marked according to certain criteria, for example, relevance to research aims; analytically interesting i.e. that there was a lot going on in the extracts and good illustrations of dominant themes emerging. Further notes were therefore made and kept of these points as I transcribed each of the eight interviews.

Step 3 – discursive constructions

Following transcription, my reading of the notes and the repeated reading of the transcripts aided me not only to explore the accounts but also to highlight and identify the ways in which a 'discursive object' is being constructed within the text. According to Willig (2001) in order to assist the researcher in this first stage of her procedural guidelines every mention of the object, both implicit and explicit must be identified.

Step 4 – discourses

Following this process, the next step that I needed to attempt was to identify the wider discourses in which these constructions might be located (Willig, 2001). I asked such questions as:

- What kinds of words have been used?
- What are its connotations?
- Does it reflect wider discourses available in our social world?

In the case of this research for example, a construction of 'BPD' as 'risky and dangerous' might be considered to arise from the wider 'discourse of risk' that may operate within mental health and wider society.

Step 5 - action orientation

This next stage aims to consider the 'action orientation' of the constructions (Willig, 2001). That is, what is gained by constructing the discursive objects in a particular way? What 'functions' do the constructions serve?

Step 6 – positionings

The next step that I then engaged in was to analyse the scripts for 'subject positions'. How does the construction of the discursive objects and the wider discourses offer subject positions? From which locations are individuals allowed to speak or act from within the text? This step is important in the Foucauldian discursive approach because the subject positions that are made available open up some ways of speaking and acting for certain individuals while closing them down for others (Willig, 2001).

Step 7 – practice

Following on from *step 6* the next step that I engaged in with regard to the analysis of the interviews involved an in-depth exploration and examination of how the discursive objects and the subject positions contained within them influenced opportunities for action. Thus, each way of viewing the discursive object can make available differing subject positions, which can enable or constrain what can be said and done from that location (Willig, 2001).

Step 8 – subjectivity

The last step in this analysis involved drawing upon the earlier steps and examining the impact of the discourses, constructions, and practices and subjects positions on an individual's subjective experience. How do they impact on how an individual feels, thinks and experiences their everyday social encounters?

Reflecting on [*my*] selves in the analytical process

At this point in the chapter I think that I need to present and discuss [*my*] selves in relation to these stages of analyses as I went through quite a learning and developmental process with regard to my 'research-based selves'.

Being a naïve researcher

At the outset of the data analysis process I believe that I was really quite naïve regarding the amount of information that I may obtain through the use of a discursive analytic approach. In line with Willig's (2001) rigorous approach I began the analysis by reading the first transcript line by line and exploring what might be constructed in each phrase and sentence. This process of analysis I found was extremely arduous and extensive and I had not taken into account the rich and detailed information that I would identify from a single transcript. The amount of discursive objects, discourses and constructions that I identified from the one interview was vast and I had not accounted for this when I commenced this part of the research process. I therefore decided that I needed to 'step back' from the data that I had and reflect upon how I would now proceed with the process of analysing the interviews.

Being a selective researcher

Through reflecting and acknowledging my naivety at the beginning of the process of data analysis I decided that I really needed to restrict and narrow my approach so that I specifically identified the constructions of 'self-harm' and 'BPD' and the constructions of responding to the women. Throughout this 'sifting and sorting' process I still maintained a detailed line-by-line approach. The resulting analysis of the eight transcripts extended over approximately eight months and this process made me extremely aware of potentially being 'trapped' in a continuous cycle of data analysis that never ended. Detaching myself from the close contact with the texts and positioning the constructions and discourses I had identified, within the whole, was a necessary struggle.

A further astonishment for me was despite the 'sifting and sorting' process that I had engaged in at the beginning of the analytical process I still found that I ended up identifying an array of discourses. I once again had to decide in line with the aims of this stage of the research, which discourses, and constructions to include and elaborate on. In making this choice, time and space to reflect was important. At this point, I would like to make it clear to the reader that the interpretation of the analysis that I present in the next part of the chapter aims to provide a discursive account of the ways in which 'self-harm' and 'BPD' are constructed within the locality's services and the discursive resources that health professionals draw upon when delivering services to women.

Being perceived as a 'critic'

When I was writing the next part of this chapter I was extremely concerned about how *my* interpretation of 'self-harm' and 'BPD' within the locality might be perceived. I was conscious that those who had kindly participated in the study and other non- university

scholars who may read the thesis may perceive that I was only aiming to critique them as professionals and the services that they offer to the women (Kitzinger and Wilkinson, 1997). I would therefore like to acknowledge here that there are many ways to interpret the participants' talk in the interviews. Thus, my aim is therefore to present and critique the socially and culturally available discourses within mental health, not those who advocate and take them up.

Being a post-modern feminist

Lastly, I would like to emphasise that the analysis that I present here is based upon a post-modern feminist position. By adopting this perspective I believe that I am presenting to the reader an account that does not aim to offer a 'truer' version of 'self-harm' and 'BPD' than that which the participants offered. My aim here is to highlight how alternate understandings to those that are dominant can be used to illustrate the conflicts between interpretations, knowledges and truth claims (Willott, 1998). Further, I aim to create and provide a site that will contest the current meanings in this area and which will hopefully reveal the power relations that sustain and maintain them (Willott, 1998).

Introducing the mental health professionals

In line with the adoption of a social constructionist perspective a key element is the acknowledgement that knowledge is co-constructed, contextualised and situated (Gergen, 1999). Consequently, before presenting my interpretation and account I aim to provide the reader with a 'précis' of the people that participated in phase one of the research. Due to the necessity of maintaining the anonymity of participants this information is extremely limited but I believe that it is very important to offer the reader

115

context regarding their position, profession and geographic situation within the locality's mental health services.

Robert

Robert is a senor practitioner employed within the Crisis Resolution Service.

Amelia:

Amelia is a clinical psychologist employed within Psychological Services.

Stewart

Stewart is a registered mental health nurse working in the Acute Inpatients Service.

Phoebe

Phoebe is a senior professional employed within the Primary Care mental health service.

Alice

Alice is a senior practitioner working in the Forensic Services.

Henry

Henry is a community health nurse working in the locality.

Edward

Edward is a senior professional from the Assertive Outreach Service.

Stephanie

Stephanie is a consultant psychiatrist working in the locality.

Constructions of 'self-harm'

Professionals constructed 'self-harm' as individualised, a personal responsibility and not a primary concern. In their accounts the self-harming behaviours of women appeared to be constructed as indicative of individual character failings or major flaws in moral fibre. By drawing upon these constructions professionals appear to provide a deterministic explanation that emphasises and positions women who 'self-harm' as failing to adequately cope with the trials and tribulations of life events as well as having a lack of control over their actions.

Individualised and a personal responsibility

'Self-harm'-as-individualised in the professional's accounts apportions blame to the individual women and positions them as being accountable for their behaviour. Within this construction, 'self-harm' is their problem and they are held 'responsible'. When discussing previous clinical practice about helping and supporting women who had self-harmed, Henry, a professional employed in a community mental health team deployed this construction and stated,

> **Henry:** *'...this is something you could do to help <u>yourself</u>....'*

This construction positions the woman who has self-harmed as needing to help herself by gaining control and managing her emotions in order to achieve an ideal way of being. Weinberg's (1997) work in the USA on the social construction of mental disorder is relevant in this context. He discusses how a distinction is drawn within the mental health care arena between conduct that was a manifestation of mental disorder and conduct that was not. Mental disorder was regarded as an 'autonomous non-human entity' which

service users struggled with and which sometimes exercised control over their behaviour (Weinberg, 1997). Where conduct was derived from this 'non-human agency', individuals themselves were not regarded as morally accountable. However, in contrast, where conduct could be attributed to the 'self' as a human agent, then the individuals concerned are considered morally accountable for their actions (Warner and Gabe, 2004).

The importance of this distinction in relation to 'self-harm' was constructed further on a number of occasions, for example when responding to a question about whether 'self-harm' was linked to responsibility issues' another professional, Robert, responded,

> **Robert:** *"We can help you to a certain extent, but you have to help yourself as well.'*
>
> **Tammi:** *'Right, right.'*
>
> **Robert:** *'There's choices to be made.'*

In this excerpt there is a clear emphasis that the mental health services are helping women to *help themselves* they are therefore clearly putting the onus for the behaviour back onto the individual woman. The remainder of Robert's response appears to position women as having *'choices'* to make about their self-harming behaviour. 'Self-harm'-as-a-personal-responsibility therefore appears to construct women as active agents who have *moral agency* and the ability to choose. Drawing upon the work of Nikolas Rose (1999) women who 'self-harm' appear to be positioned by the mental health care arena as rational, autonomous and self-managing individuals (Rose, 1999) who can make a choice about how they behave.

Not a primary concern

Accounts of what 'self-harm' was tended to be almost exclusively in line with existing psychiatric diagnostic groupings. Professionals constructed 'self-harm' with descriptions of other syndromes. The construction of 'self-harm'-as-not-a-primary- concern was deployed by Stewart several times when talking about the history of women who 'self-harm' and how they became referred for needing assistance and support for their self-harming behaviours,

> **Stewart:** *'...I think it probably is often, well a factor, _one_ amongst many.'*
>
> **Tammi:** *'Yeah, Right.'*
>
> **Stewart:** *'I suppose referrals, when they come through may say this person has a history of depression, taking anti-depressants, _oh yes_ and they self harm...so it's kind of, part of the mix....I don't think you get many referrals where it's, self harm is being raised as the number one issue...'*

In this excerpt 'self-harm' is not constructed as being a *primary concern* for mental health professionals. Rather it is constructed as a being a *constellation* and part of a range of other illnesses or symptoms. It maybe suggested that when women present with this issue they are positioned as *occupying a lower priority position* than service users who present with other mental health issues. Thus, when women require some form of support for 'self-harm' it may be constructed by professionals as a *symptom* or *'part of'* some other illness in the psychiatric diagnostic system.

This construction is echoed at a later point by Stewart when he is asked about how 'self-harm' is viewed within the team by other health professionals,

Stewart: *'I mean it all runs along into the issue around working with people with personality disorder, it bumps into all of that...'*

It might be possible then that the concept of 'self-harm' may be located or categorised in the medical discourse of 'madness'. Within this discourse the mental health professionals are often positioned as the *expert* and *all powerful* as they are the only ones deemed capable of diagnosing, classifying and treating this thing called 'madness' (Ussher, 1991). Hence, when women present with 'self-harm' they may only be taken *seriously* by mental health services when it can be categorised or classified with another mental illness, for example, 'BPD'.

A further consequence for women that may evolve from this and which are deployed in the excerpts of Stewart's overleaf is that they may become constructed by professionals *not* as individual women who have their own history, their own roots and their own experiences. Rather, individual women may become positioned as part of a homogenous group with a constellation of symptoms. For example, previous research by Feldman (1988) has illustrated how staff react to service users as 'a depressive', 'a borderline' or, as in the excerpt above *"as personality disordered"*. These labels therefore position women to the level of the mental illness or of their symptoms (Feldman, 1988).

Childhood and traumatic histories

Discussion by the professionals about the possible reasons for the women's self-harming behaviour centred upon issues of trauma and abuse. Childhood physical and sexual abuse figured prominently in the histories of those women that the professionals

had had contact with. Amelia, Edward and Phoebe highlighted these as possible factors in their accounts,

> **Amelia:** *'...lots of quite em severe problems and trauma...I'm thinking I suppose...typically most of these people would come under the umbrella of sexual abuse and sort of been in the service, we've typically em (.) had a lot of experience within sexual abuse...'*

> **Edward:** *'Em, I think it's often characterised, again, as I said earlier, by a sort of history a sort of chaos or abuse or you know, or trauma really in, in their sort of past experience.'*

> **Phoebe:** *'Em...with complex problems...experiences in early childhood, which were around abuse and that sort of thing.'*

This recognition of histories of trauma in women by the professionals in health care is quite a recent recognition and as Judith Herman (1992) notes,

> *'...sexual abuse has been taboo, repressed for so long that it is now entering our consciousness in a very dialectical, polarised way. It has to. If it threatens establishment views, it should, because therapists have really missed the boat in an important way, one that was predictable in a male-dominated profession with a female population.' (p. 250)*

For Herman, then, trauma provides a narrative comprehensibility to the variety of symptoms expressed by women who have a history of child sexual abuse as well as

121

neglect and abandonment. However, what was interesting in the accounts of the professionals in this research was that although there seemed to be this recognition of childhood trauma and abuse as a possible causal factor leading to 'self-harm' further in their accounts the professionals stated that often they had seen in their clinical practice that professionals would not ask about these issues. Often professionals, they suggested, would not ask *why?* They would not discuss and ask the women *why* they were harming themselves. Henry, Robert and Phoebe echoed this in their accounts,

Henry: *'Em, (2) so I would talk to someone about, I mean often an obvious question that never gets asked is why do you want to do that? Why are you feeling that way?'*

Robert: *'Em, (2) I always remember I was doing my nurse training and somebody came to talk to us in one of the lecturers, training across a number of months and em (.) I think she had a history of self harming and she said in all my contact with services, nobody ever sat down and said why do you do it?'*

Phoebe: *'You know, it's such an obvious question. (I) Why do you think that is, why do you think that...? Why do you do it?'*

Within this construction, 'self-harm' appears to constitute a threat to professionals that they attempt to guard against. Professionals position themselves as 'silent' receptors when involved in this aspect of women's mental health care issues, as they may be unable to listen and speak to the women about the issues that they will tell them. Support for this interpretation was given in the accounts below when the professionals were discussing how they responded to women who self-harmed.

Responding to 'self-harm': operating within a problematising discourse

A problematising discourse

In recent years the literature in the field of mental health has attempted to illustrate professionals' experiences of responding to women who 'self-harm' (Morgan, 1979; Feldman, 1988; Pembroke, 1994). A prominent discourse that has been drawn upon by the professionals to frame their accounts is one which problematised responding. This discourse serves to construct responding to 'self-harm' as a problematic issue for the health professional. Within the context of this research study the professionals framed their constructions of responding to 'self-harm' almost exclusively within a problematised discourse.

Firstly, participants constructed responding in terms of *distancing* or *avoiding* women, who 'self-harm', for example, both Henry and Phoebe highlight these constructions in their accounts,

> **Henry:** *'...I am not aware of anybody in the team that would make a bee line for people with self harm problems, in fact (.) the reality is that it would probably be the opposite (laugh)....'*

> **Phoebe:** *'For myself I mean (2) it's incredibly uncomfortable working in this area...it feels quite frightening.'*

In Henry's account the use of '*in fact*' is emphasised and followed by a pause that indicates that 'self-harm' may hold a contested status for him, which he may not wish to struggle with or overcome. The remainder of the response appears to suggest that he would rather position himself as *staying away* from 'self-harm' issues when dealing with women.

Secondly, responding to 'self-harm' provoked responses from professionals in which they remarked upon 'feelings' and not knowing 'what to do'. Here, professionals are positioned as vulnerable to women who 'self-harm'. This excerpt by Robert seems to highlight this position,

> **Robert:** '*...You can be extremely uncomfortable, trying to talk to that person about why they feel that way and then look at alternatives that they might be able to put into place to cope with what's happening with them, <u>but</u> (.) I know people, feel incredibly pressured and never quite sure where to turn...*'

In this text Robert once again accentuates an aspect of his talk when using '<u>but</u> (.)' in this manner and then following it by a pause. This denotes that when he has to talk to women about their emotions and the issues involved with 'self-harm' it may hold a contested status for him. It may present him with problems as he literally may not know what to do, '*...where to turn...*' and therefore how to respond.

Professionals also constructed the impact of responding to 'self-harm' in a seemingly negative manner as indicated by Alice '*...it conjures up a lot of negative feeling doesn't it.*' This would appear consistent with research literature that indicates that psychiatrists and mental health professionals often experience intense negative emotional reactions

to women who 'self-harm' and who also have the diagnosis of 'BPD' (Lehmann, 2003; Cleary, Siegfried and Walter, 2002). Furthermore, professionals linked this negativity with a feeling of frustration. Edward echoed this,

> **Edward:** *'Very negatively really. Em, I believe it seems to create in professionals a degree of frustration.'*

Further, Robert reiterates that responding to women who 'self-harm' is uncomfortable, but he seems to suggest that the cause of this frustration does not lie with either the professional or the individual women but rather the lack of sufficient training when dealing with women in practice,

> **Robert:** *'I think because when (.) you're working with somebody with (.) it does (.) bring up in yourself, lots of feelings of frustration, lots of feelings of being uncomfortable, but that's probably down to not having sufficient training and how to work effectively what would effective look like? with them, and so because of this you try not to get involved (.)'*

Thus, Robert seems to suggest that responding to 'self-harm' may continue to cause levels of frustration and a feeling of being uncomfortable for professionals until training has been given. In line with this issue of responsibility for the professionals not getting involved being because of 'external' issues Alice purports that not only is specific training required when responding to the women but the *support of the organisation* is also needed to pursue these issues,

> **Alice:** *'what I would understand, (.) there's a particular way perhaps of dealing with somebody on the phone or someone in front of you talking like that, threatening to do this, em, (2) that's potentially therapeutic...But in order to pursue that you need support of the organisation and I'm not always sure that's there.'*

The support that Alice believed was required was with regard to clear guidelines, protocols, supervision and *'...a professional consensus in mental health about how to approach such things'*. This construction of responding to 'self-harm' as being uncomfortable for professionals because they lack specialist training and support implies that mental health professionals have no control or responsibility to women who 'self-harm'. Thus, professionals are positioned as 'innocent bystanders' who are not accountable to women until the organisational structure has appropriate systems and support mechanisms in place for them to respond proactively.

Lastly, a professional constructed responding to 'self-harm' through a negative metaphor. Henry deployed that responding for him was like feeling the,

> **Henry:** *'...spotlight has been turned on you to react to do something.'*

Davis (1994) asserts that a function of a metaphor is to allow individuals to construct certain elements of their experience in terms of something else. What a metaphor therefore may serve to do for an individual is to obscure other aspects of their experience from view, thereby giving them the power to create and define reality. By constructing responding to 'self-harm' through such a metaphor, Henry may be attempting to distance himself from the reality that no reaction on his part may perpetuate or increase risk for the woman who has self-harmed.

126

Some support is given for this argument, as further on in the interview he further states,

Henry: *'....But for the individual worker, you're left (.) feeling extremely uncomfortable if you don't do something practical, physical, tangible, then if something was to happen, I think there's a genuine fear there people saying well you didn't actually react to this, you didn't do anything to support this person properly...'*

The text above therefore illustrates that within this discourse a construction of responding-as-having-consequences for the health care professionals was also included. Thus, the construction of responding-as-having-consequences appeared to make the subject position 'at risk' viable to health professionals but not the women. This point is interesting as a lot of the documentation with regard to mental health service development and provision (Department of Health 1998; 1999) put forward the subject position that the service user is potentially 'at risk' from either harming themselves or others. Here it is the health care professional who is at risk.

Constructing 'BPD': operating within a discourse of risk

Discourse of risk

In recent years the concept of 'risk' has become increasingly central to mental health policy in the UK, (Warner and Gabe, 2004). Mullen (2001) asserts that debates and discussions that used to take place over whether the mentally ill were dangerous, and if so how to recognise that quality, were progressively replaced in the 1990's by discussion of risk assessment and risk management (Monahan, 1998; Snowden, 1997). These

notions first surfaced in the 1970s in the context of concerns amongst large corporations or governmental agencies about being blamed for the damage their activities inflicted on individuals and on the environment (Mullen, 2001). Soon, the professionals themselves were being held responsible and these notions of blame and accountability gradually filtered into the mental health care arena.

Knowledge in mental health therefore moved from a language of dangerousness into the language of risk. Bradbury (1989) defines risk as 'the product of the probability and consequences (magnitude and severity) of an adverse event' (p.382). The language of risk within mental health is constituted by a whole array of differing language and terminology and professionals on a day-to-day basis discuss issues of risk assessment, risk management and risk analysis. Further, Adams (2001) argues that risk in mental health is associated with hazard, threat and loss. Rose (1996) argues that within the discourse of risk the professionals are positioned as 'psychiatric experts' (Rose, 1996). They have become the manufacturers and purveyors of the discourse of risk, and inextricably engaged in the politics of risk. Risk assessment tools are generated, and risk assessment is conducted with a growing percentage of the mentally ill population. Within the context of this research study the professionals framed their constructions of 'BPD' almost exclusively within a discourse of risk.

Constructing 'BPD' as risky and dangerous

This construction of 'BPD' as something 'risky' and 'dangerous' was drawn upon when professionals were asked to comment upon their previous clinical practice when helping and supporting women with a diagnosis of 'BPD'. For example, Stewart states,

> **Stewart:** *'You know I've seen times when women with borderline personality disorder, they've utilised low secure ward, because of their chaotic behaviours and lifestyle and basically the patient's viewed as a sort of risk to others, quite a substantial risk, and there is considerable worry about risk em...'*

In this excerpt the notion of 'risk' is used throughout by Stewart to describe women with 'BPD' as being a potential danger to others. On occasions this *perceived* 'danger' has been to such an extent that the women have required treatment and care in secure facilities or as the professional name states a *'...low secure ward'*. The implication of danger is strengthened further in this account by the professional mentioning that *'...there is considerable worry'* about this woman's behaviour.

Similarly, Amelia and Alice deployed the construction of 'BPD' as risky in their extracts but the issue of risk was in relation to the *changeability* and *unpredictability* of the women,

> **Amelia:** *'Things are so changeable with this group of service users this can make them more risky...particularly to others.'*

> **Alice:** *'I don't' know if it's that kind of up and down of appearing to cope very well and then at other times not cope at all, that that makes them more of a risk.'*

Drawing upon Nikolas Rose once again, the construction of 'BPD' as risky and dangerous appears to make the subject position of 'expert' (Rose, 1996) viable to health professionals. As they are the ones that are required to assess and identify risk while the

women may be positioned as a 'risk to others'. This assumption is interesting because the women have sought support and treatments from the mental health profession for the harm that they do to themselves rather than the potential dangerousness or risk to others they are perceived to be by the health professionals.

Constructions of 'BPD' as challenging and fearful

Several professionals constructed 'BPD' as something that was both challenging and fearful for themselves in their everyday clinical practice and once again this was described through a discourse of risk. For example, Alice, Henry and Phoebe stated this,

> **Alice:** *'yes yes because people struggle with how to best manage people and the interventions which are gonna work or like I say, em working with a risk, that's a big fear factor with people, so therefore they find it a challenge.'*

> **Henry:** *'em, but what (.) you generally find em, (.) is those who present to us with the diagnosis of personality disorder, also tend to em, present the greatest challenge to services and they are possibly the most feared.'*
>
> **Phoebe:** *'they are people who can be very demanding, difficult and challenging and hard to comprehend....em, people who you need to make sure have had their risks identified properly just in case things go wrong.'*

Thus women appear positioned as a problem to be managed, but which needs to be undertaken as carefully and as cautiously as possible so that for the health professionals everything is in place *'just in case things go wrong'.* Hollway (2001) notes that the culture of blame is increasingly influencing the mental health care field in the UK. Any damage or distress that occurs to someone who is, or has been, a service user of a

130

mental health service is at risk of being transformed into a preventable tragedy for which professionals are held to be responsible (Mullen, 2001). Further, Rose (1996) has suggested that mental health professionals are increasingly controlled through standards, audits and inquiries which not only regulate their professional conduct, but hold them personally responsible for unwanted outcomes. Blame is all too easily shifted from the government to individual clinicians who are judged to have failed to follow procedures. Thus it might be suggested that mental health professionals have become increasingly pushed into an arena where they fear being blamed and the possibility that they may have liability actions taken out against them.

Risk and professional responsibilities

Nikolas Rose (1996) argues that the concept of 'risk' reshapes the obligations of professionals so that 'risk management and risk reduction, as logics for professional action, [have] come to supplement or replace other forms of professional action and judgement' (p.15). Management of risk takes place then, not only through a transformation of the psychiatric subject but also of the professional. Amelia illustrates this when she is talking about her professional responsibility to this group of service users,

> **Amelia:** *'(2) people struggle what to do em, because there hasn't been the risk management strategies in place, you know and em, and working as a team to look at em the responsibility and the owness and who carries responsibility and what is best practise and managing and working with risks they pose to others.'*

Thus, it appears there has been a shift in the professional's responsibilities to the women. There appears to have been a move from 'caring' about or for these women to one of 'surveillance' or managing. Nick Fox (1999), for example, has written about 'care as vigil' which seems to capture this move from care to surveillance. He has highlighted further that the surveillance is not only of the service user by the professionals but also of the professional themselves, existing in a panoptical space inhabited by NHS managers, government ministers, inquiry teams and the media. An effect of this according to Nick Fox (1999) is increasingly defensive and bureaucratic practice.

Risk and the subjectivity of women

Another effect of a discourse of risk is that the subject, in this case the woman with 'BPD', becomes absent. In the extracts that have been presented in this section the women become constructed as an object of risk and of mystery. The self disappears (Castel, 1991) and the subject becomes constructed as Other, an object of ambiguity who is capable of anything. Warner and Gabe (2004) draw upon Lupton's (1999) concept of 'other' that is defined as 'that which is conceptualised as different from the self' (p.124). The 'Us' and 'Them' phenomenon is an example of Othering. 'Them' are posited as 'Other', of less value than 'Us'. 'Us' defines 'Them'. Individuals do not position themselves as Other, or as 'Them' (MacCallum, 2002). Thus, Warner and Gabe (2004) argue that,

> *'otherness is often the product of observations of strangeness and danger in 'them', in binary oppositions to the safety and familiarity associated with 'us''* (p.388).

Thus, through discourses of risk various social groups come to be seen as 'the marginalised and stigmatised risky other' (Lupton, 1999, p. 124), the women in this study it could be suggested are one such group.

The social effects of a discourse of risk for women with 'BPD'

The notion of risk at a wider level has a number of effects (Harper, 1999). Rose (1996), for example, has noted some of the effects on the values of liberty, democracy and civil rights. He has called for attention to the 'forms of life and the logics of culpability to which those obligations and ambitions are attached' (p.20). The practices used to predict risk are extremely problematic since a much wider variety of factors, which are mainly situational, are reported to be associated with violence rather than mental illness. Nevertheless, because of the political and media representations about connections between mental health and violence, professionals are probably more likely to act conservatively (Castel, 1991). Current health policies give the assessment of risk a high priority, which therefore sustains professional legitimacy and answers the media's concerns despite there being a range of problems with such assessments. For example, Buchanan (1997) suggests that there is a high probability of error when such measures are used. Further, although they appear 'technical' such assessments incorporate a wide range of moral and ethical assumptions (Price, 1997).

Oppositions and dilemmas in professional talk of 'BPD'

Constructing BPD as both included and excluded in mental health care

This binary opposition includes accounts that are characterised by either establishing that women with 'BPD' should now be included in mental health services or in establishing that they should have a 'specialist' service.

'BPD': a discourse of inclusion

In this first half of the binary, the informants constructed BPD as a diagnosis that should now be included in mental health care. It was seen to be largely unproblematic and service users should be able to access the care they need from secondary mental health services. This supports the current research literature, which indicates that all Trusts delivering mental health services need to consider how to meet the needs of patients with a personality disorder who experience significant distress or difficulty (Department of Health, 2003). Robert, a senior professional employed within the locality, deployed this discourse,

> **Robert:** *'Yeah well as a mental health service, it's a diagnosis of inclusion then, so it's not, the old debate which was should we or shouldn't we?*
> *Now the debate is how do we? Not, whether we should or we shouldn't.'*

In this excerpt Robert response implies that there has been a movement in psychiatry from *'the old debate'* that encompassed traditional notions of how service users with this diagnosis should not receive treatment. It would seem to suggest that rather than professionals equating 'BPD' with being non-treatable (Department of Health, 2003)

there seems to be an acceptance within the profession that this group of women may be helped. However, it is about *'how'* this should happen and from Robert's response the underlining in the text indicates that he emphasised this point in his speech and it may still hold a contested status for him as an issue.

Stewart also echoed this possible contention by the inclusion of service users with 'BPD' in mental health by stating

> **Stewart:** *'yeah, you have got a different view coming through (.) recently, but I don't understand very much about (.) the evidence base about effective ways of working with* <u>these people</u> *(.)'*

Thus, Stewart seems to agree that within mental health 'BPD' is being acknowledged and is filtering through services, but there is the suggestion that there may be a lack of knowledge and understanding by professionals about the *'effective ways of working'* with this group of service users. Furthermore, the use of *'these people'* followed by a pause, indicates that service users with the diagnosis of 'BPD' may still hold a contested status for him even though they seem to be being approved more within psychiatry.

The construction of 'BPD' as no longer being a diagnosis of exclusion from mental health services was also echoed by Edward although this time it appeared suggestive that this acceptance was happening very slowly in mental health by professionals,

> **Edward:** *'Yeah from my perception. (2) I think that em, as a* <u>service</u> *we're very slowly starting to see some in-roads in change.'*

'BPD': a discourse of exclusion

The other side of this binary encloses a space for accounts that 'BPD' service users cannot be assisted by general mental health services and the historical view that it is still an 'untreatable' condition within women is still prevalent within services.

Stephanie: '...em, I'm not sure most staff would think that there's any sort of treatability in there or anything that can be done in a positive way...'

Amelia: '...I think the initial response would be about, this person is just like a waste of time and whatever I do is not gonna make any difference so there's no point going there'.

Stewart: 'Em, and so from, from a professional's point of view, em, it just portrays getting like, oh they're gonna be trouble so to speak...em, I mean people will say "oh they're back again, we didn't do anything last time, let's just get em out...em", I think if I was to canvas views em within the service now, the vast majority would say that they don't like working with that patient group...'

It could be suggested from these accounts that empathy and engagement with women with 'BPD' and who self-harm remains on the margins of conventional mental health care. Shaw (2002) argues that care continues to be characterised by disengagement and self-harm is more seen as 'a management problem' or as 'treatment resistant'. The emphasis seems to be on the diagnosis and behaviour and not the person, and as a result, there may be continued exclusion from support and service provision for these women.

In these accounts of 'exclusion' metaphorical language was also used by some of the key informants and rather than viewing the women as 'untreatable' they applied the metaphor 'venturing into the unknown'. Alice and Stephanie both assembled this metaphor in response to dealing with women who have the diagnosis of 'BPD',

> **Alice:** *'(.) lots of feeling (.) often not really <u>knowing</u> what to do because (.) well it's like going into the unknown, venturing out there, it's uncomfortable <u>not</u> knowing what to do.'*
>
> **Stephanie:** *'...there is a fear I think of facing the unknown not knowing which direction to take with them...'*

'Self-harm' and 'BPD', through this talk appears constructed as difficult and challenging something that may cause a sense of unease and fear in individuals. This is illustrated further in a historical overview of the term by Marin Leichtman (1989) who also characterised the image of the borderline disorders as a vast uncharted 'territory' of madness that requires discovery, exploration and demystification. Describing the evolution of the concept between the late nineteenth century and 1950, Leichtman writes:

> *'During those years what have been called borderline disorders can be viewed as an uncharted region lying between those profound and unmistable forms of madness...those who have dealt with the borderline concept in this period resemble explorers, trappers, and pioneers who ventured out from more settled areas to map and cultivate an undefined wilderness.'* *(p.230)*

It therefore could be argued that even fifty years on and with the inclusion of the borderline concept into the DSM-III in 1980 the 'borderline' construct for the professionals themselves when encountering it in their day-to-day clinical practice still continues to be an ambiguous category which is characterised as venturing into a 'wilderness that is unknown'.

Summary

A primary aim of this phase of the research was to gain an understanding of the ways in which 'self-harm' and 'BPD' is constructed by mental health professionals in the Trust. The analysis that has been undertaken of these accounts has attempted to illustrate some of the discourses and constructions that the professionals may draw upon when responding to women who 'self-harm' and have a diagnosis of 'BPD'. Drawing upon a discourse of risk, health professionals appear to frame 'BPD' as challenging, risky, dangerous and something that causes them fear. This sense of fear, it is suggested, is because 'BPD' and 'self-harm' is a 'wilderness unknown to them', which they seem to feel requires support and training before they can 'venture' into it.

Chapter 5

'Hidden Knowledge'; interpreting health professionals accounts of non-disclosure of a diagnosis of 'borderline personality disorder'

Overview

This chapter aims to explore the health professionals' accounts of providing information to women about the diagnosis of 'BPD'. This empirical work appears to support the view that the diagnosis of BPD is often withheld from this group of women or they are only given selective knowledge about it. The constructions and discourses that they draw upon are critical in revealing the experience of health professionals in responding to women who have been given the diagnosis of 'BPD' by psychiatry.

Disclosure of 'BPD' in mental health

From the interviews that had been undertaken with the eight health professionals only one professional stated that they had met women who were fully aware that they had been diagnosed with 'BPD'. The seven other professionals stated that women they had encountered had either only received selective knowledge or they were not aware at all of the diagnosis.

Storying women service users as being 'horrified'

Professionals who had encountered women who had had their diagnosis disclosed to them stated that women had only received certain aspects or selective levels of knowledge about the BPD diagnosis. They had not received a full explanation of what the diagnosis meant from the mental health profession. Health professionals voiced that the reasons women were not given information were because they may not fully understand what 'BPD' means and may misinterpret it. This is illustrated in the following extract when Stephanie, a consultant psychiatrist, was talking about having to be careful About what is said about the diagnosis to women,

> **Stephanie:** *'(.) I don't think people <u>generally</u> do understand. I mean if you've got a personality disorder label, we've had this in the team, we've had a couple of patients where we've actually discussed with them what the differential diagnosis was and the word personality, not necessarily disorder has been used and they've gone away from it in horror thinking that we're saying that they've got a personality disorder, which to them means Hannibal Lecter, you know.'*

This *perceived* lack of understanding or inability to understand, on the behalf of the women, if they were to be informed of the diagnosis is illustrated again by Phoebe, a senior professional in the Primary Care mental health service,

> **Phoebe**: *'Em...I don't think that they understand it really. Yes. I don't think that they quite know whether it means multiple personalities, they just don't seem to understand it...'*

Drawing again upon the work of Nikolas Rose (1996), it appears that the position of 'expert' is made viable here to the health professionals, as they are 'qualified' and 'skilled' to be able to deal with 'BPD' whilst the women are positioned as being 'less knowledgeable' and overall quite 'inept'. This may be because they are perceived by the health profession as not being able to understand and comprehend what the diagnosis actually means if they are fully informed, and so as Stephanie the consultant psychiatrist states you therefore,

> **"Stephanie:** *'...have to be very careful what you say.'*

It therefore appears that professionals may only inform women partially of the diagnosis of 'BPD' because they are perceived as being incapable of understanding the whole truth. Only one study to-date has assessed the perspectives of professionals toward disclosing a diagnosis of 'BPD' (McDonald-Scott, Machizawa and Satoh, 1992). This research investigated practising psychiatrists in North America and Japan and they were asked to examine six hypothetical case-vignettes based on actual service users' histories that met the criteria cases of service users meeting the criteria for 'BPD', schizophrenia, schizophreniform disorder, cycling bipolar disorder, depressive disorder not otherwise specified and panic disorder. Each vignette gave a brief description of past history and current state. The psychiatrists were then asked to indicate on a questionnaire whether or not they would provide the service users and/or the service users families with an accurate diagnosis either actively or if asked directly.

In Japan, a total of 166 responses were yielded from the practising psychiatrists whilst the North American sample obtained 112 responses. The results in table 1 showed that

very few of the Japanese psychiatrists (15.7%) would give diagnostic information to service users with 'BPD'.

Table1: Disclosure of 'BPD' diagnosis to service user

Country	Actively inform	Responsively inform	Total inform	Would not inform
Japan	15.7%	22.9%	38.6%	61.4%
North America	55.4%	15.8%	71.3%	28.7%

The results showed that very few of the Japanese psychiatrists (16%) would give diagnostic information to service users with BPD without being asked first. Somewhat more would inform service users if asked (32.9%), but over half would not disclose the diagnosis of 'BPD' at all (61.4%). In contrast, only just over half of the North American psychiatrists (55%) responded that they would take the initiative and inform the service users about their BPD diagnosis, and quite a few others would only give the information if asked directly (16%). With regard to the other psychiatric disorders that were used in the study particularly in relation to the bipolar, panic and depressive disorders nearly all the psychiatrists in both groups indicated that they would inform the service users of their diagnosis.

In contrast, just over half of the North American psychiatrists (55.4%) responded that they would take the initiative and inform the service users about a 'BPD' diagnosis, and quite a few others would only give the information if asked directly (15.8%). With regard to the other psychiatric disorders that were used in the study particularly in relation to the bipolar, panic and depressive disorders nearly all the psychiatrists in both groups

indicated that they would inform the service users of their diagnosis. The reasons given for not providing diagnostic information to the 'BPD' cases are shown in the table 2 below.

Table 2: Reasons for not disclosing a diagnosis of BPD

Country	Hurts service user	Meaningless for treatment	Lead to misunderstanding	Other
Japan	30.4%	35.36%	31.4%	2.3%
North America	20.6%	23.5%	38.2%	18.6%

The table illustrates that the patterns of reasons differed between the Japanese and the North American psychiatrists, with the Japanese most frequently agreeing that the information would be meaningless for treatment and the North Americans stating that it would only lead to misunderstanding and confusion. The fact that informing would hurt the service user and thereby negatively influence treatment was also frequently cited by both groups. If the psychiatrists were asked directly by the service user if they had 'BPD' fewer than 40% of the Japanese participants stated that they would confirm or provide accurate diagnostic information to the service user in contrast the figure for the North American participant's was just over half (54%). This study concluded that the diagnosis of BPD had the lowest total inform rates (active plus passive) for all the disorders, except schizophreniform disorder, which had a similar rate (McDonald-Scott *et al*, 1992; Lequesne and Hersh, 2004). The results of the McDonald-Scott *et al* (1992) study are extremely interesting particularly in relation to the reasons for not disclosing a diagnosis of 'BPD' as the study does not state who would be misunderstood or confused. Is it the service user? Or is it the psychiatrist? Further, it must also be

remembered that the figures in this study only reflect what the psychiatrists have said 'they would do' when presented with such service users.

Discovering 'BPD' by accident

One health professional stated that several women she had met had not been made aware of their diagnosis through discussions with health professionals but had found out about the diagnosis by mistake. This is supported by an excerpt from Alice, a senior practitioner in the Forensic Services, below,

> **Alice:** *'...I have come across service user groups elsewhere (unclear) nationally where people have actually told me they discovered by accident from a GP that they'd been given a diagnosis of a borderline personality disorder.'*

BPD provokes difficulty and uncertainty in professionals

Other participants stated that the reasons for professionals withholding knowledge or only giving selective knowledge to women about the diagnosis was because the professionals themselves may find it difficult and not easy to describe to women. In the extract presented below Alice gives an example of when a woman discovered by accident that she had been diagnosed with 'BPD' and she attempts to explain why professionals may have withheld information from her,

> **Alice:** *'...the one individual I'm thinking of was quite angry that it hadn't been shared with them and her perception, having gained knowledge of what the diagnosis meant was that people found it too difficult to explain...I think what,*

what, what she interpreted was in this, was the diagnosis was too difficult to talk about.'

The whole notion of the diagnosis being difficult to explain for professionals is echoed again by Stewart, a registered mental health nurse in the Acute Inpatients Service. Stewart stated that women often do not know that they have this diagnosis,

Stewart: *'...professionals find it too difficult to explain.'*

However, what is very interesting in this account is that Stewart does not only provide this as the only potential reason for non-disclosure. He goes onto suggest that professionals may be being quite cautious and careful about this diagnosis on purpose,

Stewart: *'I think it's an area where I think multi-disciplinary teams are very cagey on really, I mean em medical staff don't like putting down this diagnosis in the first place."*

Tammi: *'Hmm. Why do you think that is or why are they quite cagey of this particular diagnosis do you think?'*

Stewart: *'I think it's cos they are uncertain of some of the repercussions, really that you can have with the patient em, I suppose people are concerned that people may sue them or <u>whatever</u> for wrong diagnosis.'*

It may be possible then that professionals may be reluctant to disclose the diagnosis to women as they may have a degree of uncertainty about the validity of the actual diagnosis. Parascandola *et al* (2002) have described a great unwillingness on the part

of health professionals to involve service users in decisions regarding their care when diagnosis, prognosis, or treatment options are uncertain. It may therefore be suggested that this diagnostic uncertainty may affect the disclosure of knowledge to women with this diagnosis. Further, the diagnosis of 'BPD' may be uncertain for professionals because they may find it difficult to differentiate 'BPD' from other mental health conditions, for example, depression (Gunderson and Phillips, 1991) and anxiety.

This difficulty to distinguish 'BPD' from other diagnoses is illustrated in the interview that was undertaken with Stephanie the consultant psychiatrist. She states,

> **Stephanie:** *'...I'm thinking well just globally about all the people I've ever seen borderline personality disorder that I <u>thought</u> had borderline personality disorder, probably the majority of them (.) were not formally labelled as such and I would say the commonest misdiagnosis is depression and anxiety.'*

So in this account it may be seen that those who have the power to impose a diagnosis of 'BPD' on women are not in total agreement about it as a diagnostic entity. Furthermore, there is still an ongoing debate as to whether 'BPD' as a diagnostic entity itself is a valid knowledge position (Lequesne and Hersh, 2004). Although several studies (Sanislow *et al*, 2002; Zanarini *et al*, 2000; Gunderson *et al*, 2000) have demonstrated that the DSM diagnosis of 'BPD' is statistically valid, others have argued that there is too much heterogeneity within the diagnosis. For example, Tyrer (1999) has suggested that individuals who meet different sets of five out of the nine criteria for 'BPD' could appear to have very different illness. Thus, it appears that the diagnosis of 'BPD' may provoke difficulty and uncertainty in professionals.

146

A sense of stigma in the diagnosis of BPD

Within the research literature the term 'BPD' itself has acquired stigma among the health profession. Current discourses, particularly in mental health, have framed the behaviour of women with this diagnosis as, 'treatment resistant' (Valente, 1991; Department of Health, 2002), a 'management problem', 'attention-seeking' and 'manipulative' (Feldman, 1988; Arnold, 1995, Department of Health, 2002). As a result, research has illustrated in the past that this diagnosis has evoked feelings of rage, helplessness, and/or frustration (Pembroke, 1991; Arnold, 1995) in health professionals when they encounter women in their everyday clinical practice.

This sense of stigma in the diagnosis of 'BPD' was evident in the accounts of several of the professionals that were interviewed. When discussing the response of women that they had encountered who had received some selective knowledge about the diagnosis they stated that this had evoked strong and often negative reactions. This is illustrated in the excerpts below,

> **Edward:** *'I've never known anybody, I've never met anybody who's ever accepted the diagnosis of personality disorder.'*
>
> **Tammi:** *'Right. So have you met people then who are aware of it, but they don't accept that as being their actual diagnosis?'*
>
> **Edward:** *'Yeah. I've seen a lot more people who accept the psychosis now but not personality disorder. I think of the two, personality disorder is more stigmatising.'*

Robert: *'Em a <u>mixture</u> of people who are shocked, distressed, em, and em (.) challenging of it.'*

Stewart: *'From the patient <u>themselves</u>, the few I have seen, I think once they are aware they've got that label, then they think everybody will see them as not being worthy and not fit and a waste of time and you know, nobody can be bothered with them and so therefore it kind of like, em, em, oh I've got this label now so there is no hope for me.'*

From these accounts women appear to resist the diagnosis of 'BPD' for their problems or needs. It seems that 'BPD' is constructed as eliciting negative feelings and emotions for women and they appear to challenge this diagnosis because for them it appears that the term 'BPD' continues to be associated with derogatory connotations (Reiser and Levenson, 1984).

As previously highlighted research on whether or not to disclose a diagnosis of 'BPD' is extremely limited. However, this debate has not only been confined to the area of mental health it has also been practice in other areas of medicine for practitioners to withhold information from service users. For example, in the cancer literature (Pinner, 2000; Novack *et al*, 1979) it has been extensively documented that in the 1950s most doctors did not tell people with terminal cancer their diagnosis. A study in 1961 showed that 90% of American doctors usually withheld it, with the aim of maintaining their service users' hope (Oken, 1961). Nevertheless, by the late 1970s, 97% of American doctors said they preferred to tell service users with cancer of their diagnosis and the prognosis (Novack *et al*, 1979). Emmanuel and Kass (1993) argue that there has been

a shift from an emphasis on catering for service users' needs, as defined by doctors, to service users' rights and self-determination. This shift may have been due at least in part to better treatments for cancer becoming available. Thus, it may be suggested that professionals refrain from disclosure of their knowledge as a way to do no harm (Lequesne and Hersh, 2004). For example, research (Hassan and Hassan, 1998) has suggested that learning of a cancer diagnosis could cause the service user unnecessary emotional suffering, and perhaps, some argued, an abrupt death.

It could be suggested then that a possible reason for clinicians in the mental health profession not telling women they have 'BPD' may be because they are concerned that the knowledge they give might create feelings of hopelessness, worthlessness and despair in the women (Lequesne and Hersh, 2004). This suggestion seems to have some support in the account given by Stewart when he talks about women feeling

> **Stewart:** *'not being worthy'*, a *'waste of time'*, *'nobody can be bothered'* and having *'no hope'*.

Lequesne and Hersh (2004) propose that professionals may avoid communicating the diagnosis to women because they fear women will experience this as a criticism or reach a conclusion that they are bad or annoying. In order to illustrate this point further they cite a quote from Susanna Kaysen's (1994) acclaimed journal memoirs *Girl, Interrupted.* Susanna was a young woman who voluntary admitted herself into a mental health institution in 1967 in America for nearly 18 months whilst there she was given the diagnosis of 'BPD'.

'What does borderline personality mean, anyhow? It appears to be a way station between neurosis and psychosis: a fractured, but not disassembled psyche. Thus to quote my psychiatrist: It's what they call people whose lifestyles bother them. He can say that because he's a doctor. If I said it, nobody would believe me.' (p.151)

Summary

In this chapter there has been an exploration of the possible reasons why the mental health profession may be reluctant to disclose the diagnosis of 'BPD' and why the women appear to be unwilling to accept it. 'BPD' therefore seems to be constructed as knowledge that cannot be told or heard. In my view the care and support of women who self-harm and have a diagnosis of 'BPD' can no longer be approached from a paternalistic standpoint. Women, like anyone else, are entitled to autonomy and to the information and support they need to exercise their autonomy as much as is possible, they deserve an explanation.

One of the mains aims of this phase of the research was to gain an understanding of the ways in which 'self-harm' and 'BPD' is constructed within the locality. The constructions and discourses through which 'self-harm' and 'BPD' were structured in the first phase interviews appear to situate them within an intricate network of power relations. These power relations would appear to exist both within and between the mental health services across the locality, where women may access support in relation to their needs.

This phase further aimed to gain an understanding of the discourses and constructions drawn upon by those responding to women who 'self-harm' and have a diagnosis of

'BPD'. Mental health professionals' accounts drew upon discourses of risk and horror and they appeared to locate responding to the women as frightening, challenging, and distressing and something that they would rather avoid doing. In their accounts health professionals appear constructed as 'at risk' and vulnerable when responding to the women.

The next phase of the research aims to explore in-depth the accounts of the women and explore how they make meaning of their experiences. This phase is explained over the next two chapters of the thesis, beginning with an account of the methodological approach that was used.

Chapter 6

Developing the methodological approach for phase two

Overview

This chapter aims to build upon the methodological approach that was introduced in chapter three for phase one of the research, by providing a detailed account of the methods and procedures that were undertaken in the second phase of the research. Phase two of the research presented as much more challenging than the process that was employed with the first phase of the project. It was challenging because I was not only engaging in a different technique, which involved encouraging the women to give narrative accounts (Reissman, 1993), but also attempting to gain access to the women in the first instance brought with it certain challenges and research issues (Robinson, 2002). The chapter therefore begins with a reflexive section that aims to illustrate the impact of my experience of conducting phase one of the research on the development of the methods for the second phase. It then progresses to consider some of the techniques of obtaining narratives in interview situations and examine some of the implications of this approach. The chapter will then explore some of the difficulties that I encountered when attempting to undertake research with the women which includes issues to do with ethics and access and my attempts to overcome such challenges.

Moving on from phase one

In the first phase of the study that I undertook with the mental health care professionals the methods employed were influenced by the theoretical approach that I was considering at that time. Utilizing a Foucauldian approach (Foucault, 1977; 1979) I therefore engaged in a series of conversational interviews (Nichols, 1991) with the professionals so that I could attempt to gain an understanding of the discourses and discursive practices through which 'self-harm' and the diagnosis of 'BPD' were being constructed within the locality. Furthermore, I also wished to explore the discursive resources that the health professionals drew upon when delivering services to the women on a day-to-day basis. The development and use of the conversational interviewing technique in phase one of the research and the guide that I subsequently developed was suitable for this part of the research because it was both 'flexible' and 'exploratory'. As the interviewer I had an outline of topics or issues that may be explored with the professionals but the wording and order of these questions could be varied as necessary to help the professionals understand the questions (Mishler, 1986).

However, I must admit at this point that I can remember *being frustrated* with the professionals on occasions when they insisted on moving away from the outline and what appeared to be a telling of a 'story'. When this occurred I attempted on many occasions to limit or control the stories that they were telling me so that they remained within my remit. Upon reflection of the interview transcripts for this phase and my increased awareness of my mistakes, I looked towards developing an appropriate data gathering technique for the interviews with the women that would encourage their accounts as much as possible.

Deciding upon an interview method

Before I begin to explore the technique involved in interviewing the women I believe that it would be beneficial at this point to remind you of the epistemological position with regard to this phase of the research. As discussed in chapter two the theoretical journey that I have explored and negotiated my way through is significantly different for each phase.

In phase one I drew upon a Foucauldian approach (Foucault, 1977; 1979) in order to analyse the discursive processes that may shape the values and beliefs of the professionals about the women and how they may then subsequently respond to the women's emotional distress. However, as I proceeded through my theoretical journey it became apparent that this stance had a number of limitations at an ontological level. The most significant one for this research was with regard to the conception of the subject and its potential for understanding, exploring and theorising subjectivity (Henriques, Hollway, Unwin, Venn and Walkerdine, 1984). This limitation was significant for phase two because a key aim was to explore and understand the women's lived experiences. I therefore needed to explore and find an epistemological approach that also had an appreciation of agency and an awareness of the histories or the social and material structures that gave rise to the women's experiences (Willig, 2001).

Through exploring and discussing the work of Harre (1991), Stoppard (1998) and Radley (1991) I started to move forward in my theoretical journey and I could see how material and discursive approaches might be integrated. However, I was still concerned that these frameworks may still not go far enough in terms of fully understanding the experiences of the women in this research. These approaches did not appear to take

into account the factors that operate at the level of the individual, for example, the mechanisms that the women may use for dealing with difficulties or psychological pain. I therefore drew upon the work of Ussher (1999; 2000; 2002) and her Material-Discursive-Intrapsychic (MDI) model[12] which incorporates all three levels together – material, discursive and intrapsychic – without privileging one above the other, in order to provide a multidimensional analysis of the women's accounts.

Adopting a Material-Discursive-Intrapsychic approach to data analysis

An MDI perspective is grounded within a critical realist epistemological paradigm. Such a perspective does not make *a priori* assumptions about causality and objectivity nor does it highlight what type of methods can or should be used (Ussher, 2005). This standpoint supports the application of any suitable approach, qualitative or quantitative, to answer the research questions being asked. Critical realism does not set out to predict cause and effect relationships, but sets out to explain and describe the object of study in a way that might improve psychological knowledge of phenomenon like 'self-harm' and 'BPD'.

Critical realism

Critical realism is a relatively new philosophical approach that integrates a realist ontological perspective (theory of being) with a relativist epistemology (theory of knowledge) (Issac, 1990). A leading proponent in European critical realism is Roy Bhaskar (1978; 1986; 1989). Bhaskar (1989) affirms the existence of reality, both physical and psychological, but he also recognises that its representations are

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As previously discussed in chapter two.

characterised and mediated by culture, language and politics. Critical realism holds that what we can experience is only a small proportion of what actually happens in the world. And what actually happens is only a small proportion of what could potentially happen, given the right combination of underlying mechanisms that exist in reality (Littlejohn, 2003). Pilgrim and Bentall (1999) capture the advantages of this paradigm in the following,

'In a critical realist account it is not *reality* which is deemed to be socially constructed, rather it is *our theories of reality*, and the methodological priorities we deploy to investigate it. Our theories and methods are shaped by social forces and informed by interests... Thus deconstruction has a part to play in this exercise, but human science should not be reduced methodologically to this position alone.' (p. 262)

Therefore, in order to examine human behaviour and the social sphere the critical realist framework puts forward that we are dealing with open and not closed systems and we can only explain and describe – not predict (Williams, 2003). Further, Pilgrim and Rogers (1997) assert that because of the complexity and fluidity of human agency and the effect of constantly shifting cultural and historical contexts there is no possibility of accurate prediction in the social sciences. Ussher (2000) therefore suggests that the critical realist approach allows researchers to describe, explain, and understand the symptomatology women experience: what it means to women, the factors which may be identified in both the timing and degree of symptoms, and the ways in they cope with perceived difficulty.

Lastly, critical realism acknowledges the legitimacy of lay knowledge and views this knowledge as having equal, although not superior, status to expert knowledge (Bhaskar, 1989; Pilgrim and Rogers, 1997). By integrating this acceptance into the approach this allows the voice and views of women diagnosed as having 'BPD' and being a self-harmer to be a legitimate part of the mental health research agenda; it explicitly acknowledges subjectivity (Ussher, 2000).

Hence, within the critical realist approach the role of hormones or physiological arousal, as well as the influence of social stressors, age or economic factors, can be acknowledged and studied as 'real'. The existence of authentic symptoms is therefore acknowledged whether they are psychological or physical. Reality and experience for critical realists is therefore always a product of the symbiotic relationship between material, discursive and intraspychic factors.

Critical realism appears to lead naturally to the MDI approach as it can bring together both the bio-medical and psychosocial aspects of experience. This approach also recognises the cultural and historical context in which individuals are positioned, and in which meaning about experience is produced (Ussher, 2005). The next part of the chapter will briefly recap what is meant by the MDI approach and highlight some of the possible tensions with this perspective.

The level of materiality

'Material' factors are those that exist at a corporeal, a societal or an institutional level. Ussher (1997) maintains that this would include biological factors associated with psychological symptomatology, such as hormones or physiological arousal; material

factors that institutionalise the diagnosis and treatment of experiences as 'BPD', and the physical effects of past abuse and trauma. There may also be many material consequences of experiencing or being treated for 'self-harm' and 'BPD', in terms of physical and psychological vulnerability, as well as may be powerlessness at an economic and societal level (Collins, 1991). The social isolation which can be a consequence of mental health problems, or which can act to intensify its effects, is in part a material issue (Ussher, 2005).

The level of the discursive

The 'discursive' centres on the social and linguistic domains – language, visual representation, ideology, culture and power (Ussher, 2002). With regard to this research what is arguably of most relevance is the discursive constructions of 'self-harm' and 'BPD', of mental health and illness (Foucault, 1977; Ussher, 1991), and of gender (Smith, 1988; Ussher, 1997). With regard to women's mental health in general there is now a growing body of feminist social constructionist researchers (Caplan, 1995; Figert, 1996; Rittenhouse, 1992) who argue that certain diagnoses have been discursively constructed in society to account for a whole range of distress and dysfunction experienced by women. For example, in the case of Premenstrual Syndrome[13] (PMS) Chaturvedi (1994) has provided evidence that indicates that in societies where 'PMS' does not circulate widely as a discursive category, women do not associate the pre-menstrual phase of the cycle with psychological symptoms, and 'PMS' as a diagnosis is rarely applied. As a result of this some feminist writers (Figert, 1996; Ussher, 1999) have rejected 'PMS' as a diagnostic category and maintain that it merely acts as a mechanism to medicalise the unhappiness and distress of women.

This diagnosis is characterised by a mixture of physical and psychological symptoms that some women experience in the days, or sometimes weeks, leading up to their menstrual period (BUPA, 2003).

The level of the intrapsychic

'Intrapsychic' factors are those that operate at the level of the individual and the psychological: factors which *'...are traditionally the central focus of psychological analyses of women's madness.'* (Ussher, 2000, p.221). Analysis of this area may therefore focus upon the way in which women blame themselves, or their bodies, for problems in their lives which they experience (Ussher, 2003). Ussher (2002) argues that such factors as low self-esteem, the psychological impact of previous neglect or abuse, guilt, shame, fear of loss or separation should also be incorporated. Further, analysis would include an examination of the psychological defences that the women may use, such as denial.

Incorporating the material, discursive and intrapsychic (MDI)

The MDI model does not privilege either psychological or biological factors and gives equal status to discursive representations. Although Ussher's MDI model (1999; 2000; 2002; 2005) discusses these three factors separately it does assume that it is their relationship with each other that produces experiences that women, in the case of this research, may label as 'self-harm' and 'BPD'.

It needs to be recognised at this point that although the MDI analysis allows the women's subjective experiences to be brought to the fore a tension exists between the application of this model, particularly the intrapsychic level, and its framing within a post-modern perspective. For example, social constructionism has been identified by Guba (1990) as a paradigm in which multiple perspectives on reality may be foreseen, and where investigation aims to demonstrate that research can only ever produce a partial understanding of reality. From this position, research also focuses upon the historical

and cultural specificity of all knowledge, and in so doing aims to bring to light the effect that all forms of discourse have on the construction of knowledge and the understanding individuals construct about themselves. Social constructionists therefore seek to understand the values and beliefs within which 'facts' about reality are organised, and to interpret that reality in light of those beliefs.

By taking this position, social constructionism is able to demonstrate the relative nature of knowledge that is identified as accurate or factual, and thereby capture the context in which the researcher and the researched build their interaction. I would acknowledge that social constructionism within the post-modern paradigm provides an important critical lens through which to examine the taken-for-granted ideas that form the basis of psychological knowledge. However, social constructionism continues to leave many questions unanswered in terms of the women's experiences in this study. This position within the post-modern perspective cannot account for the 'felt' reality that women express; it cannot demonstrate or explore anything about the intrapsychic experience of 'self-harm' and 'BPD'. It diminishes the meaning ascribed to the body (Turner, 1984) and positions it as irrelevant in the interpretation of reality (Yardley, 1996). Experiences of mental health problems can therefore appear to be conceptualised from this position as merely a social label, a category or just another discourse. However, as Ussher (2000) identified 'many women adopt a biological narrative in explaining their psychological symptoms' (p.218); consequently, social constructionist analyses has little to say to these women. It is important that women's ongoing appraisal and negotiation of changes in emotion or bodily sensations and their subjective experience of these changes is acknowledged because individual women experience them and they are 'real' to them.

Thus, it is apparent that a tension therefore exists with the application of the MDI position within a post-modern perspective. I am therefore aware that the research has to be careful that it does not fall into the trap of naïve realism. I believe that the critical realist standpoint which the MDI approach adheres to may resolve this problem since it *"affirms the existence of reality" (p. 107)*, while also acknowledging that the representations used are often mediated by disciplines such as psychology. Critical realism offers only one version of reality but at the same time also acknowledges the legitimacy of lay knowledge. 'BPD' and 'self-harm' are phenomena experienced by individual women at a bodily level, a psychological level and a social level. One cannot be disentangled from the other, its meaning to women has to be understood in the specific historical and cultural contexts in which they are positioned (Ussher, 1996). Hence, through the application of the MDI approach in this phase of the research I do not attempt to provide a more 'true' vision of reality rather I will attempt to show a range of experiences from the individual women that are fluid, complex and forever changing.

Moving forward with phase two

Due to the shift in the epistemological position for phase two of the research I therefore believed that I needed to use a method of interviewing that would be flexible and not restrict the elicitation of the accounts that would be 'generated' by the women themselves (Mishler, 1986). The first step that I took in order to find an interviewing method that would enable the generation of such 'participant centred' accounts was to go back to the qualitative research literature. Through this review I found that there were a number of different interviewing techniques available to me, amongst them life history interviewing (Cole and Knowles, 2001), biographical interviewing (Atkinson, 2002) and narrative interviewing (Reissman, 1993; Crossley, 2000). However, I was increasingly

drawn to the narrative interviewing approach because eliciting narratives seem to compliment my ontological position. I became further drawn to this approach after I had participated in a narrative workshop at Huddersfield University in April 2004. Professor Catherine Reissman had facilitated this seminar and throughout this session she reflected upon the rise of narrative research that had taken place in the social sciences over the last 20 years and she discussed how this approach could give voice to human feelings and experiences. She explained how being human involves narrating stories to ourselves and to others and that as humans we use narratives to express emotions and convey our beliefs about how 'things should be'. Thus, storytelling is such an important activity because narratives help people to organize their experiences into meaningful episodes. From this workshop, the literature review (Reissman, 1993; Mishler, 1986) that I had undertaken and the subsequent methodological discussions that I had with my supervisory team it was therefore agreed that an in-depth narrative interview method would be developed to interview the women (Ussher, 2000; 2003). This technique it was believed may allow me to explore the meanings that the women gave to their experiences of 'self-harm' and of being diagnosed with 'BPD'.

Developing a narrative interview approach

Narayan and George (2000) maintain that when undertaking in-depth interviews the researcher has to be prepared and equipped to deal with the unforeseen events that may emerge during the interview situation. As previously highlighted I sought to explore approaches that appeared to impose the least structure and which would allow the women to tell their 'own story' in their 'own words' in their 'own way'. Since I wanted to avoid as much as possible making assumptions about what may be important and meaningful to the women about their experiences I decided against using the narrative

approach put forward by McAdams (1993) to generate stories. McAdams (1993) outlines the use of an interview protocol within the semi-structured interview domain. This protocol then maintains control over the interview structure but is used to gather the stories of those being interviewed. In this situation participants are asked to think about their life as if it were a book and divide it into 'chapters' about their life. Participants are then asked to think about who the significant people would be in the book, what the 'key events' would be, what the future looks like, what are the stresses or difficulties in this life story and lastly they are asked to sum up their life in a coherent theme. I must admit that McAdams (1993) narrative approach did appeal to me because of its reassuring structured nature, however, in these interviews with the women I did not wish to have anymore control over the situation than they did. I did not want to restrict the way in which they constructed their accounts.

Moving on from McAdams (1993) and exploring the field of narrative research (Reissman, 1993; Flick, 1998; Wengraf, 2000) further I found that an unstructured interviewing method might be more facilitative in meeting the research objectives. The aim within this work is to ask one broad question during the interview situation, for example 'tell me your life story', following this the interviewer remains silent only speaking to repeat the question or indicate that they are listening to the interviewee (Flick, 1998). By asking one question in the interview it is suggested that the narratives or stories that may be elicited in this situation will be led entirely by the storyteller and will not be influenced by the researcher (Flick, 1998). Whilst this approach was appealing because it seemed to facilitate the women to produce an account that reflected what was meaningful to them about 'self-harm' and 'BPD', I felt that it may be restraining in the distancing effect it seemed to create between the researcher and researched. In this situation the role of interviewer in the process of narrative production

is relatively passive and they are not an equal partner in data production (Enosh and Buchbinder, 2005).

Further, by remaining silent throughout the women's storytelling the development of a trusting relationship is limited because there is a lack of rapport. Developing trust and rapport is crucial I believe in this study because of the sensitive topic area that I am exploring with the women. Furthermore, Edwards (1998) has argued that when exploring sensitive topics of enquiry the relationship between the researcher and researched is imperative. It is facilitated Edwards maintains by the development of trust and the building of rapport between the interviewee and the interviewer.

In order that the research aims would be met I realised that the interview needed to be a relational and interactional act whereby the women and I were treated as partners, rather than objects (Rubin and Rubin, 1995). We would produce the interview narrative jointly in an ongoing way (Mishler, 1986). The interview would therefore become an interactive process of meaning making and would inevitably become a collaborative, co-constructed event. My purpose in the interview would be to 'empower' and help the women to unfold and fully develop their narratives on their own terms. In order that the interviews could progress in a co-constructed fashion I realised that I would require some 'loose areas of enquiry' that may prompt the interview. However, I was concerned that these broad areas did not direct and effect the production of the mean making of the women's accounts (Arskey and Knight, 1999). Thus, in order to accommodate this I decided to adopt five or six broad questions that could be supplemented by probing techniques (Reissman, 1993).

Narrative interviewing; the role of power, reciprocity and self-expression

As I have already highlighted it has been argued that the interview is an interactive process, in which both knowledge and meanings are generated (Enosh and Buchbinder, 2005), however, by undertaking this perspective it does raise concerns regarding the issues of power, reciprocity and self-expression. Several researchers (Oakley, 1981; Finch, 1984) have raised this issue and they have noted how in traditional methods, the interviewer expects the respondent to contribute but does not give anything of themselves in return. They argue that such methods create unequal power relations and objectify women's experiences. Furthermore, Reinharz (1983) describes conventional research as 'rape', whereby researchers take, hit and run. They intrude on their subjects' privacy, disrupt their perceptions, utilise false pretences, manipulate the relationship, and give little or nothing in return. When the needs of the researchers are satisfied, they break off contact with the researched (Reinharz 1983). I therefore felt that the interviews should be based upon reciprocity and self-expression whereby the women and I are active and interactive in the interview so that it becomes a collaborative and co-constructed event (Enosh and Buchbinder, 2005).

Further, Lee (1993) argues that the interview as co-constructed is even more critical when dealing with sensitive topic areas because they are often typically characterized as stressful, threatening, and problematic for both the interviewee and the interviewer. The women were therefore given the opportunity to ask any questions that they had about the research or about myself at the onset. Through this I aimed to communicate to the women that whilst I could never know what *they* had experienced I wished to reassure them that my interest was in hearing their narrative accounts but as part of this I was

also willing to discuss my own experiences. Having considered how I anticipated the interviews might progress I began the development of questions/areas that would enable the exploration of the experience of 'self-harm' and 'BPD' with the women.

Developing the questions

Drawing upon Reissman (1993) I decided to explore several broad areas in the interview setting. These included the first time that the women had self-harmed, how they coped when they self-harmed, how the diagnosis of 'BPD' had initially been disclosed and the impact of this, and an exploration of the support from health services that they had received in relation to 'self-harm' and 'BPD'. In order to deal with these areas I developed a number of 'loose' questions that may or may not have been covered depending upon the accounts that the women gave in the interview situation (see appendix 4). At the beginning of each of the interviews I decided to open the interview with a short introduction, or storyboard (Reissman, 1993) in order to contextualise the research for the women (Reissman, 1993),

'I am interested in trying to understand what it is like to be a woman who self-harms and has a diagnosis of 'BPD'. I would really like to hear from you anything and everything that you think is relevant. I have several areas that I would like to cover but what is important to me is that I listen to your particular experiences. Please feel free to talk in, as much detail as you feel is relevant. In order to start talking about these important experiences I would like to ask you to think about the first time that you self-harmed and once you feel ready can you please talk to me about that?'

By opening the interview with this introduction my aim was to give the woman an idea as to the area with which the research was concerned but also presented in the closing section of this statement was also the first generative question that aimed 'to get them talking'. Due to the sensitive nature of the research I was aware that I needed to have certain skills and a repertoire of responses available to me that would allow the women to keep talking. Drawing upon the work of Reissman (1993) I therefore followed her advice in relation to the use of questions such as 'Can you tell me more about that?' and 'What was that experience like for you?' Likewise, Hollway and Jefferson (2000) argue that in order to elicit stories from participants the questions that are used need to be open-ended questions as far as possible. By doing this they maintain that the researcher may discover more detail about the storyteller's meaning-frames rather than them being suppressed by the use of closed questions. Thus, I attempted to do this by using such phrases as 'Can you tell me about a time when...' and 'Can you think of something that...' which invited the women to tell their stories.

Lastly, with regard to developing the questions for this phase of the research I believed that it was imperative that I thought about how I would follow-up each individual woman's themes as the interview proceeded. In line with the recommendation of Hollway and Jefferson (2000) I therefore listened attentively and sometimes took brief notes so that my questions back to the woman would be using her own words and phrases.

Preparing for the interviews with the women

The process of preparing for the interviews began early in the PhD process with the development of close relationships with the managers and mental health care professionals who had supported and participated in phase one of the research. It was

anticipated that by having this involvement that they would form a key resource in enabling the research to gain access to the women for phase two. However, when I attempted to do this I experienced a number of difficulties that had a significant impact upon the development and conduct of this phase of the research. The next section of the chapter aims to outline in more detail some of these issues, their impact on the research and the ways in which I had to solve and overcome them.

First steps towards accessing and supporting the women

Following the development of the interview framework in September 2004 and the confirmation letter from the ethics committee in November 2004 I contacted the senior managers of the mental health services in the locality who had supported and participated in phase one.

Initial meetings with the managers

November 18th 2004 was the date of the first meeting that I had with a senior operational manager in relation to gaining access to the women and this was very interesting and informative as she made me aware of the health care professionals that I needed. I came away from the meeting feeling very motivated, enthused and eager to get in touch with these professionals as I thought that once I did this the process would move on quite quickly so that in no time at all I would be talking to the women. However, this did not happen. By reflecting back I can now see that I was again *naïve* with regard to this part of the research process. I did not foresee how difficult and complex it would be to gain access and meet the women themselves. Over the next few months I went to and from the locality to various meetings with different health professionals representing

different mental health services. I also engaged in frequent email and telephone conversations with the professionals in order to enhance my access to the women.

Throughout this period when I was taking the first steps to gain access I moved from being *naïve* to a position of *being suspicious and distrustful* of the professionals that I was encountering. I felt that there seemed to be something happening in these mental health services, which I had no control over; as if there was some kind of 'invisible barrier' stopping me from accessing the women. This mistrust developed partly from the introductory discussions that I had with the professionals when I was speaking with them about interviewing the women. Initially the professionals were very forthcoming and would be very encouraging of the research when I mentioned that I wished to speak with women who had a history of self-harming behaviour, and they stated that they had a lot of women with this behaviour who were accessing services. They voiced that I should have no problems accessing and speaking with them. The difficulty however occurred when I informed the professionals that the women had to have and be aware of their diagnosis. This seemed, in my view, to raise 'alarm bells' in each professional that I spoke to and the encouragement and support that had been there earlier, in my view, seemed to fade away. An extract from my research diary seems to illustrate this point further:

'I have just left one of the services but I really do not hold much hope of receiving any information or assistance. She (the professional) has taken all of my details down on a post-it note and has stuck it onto a wall on the other side of the room, which is far away from her desk. I really cannot see how she will remember to contact me.'

In all of the meetings that I had with the professionals I was repeatedly told that it would be 'hard' and 'difficult' to access women and discuss their experiences of 'self-harm' and 'BPD'. To my surprise, the professionals constantly informed me that the women were not aware, and had not been informed, that they had been given a diagnosis of 'BPD'. Furthermore, several of the professionals stated that the 'BPD' diagnosis would often be written in the women's case notes, which again the women themselves were not aware of. It therefore appeared that the professionals within these mental health services were not disclosing and sharing this knowledge with the women. This raised immense difficulties for me because unless the women had knowledge that they had been given the diagnosis I could not explore with them their experiences of living with a diagnosis of 'BPD'.

Developing alternative strategies for accessing women

By the end of March 2005 despite all of my efforts and discussions with the key professionals I was now in a position whereby I had not engaged in a single interview with a woman. Throughout this period my supervisory team and I had met regularly to discuss other potential avenues to overcome the difficulties that I was being presented with but this was to no avail. The diagnosis of 'BPD' appeared to be a 'hidden' phenomenon in the mental health services and having this aspect incorporated into the research appeared to be making the recruitment of women from within the locality extremely difficult. It was therefore agreed in a supervisory meeting on the 26th March 2005 that I may have to change the research aims for this phase of the research and also re-design the broad areas that I had identified for the narrative interviews. This change meant that rather than asking the women in the interviews to talk to me specifically about 'BPD' I would now explore with to them what they had been told by professionals about their diagnosis. This suggestion had originally come from most of

the professionals themselves when I had met with them at various points in January 2005 and February 2005 to discuss ideas to enhance recruitment. They had disclosed that as the term 'BPD' was not used directly with women it might be worthwhile to use other terms such as 'personality problems', 'personality difficulties' and 'personality issues' in the information sheet. Professionals voiced that if this terminology was used it may improve my access to women because this is how they often explained the diagnosis of 'BPD' to women if they had been given this by a psychiatrist. I was reluctant to do this at that time because I felt that if I started using these phrases I too would be 'hiding' things from the women. However, due to the fact that by the end of March 2005 no progress had been made it was decided that I would explore generally with women what they had been told about their diagnosis but I would not be using the three phrases above in the interview situation.

It was also agreed that in order to try and explore further why I had such difficulties in accessing women in this area that I should attempt to undertake a focus group with the key professionals. My other concern at this point was also whether or not I would need to go back to the ethics committee due to the changes that I was making because it had already taken me from March 2004 to November 2004 to gain ethical approval for this phase originally. However, after contacting the ethics committee they made it quite clear that because this was not a significant change I only had to provide them with a letter stating the planned changes. At the end of the meeting in March 2005 I was quite disheartened and de-motivated by the outcome because I felt that women in this area had a very important account to give and (through no fault of their own) they were not being given the chance to do this.

Over the next two weeks I proceeded to devise a letter to the professionals who had been involved in phase one which invited them to participate in a focus group. Within this letter I also highlighted the difficulties that I had been having with the recruitment of women and that it had been decided following consultation with the supervisory team that I adapt some elements of the strategy to facilitate the recruitment of women. By the end of April 2005 I still had not received any information from professionals about any women wishing to participate in the research and I had also only received one letter from a professional stating that they could participate in the focus group[14].

Following these developments the supervisory meeting held in April 2005 discussed how it might be worthwhile to look outside the locality to other areas within the region with regard to recruiting women. This was partly because I had professional contacts in this area and I was aware when I was encountering difficulties in phase one by knowing someone on the 'inside' can enhance the recruitment process. It was hoped that by employing this method I might then access women who had previously lived in the locality but may still be able to provide me with an 'anecdotal' account of their experiences. As a result of this suggestion I left the meeting feeling completely flat and I felt like I was back at square one. I contacted the ethics committee that same day and they stated that I would have to complete some new documentation for them because I was making 'significant' changes to the original protocol. This process could take up to 28 days once they had received the relevant papers from myself I therefore embarked upon this process straight away.

Four other professionals out of the eight did reply but stated they could not make the day and time stated in the letter. I did not receive replies from three professionals.

When it all starts to go right; the intervention of the service user and carer research group

May 9th 2005 was a significant event for the second phase of the research because when I arrived in my office that morning there was a message on my answering machine from a professional stating that a woman had volunteered to be involved in the project. I rang her back straight away to find out the details. The professional informed me that she had read the information sheet and she had already signed the consent form and that if I could give her dates and times that I could meet her I would be able to interview her. I informed the professional that I was very flexible and that it may be better for the woman to suggest a time and date. The professional also informed me that the woman was aware of her diagnosis of 'BPD' which meant that I could use the original narrative interview format that I had devised in September 2004. The next day the professional contacted me again with a date, time and location of where the interview would take place. By the middle of May 2005 I had finally made contact with the first participant and interviewed her.

Following this first interview another supervisory meeting was arranged for the last week in May 2005 as one of my supervisory team felt that it might be worthwhile accessing the service user and carer research group within the locality. I had had previous contact with this group in the first year of the PhD when I had taken the information sheet and consent form too them that I had planned to use in phase one with the professionals. This group had previous experience of taking part in and developing their own research projects and it was felt that they might be able to provide further advice on the development of these forms which they kindly did. With regard to phase two I felt that

this might be a good idea as they may have access to knowledge that the professionals do not have and so I proceeded to contact the group.

The group replied within a couple of days and I was invited to present in a fifteen minute slot at their next meeting which was only a few days away I immediately replied stating that I would be delighted to attend. What was to occur after I attended this meeting was immense because within the space of four weeks after this meeting I would have completed three more interviews. The three women that came forward to volunteer were not identified to me via any professional. They heard about the research either through reading the minutes of the meeting that I attended and which were subsequently sent out by this group to service users in the locality or through word of mouth from service users to service users. The women that I interviewed all lived within the locality, self-harmed, had knowledge of their diagnosis of 'BPD' and were currently receiving support in the locality from mental health professionals. By the end of June 2005 I had made contact with and interviewed a total of three participants. Thus the final sample size for this phase of the research was four women.

Closing the recruitment process

Throughout July 2005 I was still prepared to undertake interviews with women who volunteered however by the end of July 2005 I decided to close the recruitment of the women. I subsequently sent out a range of thank you letters to all the areas that had received information from me with regard to the research and the recruitment of women for this phase of the research.

Having informed the reader of the strategies employed and established to recruit the women I believe that attention should now be turned to some of the ethical considerations that underpinned this phase of the research.

Returning to the ethics committee

As previously highlighted in chapter four the ethics committee had already received a thorough application that covered the whole of the research study in April 2003. However, they had only received relevant paperwork for the first phase of the project at this time because the supervisory team and myself had decided that a phased approach to the research would be undertaken. This was decided because each phase of the study would inform the development of the next, and thus an application for both phases could not be made at the same time (Palmquist, 1998; Stake, 1995). In order to gain ethical approval for this phase I therefore developed an in-depth and comprehensive crib sheet for the ethics committee that not only raised the ethical considerations of the project but also gave an account of the methods and theory underpinning the research. The section that follows outlines some of the ethical issues, which fed into the application.

Support for women

What might be described as the 'psychological safety' of the women that were involved in this study was of prime importance. This was in relation to the potential vulnerability of the women when talking about such emotive issues. In order to address this several steps were therefore implemented to support women. Firstly, due to the sensitive nature of the area I recognised that the process of interview and the experiences that may be discussed might result in emotional disturbance for the women. In order to address this

issue, prior to interview, it was arranged for the women to be able to access their key worker/professional, if required, after the interview.

Secondly, due to the sensitive nature of this enquiry it was anticipated that some of the women might become upset or distressed when discussing their own personal experiences in the interview situation. Hollway and Jefferson (2000) maintain that 'containment' is important when dealing with painful accounts by individuals rather than offering to terminate the interview. Further, they assert that this offer to terminate the interview is more in the interests of the interviewer escaping from a difficult situation than acting in the interviewee's interests. The idea of 'containment' involves the passing of emotions between people (Hollway and Jefferson, 2000). By using phrases that try and reflect the 'reality' of the individual's emotional experience, they may feel safe in the interview and feel that their accounts are being acknowledged and recognised. This may allow the individual to feel more in control of the interview and talk about things that are significant to them. I therefore tried to adhere to Hollway's concept of 'containment' in the interviews with the women.

Lastly, each of the women was given a Resource Guide (see appendix 7) at the end of the interview which gave them information about organisations for individuals who self-harm. I compiled this resource in order to provide women with a list of services that exist nationally to support women affected by self-harm. This was primarily devised because nothing existed at a local level in terms of support groups for women in the locality.

Identifying and dealing with critical incidents

When the women were talking about their experiences a contingency plan had been developed in case they voiced comments of poor or unacceptable practice. This

practice may have been in relation to services they had accessed or the clinical practice of professionals they had encountered throughout their life. If this happened I had a duty to report the women's concerns. In the first instance the issue was discussed with the woman since there would be a need to raise the issue with others and break confidentiality. Under these circumstances it was considered that potential benefit to others outweighed the need to maintain anonymity. I would then raise this with the members of the supervisory team, in particular, with the supervisor who was also a clinician within the locality where the research was being undertaken. After discussion it would then be decided if the relevant service manager and locality management needed to be informed so that action could be undertaken with regard to the incident. The supervisory team would support and direct me throughout this whole process if it occurred.

It was also thought that the women might comment upon issues that involve a risk to themselves and/or others. Once again under these circumstances it would be considered that the risk of such behaviour would outweigh the need to maintain anonymity. I would once again raise the matter with members of the supervisory team, who would then decide if the relevant service manager and locality management needed to be informed. If concerns were raised with regard to child protection issues then I had a clear plan of action regarding the relevant Child Protection professionals to contact in the locality. Furthermore, I had been made aware of how to identify and deal with child protection issues particularly with regard to mental health service users, as I had undertaken a 2-day 'Child Protection Course' in September 2004 and October 2004.

All of the women were made aware that all of the information they gave would be treated in the strictest confidence. However, they were made aware that specific information to

other professionals would be passed on if serious concerns were raised about poor or unacceptable practice, and/or there was a risk to the participant or others and this included child protection issues. All of this was outlined in detail for the women in the information sheet (see appendix 5) and the consent form (see appendix 6). Furthermore, all of these issues were discussed again with each of the women prior to the interviews commencing.

Security and safety measures for the researcher

My physical safety was achieved by remaining in close contact with the supervisory team, who were informed of the location, time and duration of each interview. All of the interviews would be conducted during the daytime (generally office hours) and they were pre-arranged by telephone. I always carried a mobile phone and would call a member of the supervisory team prior to the commencement of the interview. At the end of each interview I would then phone in and inform a member of the supervisory team that the interview had been completed and I was on my way home.

My psychological safety was achieved through regular supervision and debrief with the Director of PhD studies and the University supervisory team, and where necessary access to trained counselling support through the University Counselling Service. I also had access to a Consultant Clinical Psychologist who gave advice on clinical issues. Furthermore, it must also be noted that I am a qualified mental health nurse who has had clinical experience of working with and supporting mental health service users since 1997.

Summary

In this chapter there has been an exploration of the methodological approach that I undertook so that the research could move on to phase two. It highlights the shift in my theoretical journey from a Foucauldian position (Foucault, 1979) towards a material, discursive and intrapsychic position (Ussher, 2000; 2002). Due to this movement I therefore decided to develop an interview approach drawing upon narrative psychology (McAdams, 1993) which would allow me explore in-depth and in detail the women's accounts. The chapter ends by a detailed discussion of the differing strategies that were required to meet the women in this study and the ethical considerations that were identified for this sensitive and emotive area.

Chapter 7

Developing a narrative analysis of women's experiences

Overview

In this chapter I aim to present the analytical strategy that I employed to explore and interpret the four women's personal narratives. Here the reader is presented with a rationale for, and a description of, the analytical strategy employed in the analysis of the accounts provided by women in phase two. Within this I have chosen to provide a description of the method of analysis and discuss the focus of such an analysis employed on these rich and detailed experiential accounts.

Prior considerations before developing an analytical strategy

In contrast to the earlier interviews with the health professionals it was always my intention that this phase of research would attempt to explore the women's lives and gain an understanding of the meanings that the women gave to their experiences of 'self-harm' and of being diagnosed with 'BPD'. I hoped that the information that would be generated in this phase would facilitate the women in expressing their emotions, conveying their thoughts and beliefs and thus empower them to have a 'voice' (Langellier, 1989). In developing an analytical framework I therefore aimed to develop a method that would enable the women to tell stories of their experiences. Langellier and

Peterson (2004) argue that such storytelling matters because *'...it is an integral and consequential part of daily life*(p.1). Individuals make sense of their experiences, claim identities, interact with each other, and participate in cultural conversations through storytelling. Simple speech acts '*...announce, request, declare, promise, and invoke stories'* (p1). Thus, as audiences gather around storytellers, *narrative* becomes a significant site of communication and study (Langellier and Peterson, 2004).

With regard to this phase of the study, adopting a narrative approach was consistent with my ontological and epistemological position.[19] To recapitulate my stance, I was eager to ensure that this piece of research would recognise the diversity of women's experiences. This is an imperative aspect of the research since the study was partially formulated in response to the Government's White Paper *Women's Mental Health: Into the Mainstream* (2002), which emphasised the importance of listening to women. Prior to this document past research (Feldman, 1988; Shaw, 2002) had suggested that women who 'self-harm' and who receive a diagnosis of 'BPD' are often constructed as being manipulative, attention-seeking, difficult to manage and in some cases untreatable.

In conjunction with recognising diversity the analytical method would also need to enable me to achieve another research aim, specifically, to explore the women's lives who were taking part in the study in ways that would recognise them as 'active agents'. Women who present themselves with physical and psychological symptoms within mental health are not passive objects. Seeking treatment for their problems is a '*...process of active, reflexive negotiation with symptomatology, current life events and life-style, and cultural, medical or psychological ideas about madness*' (Ussher, 2000, p. 211). Thus, women in this study live a reality that causes them 'real' distress and anguish and the approach

that is developed needs to be consistent with this. Specifically, women need to be enabled to tell their 'own stories' in their 'own words'.

A further aim of the study was to recognise that narratives are interactive and co-constructed (Mishler, 1986; Riessman, 1993; Jackson, 1998). The accounts that are narrated by women in this study are a co-construction, which develops jointly in an ongoing way (Mishler, 1986) between myself as researcher and listener and the women as narrators. The analytical approach that I adopted would therefore need to allow for an exploration of this relational and interactional act. A critical examination would be required of how my own social, cultural and material context may have affected the relationships between the women and myself but also how I then subsequently listened to and interpreted their narrative accounts.

In summary then, in order to interpret the women's personal narrative accounts in ways that would sufficiently address the research aims and be consistent with the philosophy of this phase of the research project, I would need to develop a framework for narrative analysis that would enable me to:

- explore the lives of the women taking part in the study which would recognise their individual agency;

- acknowledge the social, material, cultural and political domains which institutionalise experiences and how these are likely to impact on how the experiences are subsequently understood and narrated by women;

- recognise and highlight the variety and difference of women's experiences; and

- explore the 'interactive space' (Coulter, 1989) in which the accounts are co-constructed by a narrator and a listener.

Concept of 'narrative'

'Narrative' is a mode of knowing and understanding that captures the richness and variety of meaning in humanity as well as a way of communicating who we are, what we do, how we feel, and why we ought to follow a certain course of action (Bruner, 1991). A narrative involves facts, ideas, theories, and dreams from the perspectives and in the context of someone's life. Thus, narrative is a fundamental aspect of meaning construction, which is a negotiated activity that starts in early childhood and characterises the whole of human life (Fusai *et al.*, 2003). Storytelling gives individuals chances to understand others' narrative in a social context, and to clarify their own thinking.

Riessman (2005) maintains that there is considerable variation in definitions of personal narrative, which is often linked to discipline. For example, in anthropology, narrative can refer to an entire life story, woven from interviews, observations and documents (Myerhoff, 1972) or in sociolinguistics the concept of narrative is restricted, referring to brief, topically specific stories (Labov and Waletsky, 1967). How researchers define a narrative will obviously lead to different models of analysis, however, Riessman (2005) sustains that all require them to construct texts for further analysis, that is, '…select and organise documents, compose FIELD NOTES, and/or choose sections of interview TRANSCRIPTS for close inspection' (p.2). Narratives therefore need to be read and analysed as they '…do not speak for themselves…' (Riessman, 2005, p.2). Furthermore

they '...require interpretation when used as data in social research...' (Riessman, 2005, p.2).

Models of narrative analysis

'Narrative analysis' is a placeholder for different ways of conceptualising the storied nature of human development (Daiute and Lightfoot, 2004). Several typologies exist (Labov and Waletzky, 1967; Mishler, 1995; Williams, 1984; Cortazzi, 2001). In this next section of the chapter, I focus upon and describe several contemporary approaches that are suited to verbal or oral narratives of personal experience (Riessman, 2005).

Structural analysis

The American sociolinguist William Labov developed one of the first approaches of narrative analysis in the 1960s and 1970s. Labov's description of what a narrative is derived initially from stories told to him and his colleagues by African American informants in South Harlem and applies primarily to spoken event narratives, told in natural situations. Labov and Waletzky (1967) maintain that such stories have a general structure that includes six common elements. These are: abstract (what the story is about), orientation (sets the scene), complicating action (what happens next), evaluation (indication of the point of the story), resolution (gives an ending), and coda (returns the story to the present).

This structural approach analyses the *function* of a clause in the overall narrative – the communicative work it accomplishes (Riessman, 2005). However, while Labov and Waletzky's (1967) approach has been widely used by narrative researchers (Bamberg, 2002; Bell, 1988), with regard to the aims of this research it presents as being quite restrictive. The structural approach put forward by Labov seems to restrict the 'story'

category, not just through his definition of narrative clauses and his emphasis on the co-presence of all narrative elements, but also through his insistence on event narratives told monologically (Squire, 2000). From this perspective, stories do not get told in reverse, in fragments, or collaboratively nor do stories include thoughts, emotions or things that happened to other people. (Squire, 2000).

A structural approach may therefore decontextualise narratives by ignoring historical, interactional and institutional factors (Riessman, 2005). With regard to this study these features of the narrative are important if we are to gain an understanding of how women make sense of and give meaning to their personal experiences and also how these accounts are a product of an interaction between teller and listener.

Thematic analysis

A thematic approach is another form of narrative analysis that is underpinned by language. However, the focus of his approach is on the content of text, *'what' is said more than 'how' it is said, the 'told' rather than the 'telling'* (Riessman, 2005). When researchers employ this approach they collect many narrative accounts and inductively create conceptual groupings for the information that has been generated (Flick, 2003). Content of the analysis is presented as 'themes' and these often cross over question boundaries (Banister, Burman, Parker, Taylor and Tindal, 2003). Williams (1984) employed this approach when he was attempting to show how individuals manage their identity when they have rheumatoid arthritis. Individuals in their accounts narratively reconstructed the causes of their illness and from these personal accounts Williams, using three cases as exemplars, constructed a typology to extend existing theory on chronic illness in this area. Thematic analysis can therefore be seen as a 'category-

centred' form of analysis rather than 'case-centred' (Reissman, 2004; Milnes, 2003). It attempts to find common thematic elements across participants in studies and the events and experiences that they report. Many narratives are grouped into a similar thematic category and everyone in the group is taken to mean the same thing. Thematic analysis has been used by narrative researchers (Cain, 1991) however with regard to the aims of this study it presents once more as being problematic. If this approach was employed it would not enable me to highlight the diversity in the women's experiences and they may continue to be seen as a homogeneous group within the mental health care arena (Department of Health, 2002). Furthermore, if a 'category-centred' approach was employed the analysis would not enable me to recognise the social and material contexts within which the women's experiences are lived and which are likely to impact upon how those experiences are understood and later narrated.

Interactional analysis

The emphasis of this form of narrative analysis is on the interactive process between the storyteller and questioner. Narratives of experience are brought forward through a process of co-construction, jointly in an ongoing way (Mishler, 1986). The teller and listener are treated as conversational partners, rather than objects (Rubin and Rubin, 1995), who monitor and affect each other's speech events or activities (Enosh and Buchbinder, 2005). Both parties are therefore 'active' in meaning making, constructing stories of personal experience through their interaction. Susan Bell (1999 cited in Reissman, 2005) utilises this approach to compare the illness narratives of two women, separated in time by the women's health movement. In her analysis she collaboratively illustrates with the women how their personal narratives are situated historically and politically. This model of narrative analysis appears to provide a more comprehensive

approach as it addresses the language and interactional context, in addition to narrative organisation and structure.

Analytical strategy

In developing the analytical framework for the analysis of the women's accounts I decided to draw upon aspects of the 'performance' approach developed by Langellier (1989; 2001) and a 'narrative thematic' approach (Reissman, 1993). The performance approach is underpinned by an ontology that sees human interactions and communication as fundamental aspects of lived human experience. With regard to my own ontological stance my assumption is that storytelling is one of the principal ways in which individuals make sense of their own experiences and of the world around them. I therefore believe that the ontological assumptions that underpin the performance approach are compatible with those underpinning my work.

A performance approach to personal narrative views it as oral storytelling in a social situation – in a word, a performance (Langellier, 1989). A story involves storytelling - a reciprocal event between a teller and an audience (Reissman, 2000). Further, performance as an analytic framework gives access not only to the social, structural and cultural contexts in a narrative account but also the embodied context. Performing narrative requires bodily participation: hearing and voicing, gesturing, seeing and being seen, feeling and being touched by the storytelling (Langellier and Peterson, 2004). Thus, Langellier and Peterson (2004) argues that a performing narrative is '...not a discrete event –somehow external to the body...it is lived through the body and it is meaningful to the storyteller...it is a site of intrapersonal contact' (p.9). I would therefore argue that drawing upon the performance approach put forward by Langellier (1989;

2001) will allow me to embrace the diversity of the women's accounts, whilst adhering to the specific analytic objectives. As such my method of analysis for the women's accounts tended to take the following steps:

- Reading 1: Familiarisation of content and topics in transcripts.

- Reading 3: Taking notes, highlighting and identifying pertinent themes/narratives.

- Reading 4: Identification of how 'self-harm' is narrated in each woman's account.

- Reading 5: Identification of how 'BPD' is narrated in each woman's account.

- Reading 6: Analysis of contradictions and tensions within each woman's account.

- Reading 7: Exploration of the contradictions, tensions and consistencies across the women's accounts.

Each of these readings was followed in turn for the analysis of the women's personal accounts. Although a narrative analysis of this sort involved some comparison across interview accounts in order to identify possible themes that may be common to other accounts, I recognised that this analysis was to be 'case-centred' rather than 'category-centred' (Reissman, 2004). That is, led by each interview account as a separate case study exploring individual accounts to emphasise the 'performative elements and features' rather than being led by a search for commonalties. Thus, as much attention was paid to the differences and contradictions within and between the accounts as was paid to similarities and consistencies.

Approaching the individual accounts in terms of performance (Langellier, 1989; 2001) allowed for consideration of what it means to tell a story in a certain way, what is described and in what way (Daiute, 2004). In this way it is recognised that when we tell

stories about our lives we perform our (preferred) identities (Langellier, 2001). Each account therefore needs to be understood and explored within the context within which it was produced. To emphasise the performative element is not to suggest that identities are inauthentic, only that they are situated and accomplished in social interaction (Reissman, 2000).

Applying these insights to the women's accounts allowed me to identify how the women want to be known in the stories that they develop collaboratively with me (Langellier (2001). The women in their accounts would not "reveal" an essential self so much as they perform a preferred self, selected from the multiplicity of selves or persona that individuals switch between as they go about their lives (Reissman, 2000). I therefore envisaged that the personal narratives of the women would contain many performative features that enable the "local achievement of identity" (Cussins, 1998). By intensifying words and phrases, the women may enhance sections with narrative detail, reported speech, appeals to the audience, paralinguistic features ("uhms") and gestures (Bauman, 1996). Throughout the analysis observations were made for such details.

Social positioning in the stories was also analysed. That is, how the women chose to position the audience, characters, and themselves in their accounts. It was envisaged that they might shift among positions as '...fluid positioning, not fixed roles, are used by people to cope with the situations they find themselves in...' (Harre and van Langenhove, 1999, p.17). Attempts were therefore made in the analysis to identify the fluid semantic spaces (Reissman, 2000) that they may create for themselves in order to construct who they are, for example, framing actions as voluntary rather than compulsory, or grammatical forms that intensify vulnerability (Capps and Ochs, 1995). These positionings of the self in the women's personal narratives signify the

performance of identity. They are enacted in an immediate discursive context, the evolving interview with a listener/questioner (Reissman, 2004). In order to explore social positioning in the analysis the following questions were asked:

- What kind of a story does a narrator place herself in?
- How does she position herself to the audience, and vice versa?
- How does she position characters in relation to one another, and in relation to herself?
- How does she position herself to herself, that is, make identity claims? (Bamberg, 1997)

Lastly, the analytical strategy also explored how the narrative accounts had been co-constructed between the participant and myself. This involved asking questions such as:

- What impact has the interview had on the women's personal narratives?
- How is the woman communicating to me about the social, material and cultural contexts of her life?
- How have my personal experiences affected the questions that I chose to ask?
- How has the social, material and cultural contexts of my life affected my understanding of the responses given by the women to those questions?

Summary

The performance approach put forward by Langellier (1989; 2001) can be seen to fulfil all of the criteria that I discussed earlier in this chapter. This approach enables me to

consider the women's individual agency whilst also examining the social, material, and cultural domains which institutionalise their experiences. Secondly, as a case centred approach, this method allows me to recognise and highlight the variety and difference of women's experiences and challenge the notion within the mental health care arena that they are homogenous group with identical experiences. Lastly, by the focus of this approach on the interactional context, this method allows me to explore the 'interactive space' (Coulter, 1989) in which the accounts are co-constructed by a narrator and a listener.

Chapter 8

Exploring the narration of 'self-harm' and 'BPD'

Overview

The chapter begins by introducing the women who participated in the research and offers an account of the interview experience. This is followed by an exploration of the narrative accounts of 'self-harm' and 'BPD', generated with four women living in the locality. I present an analysis and interpretation of these rich and detailed experiential accounts. Specifically, I explore how the women appeared to understand, experience and make sense of their initial experiences of 'self-harm' and 'BPD' and I explore the stories that are told in recalling their experiences.

Introducing the women

In this section I aim to introduce each of the four women who volunteered to participate in the research. Brief details are provided of each woman as well as contextual information about the interview experience, which is informed by the notes that I made in my research diary after each of the interviews.

Charlotte

Charlotte was the first woman to participate in an interview. She was 39 and lived in the southern region of the locality. Charlotte was a single woman who had never been married and she had no children. Currently, Charlotte was not employed and she lived

with her elderly mother in the locality who acted as her main carer. Mental health professionals had diagnosed Charlotte as having 'BPD' and 'depression'.

Charlotte agreed to be interviewed at the Community Mental Health Team facilities where she attended to meet her Community Psychiatric Nurse (CPN). It was raining on the morning when I arrived at the facilities and I was an hour early to allow time to set up my equipment and make some adjustments to the room so that it was informal and relaxing. The room we were to use was the psychiatrist's office and in order to make the room less formal I rearranged the furniture in the room. I placed two, low comfy chairs at an angle so that they were more or less side by side and I also placed a small table between them. On the table I placed a bottle of water, two glasses and some tissues that I had brought with me. I had a notice prepared with me to place on the outside of the door, which stated that an interview was in progress. I hoped that this would avoid anyone entering the room when we had started the interview. I was quite nervous that the room may still appear formal but there was little more I could do to improve it. Fifteen minutes before Charlotte arrived the CPN who supported Charlotte came into the room to discuss the final arrangements regarding her availability to meet with Charlotte, if she wished, after the interview. When Charlotte arrived I went into the reception area to meet her and we introduced ourselves. My first impressions of Charlotte were of a quiet and reserved woman but she appeared quite happy to participate in the interview.

I began my briefing and throughout this I was extremely nervous and I wondered how I might establish rapport with Charlotte as she seemed so quiet and did not ask me anything even in relation to the research. After I asked her the first question Charlotte began to speak in a quiet and almost emotionless tone. The social psychologist Dan McAdams (1993) argues that an individuals narrative is not 'just a story' – it is a

structure, which provides a feeling of identity and a steering point through life for those who participate in it. A personal story is, '…an internalized and evolving narrative of the self that incorporates the reconstructed past, perceived present and anticipated future' (McAdams, 1993, p. 304). And such a story can be told in different tones,

> *'The most fundamental relationship between the personal myths we fashion in adulthood and the first two years of our lives may be expressed in what I call narrative tone. While some life stories exude optimism and hope, others are couched in the language of mistrust and resignation'* (McAdams, 1993, p.47).

Narrative tone speaks to the author's underlying faith in the possibilities of human intention and behaviour. It reflects the extent to which a person dares to believe that the world can be good and that one's place can be more or less secure within it. McAdams (1993) therefore argues that every story has a characteristic emotional tone, ranging most simply from extreme positivity (happiness, joy, and optimism) to extreme negativity (despair, fear, and pessimism). If we apply McAdams (1993) notion of narrative tone on to Charlotte's opening manner it may be suggested that she had a negative outlook and that her world appeared capricious and unpredictable. Further, her posture in the interview appeared to reflect this pessimistic tone or still flatness and this was the manner in which she talked about all of her experiences. On occasions I found this lack of emotion quite difficult to interact with particularly when she was giving details of her experiences which appeared to me to be traumatic and distressing.

Throughout the course of the interview Charlotte provided quite rich and detailed accounts of her many experiences within the mental health care arena. At the end of the interview, Charlotte told me that she had found participating 'beneficial' although she

did not feel able to elaborate what she meant by this. When we went out to meet the CPN Charlotte reiterated this sentiment and she declined the offer of the planned de-briefing and support session.

Eve

Eve was the second woman to participate in the interviews. She was 54 and lived in the eastern region of the locality. She had an adult son who was married with a family of his own, and she was divorced from her husband. Eve lived alone and was not employed. She had been diagnosed as having 'BPD', 'depression' and 'agoraphobia'.

The interview with Eve took place at the local mental health hospital in the psychological therapies department. Eve had stated that she wanted the interview there as she also had some other business that day at the hospital. Once again I arrived early to allow time to set up my equipment and recreate a similar seating arrangement that appeared to have worked well with Charlotte's interview. However, I found that I did not need to do this because the room that I had at the psychology department was private and the chairs were already arranged in a manner that would hopefully make Eve feel comfortable.

When Eve arrived the receptionist of the department brought her to the room because, unknown to me, she had visited several times before and she knew various people in the department. My first impressions of Eve were of a bright woman who was smiling and humorous and who appeared eager to participate in the interview. Eve made beginning the interview quite easy for me, as she appeared enthusiastic to *tell* and *perform* her stories. Langellier (1989) maintains that approaching narrative as performance involves two related but distinct arguments about the pragmatics of putting narrative into practice.

According to Mara Maclean (1988 cited in Langellier, 1989), the effect of telling a personal narrative – 'let me tell you a story about what happened to me' - is to enhance experience and to create a two-way narrative contract between teller and audience. Significantly, this contract initiates a performance 'which is both an 'act' and an enactment, a doing and a representation of a doing' (p.72). Thus, Langellier (2001) argues that when an individual tells a story about their lives they perform their (preferred) identities. In relation to Eve as she proceeded through her narrative her enthusiastic speech that had been illustrated at the beginning of her account was replaced on occasions with anger, unhappiness and a resigned level of acceptance with the support and provision she had received in relation to her experiences.

Eve therefore provided detailed information about her health and health care experiences, and her ability to talk about her experiences often enabled me to use my secondary questions and prompts. The interview ended smoothly by Eve talking to me about her football interests and the plans that she had to follow her team to the FA cup. Eve indicated that she found participating in the interview a positive experience and that she was extremely pleased that somebody had taken the time to listen to the problems and difficulties she has had in her life. Eve declined the offer of the planned de-briefing and support session.

Megan

Megan was 41 and lived in the far western region of the locality with her husband and three children. Megan was not currently employed, but in the past had engaged in health care work in the local area. Megan had been diagnosed as having 'BPD', depression and an 'eating disorder'.

The interview with Megan took much more careful planning and co-ordinating than the previous two interviews because she was extremely concerned that she should not be seen speaking to me in case she was recognised by health professionals because of her previous health care work. I therefore met Megan prior to the interview in a coffee shop in the locality to discuss her concerns and see how they could be best accommodated. It was agreed that Megan would come to the University for the interview as she felt safe in her own mind that nobody would see her if it took place there. With regard to the support and de-briefing session Megan indicated that she would return to the locality and contact her key worker by mobile phone if she wished to see her after the interview. My first impressions of Megan after this meeting were of a 'strong', 'solid' and 'no-nonsense' kind of a woman, however, when I met Megan the following week at the University she seemed to be quite different in her presentation and she appeared much warmer in her reception.

I approached the interview as I had done with the others, beginning with the briefing and moving on to the first question. Megan's initial account was the most extensive of all the interviews, containing detailed and rich information about her family, her health and her experiences. As she progressed through the interview her responses also fluctuated between annoyance, outrage and unhappiness at some of her life experiences. At the end of the interview, Megan indicated that she had enjoyed participating and she was pleased that she could share her story with me. She hoped that it might help others to understand what women like her have gone through and continue to go through on a daily basis.

Maddy

Maddy was the final participant in the research and she was a woman of 30. Maddy was living with her two young children at her elderly parent's house in the east of the locality because she had recently divorced her husband. At the time of the interview Maddy was currently unemployed and mental health professionals had diagnosed her as having 'BPD' and 'recurrent depression'.

Maddy's interview took place, like Eve's, at the local mental health hospital in the psychological therapies department. Unlike Eve, Maddy was not known to anyone in the department and so when she arrived the receptionist left her in the corridor and asked me to come and get her. I introduced myself to Maddy and she greeted me quite warmly and enthusiastically. She seemed positive about engaging in the interview. When we went to the room everything was set up as it had been with Eve as this appeared to make Eve feel comfortable. However, what I did notice about Maddy was that she appeared quite restless and unable to sit in the same position for long periods. When I asked if she was okay, Maddy replied that she was fine and that she was always nervous in interview situations. In order to deal with this, as I wanted to make sure that she was okay with participating in the interview, I spent much longer than with previous participants talking to Maddy about the research, what it aimed to achieve and why women were such an important part of it.

Throughout this briefing period Maddy made it clear that she fully understood the aims of the research and that she was happy to participate in the interview. As the interview progressed and Maddy talked about her experiences of 'self-harm' and 'BPD' her telling was quite different in contrast to the other women, Maddy's telling was quite disjointed and disorganised. It was only on occasion that Maddy gave long and detailed narratives

in the interview.   Maddy, throughout the course of the interview, presented as quite nervous and on occasions she did cry particularly when we were talking about traumatic episodes in her life.   I was aware that Maddy was struggling on occasions in the interview and I had to consider the ethical implications of proceeding. On the one hand I was concerned that Maddy should not 'relive' something that was too distressing for her again for the sake of the research project. However, at the same time I was aware that Maddy should be allowed to relate her experience in her own way and I did not want to impose limits on how she performed her story. On these occasions I therefore engaged in 'emotional containment' (Hollway and Jefferson, 2000). Hollway and Jefferson argue that whilst this is a specific psychodynamic therapeutic principle it can be applied in an interview situation, and she argues that it enables the researcher to provide boundaries which aim to limit a participant's distress.

Upon reflection, this interview was by far the most difficult to undertake because I had to observe and view Maddy living through aspects of her distress again but at the same time provide and guide Maddy through the boundaries of the interview (Hollway and Jefferson, 2000). When I had perceived that Maddy had completed telling her story I drew the interview to a close and she said that she would like to go and see her key worker for the support and de-briefing session. It had been agreed that she would call her on completion of the interview as she was on site at the mental health hospital. Maddy ended our interaction by telling me that she hoped her story might have the potential to help other women.

Narrating the first experience of 'self-harm'

Following on from the preamble, which I read, it was interesting to explore the diversity in how women decided upon starting their accounts. It became increasingly clear that the experiences of remembering the first time that they harmed themselves were just as diverse as many other aspects of their individual experiences. Charlotte for instance, began her account of her experience of 'self-harm' by recalling her age and describing how she cut her arm with glass. She went on to say that it was the sexual abuse that she had suffered by her stepfather-dad that caused her to 'self-harm'. Eve, on the other hand, began her narrative by recalling the event that led up to the first time that she harmed herself. She took me through how her sister died and how she got a Stanley knife and cut her right arm at the top.

Megan spoke to me first of all about what the definition of 'self-harm' meant to her and then she moved on to talk about how she believed that 'self-harm' needed to be seen in the broader context of people's lives. She went on further to explain that 'self-harm' for her was a continuum which everybody is on in one way or another because for her self-harming is any form of self-destructive behaviour. Megan then went on to say how she believed her eating disorder was a type of 'self-harm' as well as the cutting of her left arm which she engaged in because of the past abuse. Maddy talked about the events around the physical and sexual abuse from her older brother and how this led her to head butting and punching the walls from the age of 11 until she was 16 years old.

> **Maddy:** *'Right the first time I self harmed I was about 11, em, I was being*
>
> *physically and sexually abused at the time by my older brother, em, it got to such*

a head that I couldn't cope and I couldn't sleep and I started head-butting the walls.'

Tammi: *'Right ok.'*

Maddy: *'Em, and punching the walls and things, just to try and get some of the aggression out that I couldn't give back whilst he was abusing me. Em, that went on till I was about 16.'*

In attempting to understand what self-harming was like for the first time for a woman it became increasingly compelling to read the accounts of these initial experiences. From the analysis it became clear that women were drawing upon differing factors to talk about their first time of 'self-harm'. However, what appeared clear across the accounts was that all the women associated a *material* factor prior to engaging in 'self-harm' for the first time. Ussher (2005) maintains that to talk of materiality is to highlight factors that exist at a corporeal, societal or institutional level: factors which are typically at the centre of sociological or biomedical explanations. In this context, what is of relevance is the corporeal, that is, the women's accounts of their first experiences of 'self-harm' were in response to abuse and trauma. The body appeared to become an inscriptive surface (Crowe, 1996) that provided an interface between how the women may signify to others what their experience means to them. Thus, language appeared to be unavailable to the women and their bodies provided a means of allowing self-expression (Crowe, 1996).

Several studies (Gratz, Conrad, and Roemer, 2002; Van der Kolk, Perry, and Herman, 1991; Zlotnick, Shea, Pearlstein, Simpson, Costello, and Begin, 1996) have found that women who engage in self-harm report unusually high rates of traumatic past experiences. Furthermore at least two studies (Boudewyn and Liem, 1995; Turell and Armsworth, 2000) have attempted to determine whether particular characteristics of

childhood sexual abuse place women at greater risk for engaging in self-harm as adults. Both studies reported that more severe, more frequent, or a longer duration of sexual abuse was associated with an increased risk of engaging in self-harm in one's adult years. The materiality of the impact of past psychological and physical abuse is therefore a factor which needs to be acknowledged.

Feelings of inner destruction

When talking about the first time that they had harmed themselves it was clear in all the accounts that 'self-harm' was, above all, constructed as a way of coping, in particular coping with the feelings and emotions that the women said that they felt 'inside' themselves. For instance, when I asked Charlotte about her experiences feelings and emotions pprior to engaging in 'self-harm' for the first time she told me, *'I just felt as if I were gonna explode inside...I felt like I was going out of control'.* However, she then immediately followed this by stating that after she had self harmed it *'didn't even make me feel any better, if fact I felt worse, I just felt guilty, that I'd let everyone (my family) down.'* Implicit in this account by Charlotte are the notions of the acceptable standards of behaviour women aspire to, and are judged against.

Discourses of femininity depict the 'good' woman, which is someone who is always responsible, able to cope, in control and maintains both the physical and emotional well-being of family members (Stoppard, 1998;, Ussher, 2002). In her account Charlotte appears to position herself as a failure and someone who cannot be relied upon. Thus, for Charlotte at this time her sense of being seemed to revolve around the presence of her family and as long as they are there she could exist and have a presence and position in life.

Similarly, Maddy also describes that the first time she self-harmed was to 'release the emotions that had been building up inside' however she differs in how she talks about thisfeels in comparison to Charlotte because for her it is constructed as allowinged her to '...get some of the aggression out that I couldn't give back whilst I was being abused.' In this account the 'self-harm' appears to serve the function of placing Maddy in a more powerful position than when her older brother was physically and sexually abusing her. She stated that it allowed her to 'control her feelings of anger and frustration' and she had the power to deal with the 'emotional overload in her brain'. She is therefore no longer positioned as a powerless victim in her story she moves to a controlling position as she recounts feeling '...calmer and in control finally' after the first time she had self-harmed.

Eve talked about feeling *'choked up with pain and grief and guilt and hurt that I didn't know how to get rid of it...the pain in my head.'* Eve went on to say that,

> *'I suddenly thought well Abigail [her sister who died] self harmed and she said it made her feel better. So perhaps that will. So I did and it made me feel better...it made all the tensions go and in a way I felt closer to our Abigail.'*

In this account it appears that the 'self-harm' not only served the function of allowing Eve to *'feel better'* and have *'all the tensions go from inside me'* but allowed her to feel closer to her sister who died traumatically in a road traffic accident. In Eve's story she goes on to say that she felt guilty about her sister's death because they had an argument the night before when she had told her that she was pregnant with a mixed raced baby. Eve talked about her sister being upset and worried about what the rest of the family would think and she asked Eve for help. In her account Eve states,

'I said there's nothing I can do for you, I said what can I do? And the result was...was that she left the party crying and upset after speaking to me and run in front of a car...I feel guilty I should have told her everything would be alright.'

It could be suggested that Eve is therefore positioned in her story as a 'guilty person' person'. She began to 'self-harm' to not only relieve the feelings and pains she had inside her but also to continue to remind herself that, in her view, she was responsible for her sister's death and she needs to be punished for this.

Employing Ussher's (1997; 2000) MDI model the account given here by Eve appears to be illustrating several 'intrapsychic' factors. Eve appears to continue to blame herself for her sister's death that took place over 30 years ago and the impact of this has led to the continued feelings of guilt within her. It appears that Eve has had to deal and cope with this difficult psychological pain for a long time. Eve's 'self-harm' it could be suggested is therefore a projection of unhappiness and self-loathing. This might be her psychological defence mechanism for coping with her self-blame over her sister's death. Ussher (1997; 2000) argues that women may engage in psychological defences such as projection, repression, denial, or splitting as mechanisms for dealing with self-blame, abuse, difficulty, and psychological pain.

Graham (1994) argues that actions such as 'self-harm' may be an attempt to punish the self for shameful past experiences and guilt, self-punishment and self-loathing underpin much self-mutilation (Graham, 1994). Thus, it might be suggested that in order to cope with her psychological pain Eve engages in 'self-harm' as a form of 'self-punishment' as it gives her a sense of relief from an intolerable state of remorse (Stone, 2006).

'Self-harm' – the progression over time

Each woman said that after they had harmed themselves for the first time they continued to engage in self-harming and in their accounts they identify that the damage they did to their body escalated and on several occasions they required medical intervention. However, what was also apparent in their accounts was that other *factors* were having an impact on their life and in order to cope with these the self-harming not only helped women control their emotions and feelings but also allowed them to deal with a range of other factors.

Charlotte in her account highlights firstly how from the age of 14 she used to superficially cut her arm with glass every three months and then how this moved to other areas,

> **Charlotte:** *'Em, about 7 years ago I moved onto my face and then I started on my stomach.'*
>
> **Tammi:** *'Did anything happen 7 years ago to cause this change of area in you're self-harming?'*
>
> **Charlotte:** *'No not really...it was easier to get to and I'd also run out of places on my arms.'*

At the time of interview Charlotte was 39 years old and she had been harming herself for 25 years, her harming it appeared had escalated in intensity on her body to the point that she had to find other areas as she had *'run out of places on my arms.'* In her account Charlotte then moves on to explaining why she had continued to engage in self-harming despite having had counselling for her past abuse issues,

Charlotte: *'It's different now...I'm normally feeling a bit low and depressed...I also have voices urging me to cut and these come when I am low...I feel I have no life and I'm no good...I've got nothing....'*

Tammi: *'You've got nothing? What causes you to feel like that?'*

Charlotte: *'I've got no kids...no husband and I'm 39 years old. Not much hope for me now is there?'*

In this account of Charlotte's there is evidence that as a woman she is seeking happiness, fulfilment and a sense of self through a man, and marriage and children are two of the key events in her life that she needs in order to be fulfilled. She appears to fear being positioned *outside* the 'heterosexual matrix' (Ussher, 2002), the traditional script of femininity that tells women they need to live their lives through a man. The hegemonic construction of heterosexual marriage To have a man and a family, is constructed as the goal of every girl's life (Ussher, 2002) and . it is the centre of a woman's existence. In the traditional discursive construction of heterosexuality 'man' is positioned and idealised as the answer to a woman's dreams and as Charlotte states if she does not reach this there is *'not much hope...is there?'*

Maddy in a similar fashion highlights a change over time not only in the 'self-harm' that she inflicts upon her body but also for the reasons why she continues. Maddy started to harm herself at the age of 13 and she would head-butt and punch walls however in her account she then identifies changes in her life which resulted in her starting to cut,

Maddy: *'When I was 22, 23. Em, I had a child who had meningitis, em, but at the same time I was 9 months pregnant and had to have an emergency caesarean section. Em, after that em it was only a couple of months after that I*

206

did try to take my own life and I cut my wrists, em and that's what started off the cutting. I couldn't cope with the stress of having this young family.'

It is clear from Maddy's account that other factors influenced why she was harming herself; it now not only involved her past experiences of abuse from her brother but also the stress of her young family. Maddy's account is interesting because she appears to take responsibility for the family and the children despite being married at the time and living with her husband. This is clearly evident in the language that she is using in her story *'I couldn't cope'* in her account there is no mention of her husband and she therefore appears positioned as not being able to cope and she blames herself for this. Self-blame is central to the traditional script of femininity. 'Woman' is positioned as coping and if she cannot there is no one to blame but herself (Ussher, 2002).

Maddy continued her account to state that she was no longer engaged in cutting herself because she now lived with her parents as her husband had left her and the children. However, she went on to say that she had started to bruise her arms over the last three or four months and in relation to my prompt she tells me a little bit more about these changes. Maddy stated the following,

Maddy: *'It's just over 12 months now since I last cut. I have actually started recently bruising my arms over the last 3 or 4 months normally when I'm low. I've been hitting myself with things like the rolling pin or banging my arm against door frames normally every couple of weeks.'*

Tammi: *'Right.'*

Maddy: *'I've been told that if I do self harm in the form of cutting that my CPN will report me to social services because I'm the sole carer of my children.'*

Tammi: *'Right and what action will be taken if she did that then?'*

Maddy: *'Em, well presumably that I'm not fit and well enough to look after the children if I'm self harming, that's the kind of attitude and impression I've got, em, and that social services will have to become involved.'*

In this account it could be suggested that Maddy is drawing upon the hegemonic discursive constructions of femininity and of idealised motherhood (Kaplan, 1993) which lead to expectations within society that women should be passive and that there should be an absence of expressive anger in women. In conjunction with this Maddy is also drawing on hegemonic constructions of mental health that circulate Western culture – the view that mood and emotions should always be stable and positive, and if not, pathology is implied. Thus, in Maddy's account it appears that if she resists the cultural representations of idealised femininity and motherhood she may become positioned by others as *'not fit and well enough'* to fulfil her responsibilities as a mother and lose her children because she is 'mad' or 'ill'.

It appears from the narrative accounts that there has been a movement in the context of a general strategy for coping and surviving their everyday lives. 'Self-harm' it appears serves various specific uses at different times and in different contexts for women and it is influenced by different factors.

Alexandra and Clare (2004) argue that 'self-harm' must be understood as a coping response that arises within a social context. They undertook individual interviews with 16 women who identified as lesbian or bisexual and who had deliberately self-harmed on repeated occasions. In the study women talked about their experiences of 'self-harm' and the role it played in their lives as lesbian or bisexual women. Alexandra and Clare

(2004) highlighted a number of ways in which social and contextual factors contributed to the development of 'self-harm' in women. In conclusion, they argued that abuse, invalidation, and the experience of being regarded as different or in some way unacceptable, were all central to the development of 'self-harm'. Further, they maintain that many of these factors might be applicable to any woman who self-harms and accesses mental health services for support.

The implication of Charlotte's and Maddy's narrative accounts and the study carried out by Alexandra and Clare (2004) is that women's 'self-harm' must be understood, not just as a symptom of individual intrapsychic disorder, but as a coping response that is also constructed by a material and discursive social and contextual factors.

'Self-harm' – seeing beyond the scars

Towards the end of their narrative accounts of 'self-harm' both Maddy and Charlotte talked about how they felt that self-harming had affected their life as a whole. Maddy stated that 'self-harm' had affected her by the scars it left upon her body,

> **Maddy:** *'em (2) I think now people tend to see the scars instead of the person, em, and I'm treat, I think, I feel sometimes like I'm treated less of a person because of the scars than other people would be without them.'*

Maddy continues her account by explaining that she had not only experienced this from the health profession when she had sought support and help but also from the general public whilst on holiday,

Maddy: *'We went on holiday about 6 or 7 weeks ago and I actually went round in just a vest, so my scars were on show, em and I was in the public toilets washing my hands and someone stood at the side of me and just said oh you poor dear and that's the only time I've actually had a comment about my scars. Em, which was kind of a positive response in a way.'*

Tammi: *'Right and how did you, when you say positive response, what do you mean?'*

Maddy: *'Em (2) well I was, she didn't look horrified, it was, you know she looked more sympathetic than sort of horrified that I'd got these scars. I think she though I'd been in an accident and been ill.'*

For Maddy it appears that the external signs from her 'self-harm' may have taken over her identity and others no longer see her or even treat her for who she is herself. It could be suggested that because the scars are seen and are permanent, they have become a 'stigma' because of their visibility. Although in Maddy's story she talked about a positive experience she does comment that the women in her story *'didn't look horrified'* which suggests that in the past when others have seen the scars they have been horrified. It therefore seems that Maddy's sense of being depends upon the reactions that she receives from others. Her sense of self seems to be based upon her developing a situation consciousness, as she must assess in advance the impression her scars will make in various contexts and situations (Asbring and Narvanen, 2002). In relation to Maddy's account here she appears to have been positioned as be given the identity of a 'sick person' who requires sympathy and understanding because the scars appear to be the result of an *'accident'* and thus not intentional.

In contrast to Maddy, Charlotte suggested that 'self-harm' had had a different impact on her life as a whole it was not to do with the scars on her face and body but more about being 'known' as someone who self-harms. To emphasis this point Charlotte talks about an experience at accident and emergency where she had attended for help with a possible infection,

> **Charlotte***: 'I'd got an infection and seen my GP and she agreed and told me to go to A & E so I gets there and they sticks me in this room, no bedding on the trolley. And this woman says, this sister says she's overdosed again to another nurse and I hadn't, I'd got an infection. Anyway then this nurse come in, not how are you or anything. What you took now? I says I haven't took anything. I was shivering, I were red hot. Anyway, no sheets on mattress whatsoever, nothing. This doctor comes in, we're gonna have a blood test and so they took a blood test and it came back I'd got an infection in my body, so they gave me antibiotics and sent me home, but they treated me as if I'd overdosed.'*
>
> **Tammi***: 'Right, so, you'd gone in with another problem?'*
>
> **Charlotte***: 'Yeah. But because they knew me history of 'self-harm' they presumed I'd overdosed. I felt awful. I mean I'd gone with a different illness, I expected treatment.'*

Charlotte opens her account by positioning herself as 'ill' and she feels supported in this claim because her GP appears to agree with her. However, in her story she is aware that when she encounters other health services she is not treated by health professionals as other women would be if they attended with a similar presentation. This is evidenced by her comments about the nurses placing her in a room that is not equipped with the right material to look after an 'ill' person. It appears that the

professionals are positioning Charlotte as 'not worthy' of the same standard of care as other women.

At this point I would like to draw upon 'othering' theory (de Beauvoir, 1952; Griffin, 1981; Fine, 1984; Weis, 1995) to explore Charlotte's story further and possibly identify how she appears to be positioned by 'the other' in this narrative account. 'Othering' is a process that "serves to mark and name those thought to be different from oneself" (Weis, 1995, p.17). 'Othering' defines and secures one's own identity by distancing and stigmatising an(other) (Grove and Zwi, 2006). Its purpose is to reinforce notions of our own 'normality', and to set up the difference of others as a point of deviance. By talking about individuals or groups as 'other', we are magnifying and enforcing projections of apparent difference (Johnson, 2004). Othering practices can, although sometimes unintentionally, serve to reinforce and reproduce positions of domination and subordination (Fine, 1994). Consequently, individuals who are treated as other often experience marginalisation, disempowerment, decreased opportunities, and social exclusion (Johnson, 2004; Grove and Zwi, 2006). This effectively creates a separation between 'us' and 'them'.

If we now turn back to Charlotte's account it appears to show that Charlotte has an almost 'invisible' presence because health professionals then proceed to talk around her without asking her anything. However, when they do interact with her it appears to be in a manner that is irritable and not caring (Creed and Pfeffer, 1981; Platt and Salter, 1987) and this is indicated in the account by the strong emphasis of '_now_' in the text. Charlotte continues to say in her account that she has not self-harmed but it appears that she is not heard, she has no voice in the health care interaction. Charlotte is a silent protagonist in this story under the power and surveillance of the health care professionals. Her lack of mobility and speech in this story is highlighted further in this

story when she states *'This doctor comes in, we're gonna have a blood test and so they took a blood test...'* Charlotte it appears it not given a choice over this nor does she have any control she is disempowered and excluded from the health care interaction. It is not until they have some physical evidence that the professionals decide that she has an infection and treat her accordingly. In this account Charlotte highlights the constraints on her agency and illustrates that she is not active and intervening within the medical examination, speaking and giving 'speech' rather she is invisible, voiceless and immobile. The account indicates that Charlotte is known and seen by her scars as a self-harmer and that professionals may never see beyond this.

Discovering 'I've' been diagnosed

When women were talking about the first time that they were told that they had a diagnosis of 'BPD' it became apparent that it was something that was kept away from them and not communicated to them by the health care profession. Both Charlotte and Maddy emphasise this when they start their accounts after I have asked them to tell me about the first time that they were told they had the diagnosis of 'BPD'. The opening lines are,

> **Charlotte:** *'Em, I read it on a computer at the doctors...my GP...by accident.'*

> **Maddy:** *'Em, I actually found out about it sort of by accident... Em, I hadn't been told anything officially, despite asking several times over the last 4 years...Em...I saw it on my screen at my GP's surgery.'*

Both Charlotte and Maddy therefore found out about this diagnosis *'by accident'* health professionals had not made them aware about what they were being treated for nor had they been given any information about how their problems were being categorised and classified in the mental health profession.

Megan also appeared to find out about the diagnosis by accident because she had asked to see a psychiatric report that had been requested by occupational health as she was applying for a new job,

> **Megan:** *'...so I saw the report and it basically, the opening line was this person has an eating disorder em, within the context of the border, borderline personality disorder and that's the first time I'd seen it.'*

Eve was the only participant, who had been told that she had the diagnosis of 'BPD',

> **Eve:** *'Back in the 70s....GP who was a psychiatrist told me'.*

However, when I indicated that this was a rather long time ago and I asked 'has anyone explained anything about it to you since?' Eve went onto say that,

> **Eve:** *'I've not asked...but saying that no-one has talked about it or mentioned it since.'*

It would seem from these accounts that, with the exception of Eve, health care professionals did not tell these women that they have been given this diagnosis. It appears that the professionals often hide it and conceal it from women and they only

214

gain knowledge of their diagnosis *'by accident'*. It therefore appears that it is something that is a secret and which is not discussed in the therapeutic relationship between professionals and women. This lack of information being given to women with a diagnosis of 'BPD' is extremely interesting because today in all areas of health there has been a strong move for the service user's right to know. That is, service users now demand more equality within the doctor–service user relationship and wish to be more actively involved (Department of Health, 1989). Furthermore, The Patient's Charter (NHS, 1992) gives service users the right to accurate, relevant and understandable explanations of:

- what is wrong,
- what the implications are,
- what can be done,
- what the treatment is likely to involve.

However, it is apparent from the opening remarks in three of the women's accounts that this is not the case. It could be suggested that they are not positioned as having equal status within the health care interaction rather they are positioned as needing protection from knowing that they have a diagnosis of 'BPD'. It appears that professionals may construct the women them as being unable to cope with knowing the truth about the mental health diagnosis that they have been given by the system, as illustrated in phase 1.

Following on from these opening accounts about finding out that they had a diagnosis of 'BPD' Charlotte, Maddy and Megan all talked about being extremely upset and unhappy. Charlotte in her account seemed to be in a position of inactivity. She went on to say that she initially did not challenge or ask anything further about why she had been given this diagnosis and why it was in her medical notes without her knowing. Charlotte stated, *'I didn't say anything to him...I were upset...I went home'.*

However, Maddy and Megan did attempt to engage briefly with the health professionals and they did attempt to ask why they had been labelled with 'BPD',

> **Maddy:** *'I did ask but my GP is very em kind of abrupt...you know, and he said that it was the end of your appointment time...and when I asked my CPN she told me to ask my consultant! Can you imagine being in this situation.'*

> **Megan:** *'I was absolutely devastated, absolutely gutted and I'd been (cough) so I arranged to see her and that took a couple of months really and I was in post at that point...And her response to that was em, well it's only a letter from one doctor to another and why did it really matter...can you believe?'*

In these accounts it appears that both Maddy and Megan attempted to confront the health professionals who managed their care and take some authorship (Langellier, and Peterson, 2004) of the decision–making processes that the health professionals had engaged in when classifying them within the diagnosis of 'BPD'. Langellier and Peterson (2004) arguesargue that the use of 'I' in an individuals account is associated with subjectivity, emotional engagement and having an authoritative voice. Thus, Maddy and Megan were not passive when they discovered they had been diagnosed with 'BPD'

they present an account of performing in an active manner, *'I did ask'* and *'I arranged to see her'*. They attempted to consult with health professionals about the diagnosis being given to them. The phrases used by Maddy and Megan initially positions them as the main protagonist and a major character in the narrated event however it can be seen in their accounts that when they do this they are not given any clear answers. There is no debate or opportunity to negotiate with the health professionals about the diagnosis as they are either passed onto another professional or it appears that the information is kept between the professionals themselves. By the end of their accounts both Maddy and Megan have shifted from being an active protagonist to an insignificant character. They both end this account by using the pronoun *you* rather than *I* (*'Can you imagine'* and *'can you believe it'*), which is a performative strategy of involvement drawing the interviewer and the audience closer to the experience (Tannen, 1989

However, both Charlotte and Maddy do not continue to remain constrained and they attempt further to ask questions at a later date to health professionals about what 'BPD' means. The health professionals present them both with very interesting and differing accounts,

> **Charlotte:** *'They just said that it was borderline personality disorder... And that means you've got no, you don't like yourself and stuff like that...And em it's bordering on the personality disorder.'*

In her account Charlotte states that she *'...did not understand it...'* she could not interpret what they meant when they were attempting to describe 'BPD' to her and when she informed them of this they just replied by saying *'...its hard to take in'*. Charlotte's sense of being and level of agency is constrained here by the power and authority of the

mental health professionals (Langellier, 2001) and she is positioned as being a woman who cannot understand what 'BPD' means as she will not be capable of processing the information. Charlotte's account moves on in an extremely interesting manner because although she appears be performing from the position as incapable of taking in the information that the health professionals are trying to explain to her she still views the health professionals as '...ever so good...' It appears that she continues to respect them even though they have not provided her with any clear and concise information about what the diagnosis actually means.

When Maddy talked about how she questioned her consultant psychiatrist about the 'BPD' diagnosis she was told what it meant in the following manner,

Maddy: 'Well, em the consultant just said well actually we don't believe in personality disorder diagnosis.... And I thought but you've given me it so you must believe in it...so I asked what do you mean and I said that I wanted more information but they just said it's like depression and then said they weren't going to talk about it anymore.'

In response to this account from the health professional about her inquiry about what the 'BPD' diagnosis meant Maddy stated that she did not say anything and that she was '...gobsmacked...' Maddy was surprised and speechless that they had said this to her and she appeared so shocked by it that she became inactive. However, in her account this position appears to have been reinforced by professionals as well because she ends her account by stating that 'they [professionals] weren't going to talk about it anymore'. Maddy has continued to remain in this position in relation to the 'BPD' diagnosis

218

because her narrative ends by her recounting that she has never asked anything else about it to the health profession.

It appears from Charlotte and Maddy's accounts that health professionals continue to have difficulty explaining what the discursive representation of 'BPD' meansthis diagnosis means and this may be seen in parallel to the issues that were raised in the phase one interviews. Mental health professionals in their accounts stated that they felt that they had a lack of knowledge and understanding with this diagnosis. Yet it could be argued where does this leave the the women – – positioned as 'borderline'!

'Borderline personality disorder' – not my diagnosis

In the interviews each woman was asked if they agreed with the health profession's categorisation and classification of their needs and problems as 'BPD'. Charlotte, Maddy and Megan were extremely resistant and challenging of this discursively constructed diagnostic category and when asked what is was that they did not agree with a mixture of reasons were given,

>**Charlotte:** *'Borderline personality disorder. I don't like the wording, I don't like the word...because murderers have that...murderers and nasty people as such...they'll think I'm mad'*

It appears that Charlotte is particularly resistant to the discursive representation of 'BPD', that is, the language that is used to describe the diagnosis and the negative connotations that surround this construction. Charlotte appears resistant to having her identity characterised within this diagnosis and wishes to detach from this. It could be

suggested that if Charlotte accepts the discursive construction of the diagnosis of 'BPD' she would become identified and characterised as somebody who is dangerous to others. This narrative therefore reveals how Charlotte resists becoming a 'case' for mental health and having her identity positioned in these terms alone (Reissman, 2003). Charlotte actively engages in strategies to resist a disease designation being placed upon her (Conrad, 1987). She therefore positions herself as a woman with agency and choice in this narrative. Further, with regard to her narrative account earlier in the chapter in relation to 'self-harm' this is not how she wishes to be positioned because she is striving to be *inside* the 'heterosexual matrix' (Ussher, 2002). If she is positioned as harmful, nasty, dangerous and somebody who is uncaring then she will continue to remain *outside* the heterosexual matrix and she will not become a mother and a wife, which she narrates in her account as wanting to be (Ussher, 2002).

In contrast, Megan did not appear to draw upon the discursive construction of murder, she talked about her resistance to the diagnosis when she told me about confronting the consultant psychiatrist who had written a report about her and had included the diagnosis within it without telling her,

> **Megan:** *'I said well borderline personality disorder, I said it's so broad it can mean anything, em, (.) so many different people with so many different experiences, would come under that and em, that isn't me, it's not me,'*

For Megan her resistance to 'BPD' is because it is such an extensive and loose term and it could encapsulate anybody's experiences but then she continues in her account to say specifically why she resists this construction,

Megan: *'Well I suppose I got (.) I suppose because there's a perception isn't there that people who've got borderline personality disorder that it's kind of an untreatable disorder...I am frightened of this bit ...And another fear is the thing about being manipulative and this frightens me...and not being seen as genuine in some way (2) this isn't me, I have my own problems and this makes me who I am.'*

Megan in her account fears the negative references that exist within both the wider health care arena and society in relation to this diagnosis. She fears that if she accepts this label then when she does attempt to access anywhere for help and support she will be identified by health professionals as being 'untreatable', 'manipulative' and not having a 'genuine' problem. It appears that Megan fears *being* the 'BPD' diagnosis because once she is she will be labelled as 'abnormal' and having a 'pathology' that consists of the negative connotations above. Megan appears to be resisting the construction of 'BPD' diagnosis because she is reclaiming the right to define herself, she has her own individual problems and this makes her who she is not a broad and catch all label. However further on in her account Megan narrates that despite confronting and challenging the health care professional she has to leave that encounter with the knowledge that the diagnosis would remain in her clinical notes and she narrates the following with regard to this,

Megan: *'....in the end I ran out of time and when she said the kind of things that she might put in the replacement report I thought, I think I might as well just leave it as it is...But I remember driving away and I don't know how I got back to work....and I just, my world, I felt as though I was just sinking, I could feel myself just sinking as I was driving along and thinking oh my god, it's official now I've got*

this diagnosis (1) and I felt terrible, I just felt absolutely awful and that's it...that's how I will be seen now for evermore.'

Tammi: *'Did you, did the report remain?'*

Megan: *'It's in my notes to this day I guess.'*

It could be suggested that from Megan's account there is a sense that she has been stripped of her identity and in the future she would now be forced to see herself differently. Further it would seem that there is also very little scope for change for Megan in relation to her identity and she realises this when she ends her account by saying *'...that's how I will be seen now for evermore.'* The air of finality in Megan's narrative and the sense that things cannot be otherwise may be characterised by what Mark Freeman's (2000) terms *narrative foreclosure*, when there is a lack of existing narrative resources for life to be lived meaningfully and productively. When this happens he suggests that there is *'...the premature conviction that one's life story has effectively ended (p.83).* In effect, individuals experience their life story as 'over' and *'there is little left to do but play out the pre-scripted ending (p.83).* Freeman (2000) maintains that these beliefs are not only at the individual level but that they might be tied to societal and cultural institutions that exist within society. For example, they may cease to support the continued renewal of the life story or they might actively assist in its premature ending.

It therefore may be suggested that the only story to be told by Megan is the one that is over because she has internalised a storyline that is entirely devoid of possible future episodes. By having the change diagnosis of 'BPD' in her clinical notes it may be suggested that for Megan there is no more to tell because there is a loss of a sense of self. Everywhere she goes and with everyone she interacts with particularly within in the

mental health care arena will be prefixed by the negative connotations that are associated with the construction of 'BPD'

However, Freeman (2000) does suggest that such endings can be altered and changed; by challenging and rejecting dominant endings and creating alternative ones that hold possibilities for 'self-renewal'. Along these lines, one way Megan might be able to mobilise herself and reconstruct herself as not just another woman with 'BPD' may be through continuing to resist, challenge and not accept this discursive representation as an explanation of her difficulties and problems. By doing this there will not be the '...death of narrative desire...' (Freeman, 2000, p.90) and the closure of a different ending but rather it will allow Megan to rewrite the future and for different stories to be told about the movement of her life.

Eve was the only woman who said that she accepted the diagnosis and this she stated was because of respect. This arose when we were discussing what she had been told about her diagnoses in the 1970s. Eve had received no information from her psychiatrist during that period and neither had she received anything recently,

> **Tammi:** *'So has anyone ever given you any information about what borderline personality disorder is?'*
>
> **Eve:** *'No...I've just accepted that's my diagnosis and that's it...I just accepted the diagnosis cos I had a lot of respect for the guy that made it.'*
>
> **Tammi:** *'Ok... so you just accept it?*
>
> **Eve:** *'Yes..and I thought well he knows what he is doing and if that's his diagnosis I'll accept it.'*
>
> **Tammi:** *'Right.'*

Eve: *'So I just accepted it and (.) here I am today.'*

Eve it would appear accepts the diagnosis of 'BPD' because she seems to have a certain level of admiration and regard for the health professional who informed her and she does not appear to question his judgement. It would appear that the health professional is positioned as all knowing and as an 'expert' because *'he knows what he is doing'* whilst Eve is positioned as the receiver of knowledge who is unquestioning and trusts everything that she is told by the 'expert'. This relationship or encounter between Eve and the health professional has an unequal power base and they are not positioned as equals in the health care interaction.

With regard to the women in this study Eve was the oldest woman to participate in the interviews at the age of 54 years old and it may be suggested that the level of acceptance portrayed by Eve in this account might be due in part to her age. That is, Eve talks about being given the diagnosis of 'BPD' in the 1970s, a historical and social context that is characterised by doctor-patient relations being non-collaborative, non-negotiable and the notion of compliance within the medical encounter (Oakley, 1987). Thus, Eve's storytelling illustrates that she has a disempowered status and that with professionals she has no power to deliberate alternatives and negotiate her opinions and options (Langellier and Jefferson, 2004). Her sense of who she is seems to be embedded in a historical and social context that is from the past and whatever her decisions entail in her life they are couched within the context of having 'BPD'. Eve concludes the story in the position of storyteller who is not in collaboration with doctors and there is no mutuality in her current doctor-patient relationship (Ehrenreich, 2001). The mental health profession depicts who she is and her identity is constructed through the knowledge that they uphold about 'BPD'.

Learning to accept the professionals' labels

From the narrative accounts there was only Eve who appeared to accept the discursive construction diagnosis of 'BPD'. However it was extremely interesting that after Charlotte, Maddy and Megan had been resistant of the 'BPD' diagnosis their accounts after this began to illustrate a change of direction with regard to other diagnoses that they had been given by psychiatry. They began to suggest what seemed to be a certain level of acceptance for the other diagnostic labels that they had been given. Megan and Maddy clearly illustrate this below,

> **Maddy:** *'Em, the recurrent depressive disorder, it's easily, it's self-explanatory what it is and it, to me it was pretty obvious that yeah ok that fits the bill kinda thing. So I wasn't bothered about that one [depression] I kinda understood it.'*

> **Megan:** *'Depression seems fairly acceptable really I guess...when I saw that on the report I thought that's great I can live with that, I understand where she's coming from.'*

For both Maddy and Megan 'depression' as a diagnosis seems to be embraced and it's 'acceptable' and they don't talk about being upset or concerned by being given that label. This acceptance seems primarily based upon the fact that they can understand, make sense of it and relate it to their life because as Maddy says it *'fits the bill!'* It could be suggested that the discursive representation of 'depression' is conceptually similar to the female role in Western society (Coyne, 1976). That is, in general, it is seen as being more acceptable for women when they are experiencing lowered mood and low self-esteem to express these symptoms because they are characteristic of their socially

prescribed gender roles. It could therefore be suggested that Maddy and Megan are more open to accepting this diagnosis because it positions them within the socially acceptable role in society that has been learned.

Summary

This chapter has attempted to explore the narrative accounts of 'self-harm' and 'BPD' that were generated by four individual women. A number of interesting issues emerged from the analysis, for instance some personal experiences and narratives bore similarity to one another, others on the other hand present differences in the way in which their 'self-harm' and 'BPD' was narrated. 'Self-harm' appeared to be linked to a variety of factors and as the years passed on it appeared that wider social and discursive factors impacted on the expression of this behaviour. The discursive construction of the 'heterosexual matrix' (Ussher, 2002) and the idealised versions of femininity and motherhood also reinforced and maintained this behaviour. With regard to the diagnosis of 'BPD' three of the four most of the women did not appear to accept the diagnosis and this positioning appeared to be unexpected and upsetting for them. Many resisted and challenged the discursive construction of 'BPD' and would not accept it as their diagnosis, however, with regard to other diagnostic classifications and categories they appeared to a certain extent to 'accept' and understand these. Thus, this chapter has posited that 'self-harm' and 'BPD' arise out of an ongoing interaction of material, discursive and intrapsychic phenomena.

Chapter 9

The long journey: the first steps towards understanding

Overview

In the interviews women often described in detail their experiences of accessing services for support and help when problems and difficulties had arisen in their life. Analysis of the interviews revealed a diversity of ways through which the women revealed the practices of responding which had been helpful and unhelpful to them. The accounts appeared to fall into two broad narrative themes, one which illustrated answers that have an unsupportive impact upon women, and one which depicted the attributes of helpful and supportive health professionals who engaged with them; and where their encounter was a positive experience. This chapter aims to explore these in more detail providing an interpretation, which may highlight the practices of responding within the locality and their implications for women accessing health care facilities and services.

An unsupportive audience

When women were reflecting upon the practices of responding all of them said that they had found services unhelpful and unsympathetic. On occasions they said that they felt that they had caused further damage to them because they may have engaged in inappropriate health care interventions. These themes appear to echo much of the research literature that has sought to highlight women's experience of the health professionals' practices of responding. This literature identifies the practices of

responding as serving often to belittle and even deny the experiences of women (Nirui and Chenoweth, 1999; House, Owens and Patchett, 1999; NICE, 2004). Thus, in the light of this research and literature it is not surprising that the women's accounts are categorised within the theme of an unsupportive audience.

Not telling – fearing the response

Charlotte and Maddy said that when they first had any contact with services this involved them not telling the truth to health professionals about their 'self-harm'. Charlotte's account of not telling occurred early in the interview and was prompted when we were discussing how she sought help when she had self harmed,

> **Charlotte:** *'Nowhere if possible I will deal with it, but if it needed stitches then you would go to casualty but you didn't tell em truth...you'd say you'd cut, you'd fallen or there was this one occasion when my brother in law were there and I'd self harmed and he said tell em that you cut it on a, my niece and nephew were only young then and he said tell em that you cut it on a modelling knife. So that's what I did.'*
>
> **Tammi:** *'Why did you not tell them what happened really?'*
>
> **Charlotte:** *'I didn't want to tell em they would think I was mad and they might even lock me up.'*

In this account Charlotte quickly orients me to the fact that if given the chance she will not go anywhere for help or support when she has harmed herself and she will manage the effects on her own: *'I will deal with it'*. She is the active agent and she positions herself as 'self-managing' and not needing input, support or help from anyone else.

228

Charlotte then moves on to say that if medical intervention was required then she would have to go to the accident and emergency section of a hospital *'you would go to casualty'*.

In this next section Charlotte's position and the salience of the events radically change. Firstly she uses the pronoun *you* rather than *I* to narrate the events to draw the audience closer to the experience (Tannen, 1989). Over the next few lines Charlotte as a character is passive and without speech as she needs her brother in law to *'tell'* her what to say. She does not have the power to speak not even with the presence of her brother in law, she is not an agent of action she is immobile and she cannot tell the 'truth'. This event is ended by Charlotte declaring what she believed would happen if she did speak the truth to the health professionals. Thus, in this final account she illustrates how frightened and worried she is and that she is now in a position of vulnerability and where others may have the power to control her life. Although she does not mention specifically any health care professionals here its as if they have an almost sinister and 'ghostly presence' (Minister, 1991) because she moves on to say that *'they would think I was mad and they might even lock me up.'* In the interaction between Charlotte and myself she states that it takes several years for her to tell the truth to professionals and this only happens because *'a very nice nurse asks me to my face am I self-harming, that was the first time in three years of going there.'* Frank (1996) argues that medicine enacts a benevolent form of colonisation, claiming the patient's body as its territory, as least for the duration of the treatment, and clinically reducing the particular experience to the unifying view required by its practices. In her performance here, Charlotte's lack of engagement with services clearly highlights the constraints on her agency – her lack of mobility and speech.

Not telling because of the shame

Eve had been accessing health care services for nearly 28 years in relation to her self-harming behaviour and when I asked her about how services responded to her and if she had noticed any changes she replied,

> **Eve:** *'well at first I didn't tell them all those years ago...I didn't tell the doctors or nurses in the beginning. I used to say I was low and I'd had an accident...I didn't talk about me sister's death.'*
>
> **Tammi:** *'Can you tell me a little bit about why that was?'*
>
> **Eve:** *'well I kept it to meself, I think cos I was embarrassed about it, I was ashamed I think...they would be shocked and disgusted.'*

Here Eve is firmly characterised as not telling professionals; *'I didn't tell the doctors or nurses.'* Likewise, the limitations of her disclosure are framed as restricted only to symptoms; *'I used to say I was low and I'd had an accident.'* She ends her account by highlighting that she is aware of the stigma associated with her self-harming behaviour, *'I was embarrassed...I was ashamed...'.* Goffman (1961) notes that the individual bears full responsibility for assuaging the social discomfort of her stigma. Through its detail and emphasis this story suggests that Eve has an awareness of and sensitivity to others' responses which costs less in terms of interpersonal conflict than in terms of social and cultural struggle over the meanings of the self-harming behaviour. Her narrative construction of 'shocked' and 'disgusted' professionals, its terms and tone, is more in line with empathy than judgement. In this account Eve appears to have an awareness of the stigmatised meanings of 'self-harm' and in this story sets the stage for her own self-harming experience. Kleinman (1988) suggests that the reactions of health professionals may contribute to patients' shame, given that doctors' discursive power

230

consolidates not only institutional interests but gender and class interest as well. Thus, it might be suggested that once Eve and any other woman admit to 'self-harm' when they are in the professional encounter then their identity becomes spoiled and it is not something that can be easily removed.

In our interaction I then asked Eve what her reaction would have been if a professional had asked her directly if she had been self-harming and she responded by,

> **Eve:** *'I think I would have told them, yeah, but it never seemed to come up.'*

Within this continuing narrative, Eve says that she is willing to talk to health professionals about why she harmed herself and thus tell her story to the professionals. However, she is not willing to take the initial step in the health care encounter implied through *'it never seemed to come up'*. Thus, Eve suggests that she did not tell because nobody asked. Here in this narrative performance the professionals are positioned as silent but yet powerful.

Not deserving of treatment

In Charlotte's account once she started to tell professionals that she was self-harming she continued to say that she was often not seen as deserving of treatment and this, in time, led her to complain about her treatment.

> **Charlotte:** *'Well I, after I had cut my face bad one time they admitted me and the doctor who were there said that no way was she gonna treat me, I didn't deserve stitches, she was really annoyed and anyway at first she just put some steristrips on and they didn't keep me face together and so after a bit she then stitched it*

231

and as she did it she kept saying to nurse that were in, she doesn't deserve treatment...and she made a right mess of me face.'

Here Charlotte says she is informed directly by the health professional that she is not deserving of care and she is positioned as worthless, a nuisance and deserving less treatment of care than individuals who accidentally injury themselves. In response to this account by Charlotte I proceeded to ask her if she said anything in relation to this behaviour from the health care professional. Her response was *'no...what could I say?'* The health professionals' responding has therefore left Charlotte in a powerless position where she appears weak and cannot challenge because she is framed in a context where she does not deserve treatment.

In summary it would appear that the themes through which women talk about their reflections of unsupportive health professionals' practices of responding to their problems and issues offers support to and is supported by the wider research literature. It is suggested that the response experienced by women within the locality is consistent with the experiences of women nationally and internationally.

An supportive audience

Nevertheless, it would not be fitting to suggest that all women's experiences were negative and components of good services and practices by the health professionals were apparent within the women's narrative accounts. The women drew upon a whole range of differing accounts and examples through which they appeared to talk about the abilities and qualities of helpful and supportive health professionals. Upon reflecting on these experiences several of the women talked about how it was assisting them to cope

and move on in their life. The section that follows in the next part of this chapter will begin by indicating how women reveal the skills and characteristics of helpful health professionals through the theme of a supportive audience. It will also highlight how women talked about the changing responses of health professionals and how it appeared that all of them were getting better in their understanding and responses to women.

Being known

When women talked about health professionals in a positive tone they appeared to characterise them as performing a range of functions. Charlotte talks about the fact that certain services and professionals have 'got to know her', such as the community psychiatric nurse and professionals employed in the accident and emergency services. Others have highlighted that they are 'already known' because of a pre-existing relationships with the health profession, for example, Eve's relationship with her consultant psychiatrist. This theme of 'knowing' provided the means for the women to reflect upon the benefits within the health care interaction. Drawing upon McAdams (1993) this optimistic narrative tone that the women seemed to highlight in their accounts suggests that they are hopeful that changes are attainable in the health care that they might receive and not everything has to have an unhappy ending.

When Charlotte was talking about the different experiences she had had in health care she starts her narrative with her description of Isobel, her community psychiatric nurse,

> **Charlotte:** *'Isobel is absolutely brilliant. She has got to <u>know me</u> over the last four years and she gives me all the support I can ever need. She always sees*

me after I've self-harmed and she always been interested in knowing why I've done it.'

In Charlotte's account the health professional appears to be empathic to her needs and this is through the verbal emphasis placed on the word know; 'know me'. Charlotte also moves onto emphasising certain characteristics, 'gives me support' and 'always been interested in knowing why'. The health professional for Charlotte appears to perform the function of someone she can rely upon particularly after she has been in distress and has harmed herself, 'she always sees me'. According to Frank (1996), the wounded storyteller reclaims the capacity to tell, and hold on to, her own story, resisting narrative surrender to the medical chart as the official story of her illness. The importance of being 'known' by health professionals is emphasised further by Charlotte when she is talking about other experiences that she has had,

Charlotte: *'A & E are all right now cos they've got to know me...the staff that work on there now know me when I present and they are not too bad now...they treat me with respect now cos they know some of my problems cos they don't talk down to me anymore, they talk to me.'*

In this account it appears that Charlotte has only recently started to develop an active relationship with the health care professionals in this service through the verbal emphasis of *'all right now'*. It appears that previously she has been silenced in the health care interaction because they *'now know me'* and she is no longer a stranger to them because *'they know some of my problems'* and they know her because *'they talk'* to her.

234

It could be suggested that Charlotte's more optimistic account that has developed between herself and the health professionals within services is because they have become known to each other and they are no longer strangers. Thus the importance of this known status for Charlotte appears a crucial element of what for her appears to determine a successful and supportive response from the health care professionals and the services that they work in.

Eve also drew upon the theme of 'being known', but she talked about it in terms of her existing relationship with her consultant psychiatrist. This discussion came as a result of my prompt 'Can you tell me what it is like when you see Dr Smith?' Eve says,

> **Eve:** *'I see him at the hospital and he's smashing, he's a sweetie, he treats me well. We talk about Star Trek first because we're both Trekkies and he loves science fiction and so do I, so we have a chat about that first and then we discuss how I'm feeling. He's my best doctor I've known him a long time.'*

Here Eve positions the psychiatrist as 'known' in her account through her positioning him as *'my best doctor'* and then extending this further to him as known *'I've known him a long time.'* Here again, as with Charlotte, Eve provides hints to the elements of responding, which characterise the contact with a known health professional. For Eve this is described through the descriptors of *'smashing', 'sweetie'* and *'he treats me well'* and the characterisation of their interaction as mutual implied by the *'we'* rather than he, or I, in *'we have a chat'* and *'we discuss'.* Thus it appears that Eve in this health care

235

relationship has a status with the professional, although not equal, but which allows them to work through issues and problems together because they know each other.

Through Charlotte and Eve's narrative accounts it would seem that 'being known' in the health care interaction may have implications for other women as it may improve the quality of the contact that they have.

Attempting to see 'me'

A further theme, which is possibly related to the previous area of 'being known', is women's notion of 'attempting to see me'. In their accounts women say that although the health professionals had not experienced 'self-harm' or 'BPD' personally on occasions when women accessed care they talked about how professionals had tried to understand their position and see beyond their 'self-harm'.

Eve and Megan drew upon this and highlighted that when professionals attempted to do this it appeared that they were responding more sensitively and trying to recognise their individual distress. This is evident in Megan's reflections upon her experience within a mental health ward where she was being detained under the Mental Health Act (1983). In her response to my prompt, 'Can you just tell me a bit about this encounter?'

> **Megan:** *'This particular nurse who as kind of primary nurse for me really was brilliant...I, I said...I remember not wanting to talk to the doctor about why I had cut my arm and so I'm saying <u>wait a minute</u>...*
> **Tammi:** *'Hmmm.'*

Megan: *'I said <u>wait a minute,</u> before she let him in, I said, I, I really don't want to talk about this right now because I just felt so exposed, do you know what I mean.'*

Tammi: *'Yeah.'*

Megan*: 'And em, she was brilliant and lovely and said oh that's fine, that's fine and she asked him to do it another time...'*

Tammi: *'Right.'*

Megan: *'I remember her because I remember thinking she was trying to see <u>me</u> I was more than just a cut on the arm she was actually trying to see me more holistically really.'*

Megan first characterises the mental health nurse in terms that are positive by describing her as *'brilliant'* and there is no contesting of her knowledge and power. However as her account moves on there are changes in her performance. First, Megan constructs her intervention within the medical routine of the narrated event with an assertive *'and so I'm saying wait a minute...'* and returns to the narrated event to perform it again with a forceful voice. Labov (1972) notes how reported speech enhances experience by suspending time and delaying narrative action. Second, the shift from past tense *'I said'* to the present *'and so I'm saying'* initiates the use of conversational historical present (CHP) as an enhancement strategy (Wolfson, 1978). The alteration of the CHP with past tense is a reliable performance strategy that intensifies the drama of a story (Langellier, 2001). Following its first use, Megan switches to past tense *'I said'*, back to CHP with *'before she let him in'*, and then back to past tense *'I said, I, I really don't want to talk about this right now because I just felt so exposed, do you know what I mean.'* *'I just felt so exposed'* is again spoken as an assertion. The *'do you know what I mean'* switches from Megan's performed voice in the past narrated event to the narrative event

with the interviewer, an offer for approval and bonding which signals a certain level of uncertainty on Megan's part; and I respond with *'yeah.'*

Narrative agency initiated by the *'wait a minute'* performance frame clearly gives Megan voice and carries her perspective. Megan is creator in this performance and she retains control of my reception of it. Megan's description and continuation of the story returns to past tense *'she asked him to do it another time'* and many of the performance features are dropped. The story concludes with a supportive response from the nurse and the fact that Megan felt that she was being viewed as a whole person and this is emphasised in the sixth sentence when she states that *'she was trying to see me'*.

A further striking feature of this story is the active participation of myself. Positive minimal responses are added at three points in this story. Wolfson (1978) argues that CHP is an interactional variable influenced by the relationship of the narrator and interviewer gains support here. Performance is intensified when norms of evaluative interpretation are assumed to be shared (Langellier, 2001). Megan and I share several social attributes, including sex, class and ethnicity. Furthermore, we are both trying, through this research project, to develop improved care and treatment for women when they present in need of support within the mental health care arena.

This particular experience seems to have been significant for Megan and she clearly remembers this supportive health care interaction and the reason for this is given further in her narrative account,

> **Megan:** *'I remember this nurse because I really felt that she was trying to empathise and trying to reflect on how it must be to suddenly find yourself here*

238

on a psychiatric ward. She used to come and sit with me and talk to me and

things like that and that was a huge help, I felt good.'

Further evidence for Megan feeling that she had had a supportive response from the health care interaction was not only through the nurse seeing her as an individual but also because of the sympathetic behaviour that she had engaged in with her. Megan portrays the sympathetic behaviour, as trying to *'empathise and trying to reflect'* and also when *'she used to come and sit with me and talk to me'.* Here for Megan the sympathetic and supportive behaviour that she needed was not something special it was only being listened to, talked to and having time spent with her. For Megan the significance and impact of this behaviour from the health professional is illustrated in the final line of the extract where she sees it as serving to boost her self confidence, expressed through *'that was a huge help, I felt good'.* In this story Megan presents as an active and initiating protagonist, intervening within the medical encounter, speaking and giving 'speech' and thus extends and deepens Megan's agency in relation to the mental health profession and the professionals working within it.

It is getting better

When women were completing their stories of how health professionals had responded to them both Charlotte and Maddy talked about how they had noticed a change in the responses from services in the past twelve months. In response to my prompt 'can you talk to me a little about how you know its changed?' Charlotte responded with,

> **Charlotte:** *'They're a bit more understanding...I know they don't understand it fully, but they treat you, they treat you better...its getting better.'*
>
> **Tammi:** *'In terms of when you say they treat you better, in what way, is that?'*

239

Charlotte: *'Well they want to know who's supporting me, they then patch me up and normally send me home and then the following day or whatever my CPN will come and see me. They [professionals] are trying to understand more.'*

Charlotte has been harming herself for 25 years in a variety of ways and what her narrative has shown is that throughout her long journey she has encountered both a supportive and unsupportive audience in the health care arena. However, as an *experienced* recipient of services she is now storying in her account a change, which she appears to frame as *'getting better'*. Charlotte appears to position professionals in her account as more accepting of her because they *'treat'* her and *'want to know'* certain things for example who is supporting her. It could be suggested that this change that Charlotte has identified is because of the discursive representation that have been introduced in health care policy recently. Discourses are being put forward that when someone has self-harmed they should be treated with the same care, respect and privacy as anyone else and that healthcare professionals should take into account the distress associated with self-harm (NICE, 2004).

Summary

Women's narrative accounts about the practices of responding in health care services appear to illustrate that women in the locality, as women in the wider research literature, recount both supportive and unsupportive responses when they access services for help. Women it appears become positioned by health professionals in a variety of ways, nevertheless, it seems that although this has been a long journey for women some

headway is starting to be made and they have narrated that *'it is getting better'*. It would

appear that attempts are being made to understand their needs and problems.

Chapter 10

Women, self-harm and borderline personality disorder: opportunities and limitations

Overview

In this final chapter I wish to highlight how the research has influenced me and how it could potentially influence future health care practice. In other words, this chapter will take a step back from the research by asking questions like 'so what?' and 'what now?' Rather than using statements and clichés like 'further research on this is needed' I will attempt to move beyond this towards an active engagement with social, political and psychological practice (Willig, 1999).

However, prior to embarking upon this I would like to explore some of the dilemmas and problems involved in the notions of 'implication' and 'applicability' within psychology. Indeed, Willig (1999) highlights that the relationship between critical analysis and progressive practice is by no means unproblematic and there is a need for researchers to have a sensitive awareness of the dangers connected to particular policies and practices.

I end this section by arguing instead for a notion of *usefulness* (Gergen cited in Misra, 1993; Harper, 1999) and the possibility of new ideas about intervening so that a change may occur to the situation of women accessing mental health services. My aim

therefore in this chapter is not to talk of 'true' but of *better* stories (Harper, 1999) and I will suggest the use of the MDI framework to inform future health care practice for women who 'self-harm' and have been given a diagnosis of 'BPD'.

Dilemmas with 'applicability' in psychology

Harper (1999) argues that the notion of applying research has repeatedly been problematic for various disciplines and that psychology is no exemption. Drawing upon the profession of clinical psychology, and its notion of the *scientist-practitioner* as a framework to which all aspire, Harper argues that this demonstrates some of these conflicts and tensions. For example, he illustrates that surveys (Norcross, 1992; Milne, 1990) within clinical psychology have found that few psychologists undertake research or consume it, as it is ordinarily understood. Pilgrim and Treacher (1992) who have discussed the *scientist-practitioner* issue at great length have also concluded that the clinical practice of psychologists is more influenced by dialogue and debate with colleagues rather than by undertaking their own research or utilising published research. Furthermore, they argue that clinical psychologists see research as nothing more than rhetoric of professional legitimation. Thus, Harper (1999) argues that although the concept of applicability has strong rhetorical power (particularly in terms of legitimating professional groups) it seems to happen less in practice than might be thought.

Potter (1982) takes this a step further, and not only focuses upon clinical psychology, he maintains that the work of psychology practitioners in general is not directly influenced by research simply and purely because the dichotomy of theory and practice are viewed as separate and are frequently divided institutionally. Gabbay (1982) highlights this position further and demonstrates how theory often seems to follow on from

developments in treatment as a *post hoc* justification. Potter (1982) corresponds, noting that 'it is not hard to conceive of theories being used as a gloss on application which has been undertaken for quite different reasons' (p.46).

Willig (1999) maintains that there are other problems with applicability and although she relates them specifically to discourse analysis I would suggest that they are important here. She highlights three major challenges to applicability: the view that application is open to abuse; the ideology of application critique; and the critique that applying any results from research might risk reification. Each of these will be discussed in turn.

The power/abuse critique

Research undertaken by Cromby and Standen (1996) focused on the ways in which psychological research findings may be easily (ab)used by governments and other powerful groups in the pursuit of political and/or economic aims and objectives. They argue that in the United Kingdom the existing government compression on research funding is because there is a direction to find answers and solutions for social problems. For example, psychological research findings have been used to rationalise the care in the community policies of individuals with mental health problems, which are in reality chiefly motivated by economic considerations, psychologists 'however unwittingly are helping to conceal a much bigger risk to health' (Cromby and Standen, 1996, p.7).

The ideology of application critique

Potter (1982) argues that there is a discrepancy within society between what he describes as 'the ideology of application' and the way in which psychological theory actually informs practice. The ideology of application 'suggests a continuum of research

244

from 'pure' to 'applied' with knowledge 'flowing' from one end to the other' (Potter, 1982, p.24). However, in reality, Potter (1982), maintains that the link between theory and practice are 'institutionally and intellectually separate' (p.25). He highlights how they have their own separate literatures and conferences, and innovations tend to be contained within each area. Potter (1982) also emphasises the situated nature of theoretical frameworks and their application, whereby 'institutional, social, political and economic interests influence the process of application' (p.45). Hence, Potter (1982) argues that there is a differentiation between an idealised conception of 'application' and the realities of application, and he ends by maintaining that it is by no means clear 'whether our discipline [psychology] is really the positive and critical social force that many would like' (p. 47).

The reification critique

Widdicombe (1995) warns critical psychologists against committing themselves to suggestions and proposals for future interventions because she believes that they are subtle manifestations of power. Psychological research findings may highlight oppressed groups but rather than liberating these individuals all it ends up doing is locking them inside different restrictive discourses and discursive practices. Widdicombe (1995) argues that social scientists should carry out contextualised analysis and allow participants to redefine themselves and their experiences in this space each time they are being researched. Giving individuals this opportunity she argues is more empowering as they avoid having imposed categories of meaning placed upon them, which may come from any progressive policy recommendations.

How to make a difference?

It would seem from the problems of application that have been highlighted above that it would be relatively easy to reach the conclusion that getting involved with interventions is so hazardous and laden with difficulties that it may be best to avoid them. Willig (1999) argues that this is just what many social scientists do, and she highlights that analysts are reluctant to devise and make recommendations for political, social and/or psychological practice. At best, the issue of 'application' of research findings is flagged up and acknowledged as important but it is rare that psychological researchers spell out exactly how their studies can inform practice.

Willig (1998) however, particularly with reference to discourse analysis, endorses the application of research because without this knowledge she argues that dominant discourses would remain and go unchallenged. She argues further that applying discourse analysis research is a necessity and her form of critical realism is a:

> 'result of the recognition that we as human agents find ourselves within a context in which things are always already going on or being done. Within this context it is impossible to abstain from involvement since inaction is always a form of action. Thus, we can only ever argue for or against, support or subvert particular practices or causes but we can never disengage ourselves from them.' (1998, p.96)

Willig (1998; 1999) therefore maintains that applying research is desirable but that it would be an error to assume that any critical psychology research is simply applicable. I would suggest that in any application there needs to be caution and as well as taking

into account the points that have already been raised above I would like to explore several more problems with applicability.

On application and usefulness

Harper (1999) argues that there is comparatively little work on understanding what counts as an intervention. Issues include what is deemed as a 'good' intervention and on understanding how effective interventions are developed. Conventional notions of applying research do not help here because it seems that they may be constrained by the unhelpful opposition between theory/practice. Thus, rather than drawing upon the positivistic ideas which assume a mechanistic, linear and reductionistic notion of theory and practice (Harper, 1999), I perhaps prefer the concept of *usefulness* (Misra, 1993) rather than 'application'. By usefulness I do not mean that '...ideas from 'research' can be taken out of context and applied to a context of 'practice' (Harper, 1999b, p.127) rather I refer to '...whether a particular idea or intervention leads to richer understanding and to just and socially responsible outcomes' (Harper, 1999b, p.128).

David Harper (1999b) utilises this notion in his analysis of users and professionals' accounts of psychiatric medication failure. He identifies multi-factorial talk and a rhetoric of chronicity as culturally available ways of accounting for a drugs failure to remove psychotic symptoms. In these accounts the user and the illness are positioned as responsible for medication failure and thus deserve the continuation of drug treatment. Harper (1999b) asserts that his analysis can be used to confront and challenge such rhetorical features and their effects and he identifies a range of interest groups to which this may be relevant. He identifies training and the development of skills as a way of putting discourse analysis to practical use and he calls upon academics to take on board

user agendas and resist the pressure of powerful interest groups upon their research questions and use of findings (Willig, 1999).

However, the notion of usefulness is not without its problems. For instance usefulness does not say *who* it is who judges whether something is useful (Harper, 1999) and there is a risk, as Danziger (1997) highlights, of the old wine, new bottles syndrome where, for example, the therapy establishment incorporates useful ideas into conventional practices. Willig (1999) picks up on this criticism arguing that professionals looking to 'empower' others fail to offer criteria for discriminating between differing definitions of empowerment. Hence, McLean (1995) notes that within the mental health ex-service user movement the term empowerment has assumed 'diverse and even contradictory meanings' (p.155) since it may refer to:

'an increase in mental health treatment options and in opportunities for consumers to voice their preferences to help determine future options. It may refer to a process, a goal to be achieved, or a combination of these. It may also refer to processes occurring in relation to the individual, the organisation or the larger social structure, or to interrelations among these levels. Finally it may be used to refer to a service approach.'

(McLean, 1995, p.1055-1056)

Many psychological researchers (Smail, 1995; Burton and Kagan, 1996) therefore caution against naive, individualised and psychological notions of empowerment.
Harper (1996) also identifies that within the deconstruction in mental health it is important that the oppositions, which are implied within clinical categories, should be challenged for example reason/unreason, pathology/normality and professional/service

user. He suggests that the value of interventions could be moderated by the degree to which they confront these oppositions. However, it must be noted that these challenges should not choose one term over another rather the challenging must focus upon the basis of the opposition, the theoretical policing that keeps the term apart (Frosh, 1992). In agreement with Harper (1996), this research suggests that what would be considered 'better' interventions for women in mental health would be those involved in the deconstruction of these oppositions as well as those tracing the influence of power and the production of gender, class and race. But there is a risk of a 'utopianism here and it may be a short-term politically effective intervention' (Harper, 1996, p.420). Thus, as Parker *et al* (1995) points out there are no ideal interventions and all involve some problematic ideas. Willig (1997) therefore warns that when individuals are engaged in different practices they should remain alert and be watchful that the 'new' practices and interventions do not merely re-assert the old problems in new guises (Harper, 1999).

Ways forward for women who 'self-harm' and have been given a diagnosis of 'BPD': how to effect change

Willig (1999) highlights in her discussion of 'applied discourse analysis' that it is possible to find research in this area that is of use in developing interventions. She puts forward a diverse range of strategies, for example, providing a space for different constructions; education; campaigning; and lobbying. Once again there are problems with these. For instance, with regard to providing space for alternative constructions, writers like Bhavnani (1990) have problematised these ideas and question whether simply giving a voice to marginalised groups is empowering. Developing this critique further Burman (1992) notes that,

'the 'voice' given to previously silenced people does not necessarily speak for them since the whole notion of giving voice runs the risk of reproducing those power relations the research was intended to transform, by reintroducing a relationship of patronage' (p.178)

So, how can this piece of research be 'useful' for women who 'self-harm' and have been given a diagnosis of 'borderline personality disorder'? In the remainder of this chapter an attempt will be made to answer this question by presenting the findings from the present study. However, it must be noted that the changes that may be suggested here for women 'living with self-harm and being given a diagnosis of BPD' are not unique to this group even if there are some problems specific to their lives (Ussher, 2000). What I would like to argue, based upon the accounts given in the present study, is that there is a need for a transformation in the wider social and political sphere, empowerment of individual women and a reconceptualisation of femininity, leading to more egalitarian relationships between women and the professionals.

Changes at a discursive level

The inclusion of the construction of "BPD' in the DSM and ICD-10 it appears continues to provide a legitimation of a set of 'truths' that health professionals draw upon in their interpretation of women's experiences as pathological. It seems to legitimate the examination, diagnosis, and treatment of individual women (Ussher, 2003) and it acts to position certain women, those diagnosed, as ill, as unstable, as a 'self-harmer', or as having 'BPD'. The present study has shown that at a discursive level it would be useful to challenge the stereotypes and prejudices surrounding the discursive constructions of

'BPD' and 'self-harm', which prevent women from expressing distress in any way other than internalisation or blaming themselves.

Further, the present study has demonstrated, particularly in the first phase, that when women presented or were referred for needing assistance for self-harming their problems/issues would become located or classified within existing diagnostic groupings. A woman within the locality who presents with 'self-harm' may therefore not be seen by the professionals as an individual woman who has her own history, her own roots and her own experiences to tell. Rather she may become positioned and categorised within the medical discourse of 'madness' as having a 'personality disorder'.

Dana Becker (1997) has critiqued the category of borderline disorder as an entity and she points out that determining whether a woman has or does not have 'BPD' is not helpful since it is such a heterogeneous category that does not refer to a singular entity. She suggests a more dimensional model of assessing a woman's symptoms (Wirth-Cauchon, 2001). Joel Kovel (1986) offers a different argument from which to consider the role of diagnostic categories. He maintains that the DSM reifies the disease model of mental illness and the service user is viewed in a decontextualised fashion, outside the social and historical contexts within which her symptoms have meaning. Kovel (1986) argues that for change to occur, the focus must be upon 'the person and her relation to the world - instead of being located in the false abstraction of mental disorder' (p.145).

In a critique of diagnostic categories, Malone, Malone, Malone and Malone (1995) noted:

'The traditional language is useful for listing and sorting but not for living and experiencing. 'Naming' a thing is not the same as 'knowing' a thing'. (p.90)

Another implication of the present study is that the women's narratives highlighted that the classification as a 'self-harmer' or as having 'BPD' meant that they were often not asked about *why* they had harmed themselves. Questions are not often asked about what has been happening in the women's lives in order for them to do this to their body or about what distress they may have been experiencing. In their accounts the women also said that they wanted to be 'known' and be heard by the professionals beyond the labels that they were aware they were ascribed. They highlighted that it was almost impossible to get beyond this and it often seemed as if they were 'invisible'.

Thus, from the present study, in order to understand or know the experiences of women who live with 'self-harm' mental health professionals may need to confront their allegiance to categories of psychopathology (Nehls, 1999) and not neglect of the stories from which such categories originated (Malone *et al*, 1995). By emphasizing stories or narrative accounts rather than psychiatric nomenclature mental health professionals will be encouraged to view women not as objects of knowledge but, instead, as authors of knowledge from whom others have something to learn (Caputo, 1993). To learn from women themselves is to confront and challenge the reification and stigmatization of any classification system (Nehls, 1999).

In addition to this, the present study has underlined the importance that the notion of 'risk' and the idea that health care professionals are protecting the public also needs to be critiqued, as it appears that it has become central in British mental health care (Bracken and Thomas, 1997; Harper, 1999). The health professional's accounts provide

support for this position, particularly with regard to their constructions of 'BPD' as these were almost exclusively within a discourse of risk. This assumption is extremely interesting because the women were actually accessing mental health services in the locality for support for themselves, and the harm that they were doing to themselves, yet health professionals constructed these women as being a risk to others. The present study has also shown that in phase one that the concept of 'risk' not only involved a transformation of the women as psychiatric subjects but also a transformation of the professionals themselves.

Thus, for the women in the present study there has been a move in the professionals' role from 'caring' about or for the women to one of 'surveillance' or managing. The surveillance is not only of the women by the professionals but also the professionals themselves and this exists in a panoptical space that is inhabited by NHS managers, government ministers, inquiry teams and the media (Fox, 1999).

Moreover, the present study has shown that 'BPD' and 'self-harm' are not phenomena that exist simply at the level of the discursive. They appear to be bound up in a set of institutions and practices that Rose, drawing on Delouse and Guitar, terms 'assemblage': a complex of, 'apparatuses, practices, machinations and assemblages, within which the human being has been fabricated, and which presuppose and enjoin particular relations with ourselves'. (1996, p. 10). It is through this assemblage, the practices and institutions that regulate women's mental health that 'BPD' and 'self-harm' seems to have a material impact on women's lives, for example, on their employment, family relationships, and women's subjective experiences of symptomatology. At the time of the interviews none of the women were in employment and they stated that this

had been the case for several years, particularly since they had been given the diagnosis of 'BPD'.

The present study therefore shows that this assemblage also mediates the relationship between the health professionals as 'knower' and the woman's body as object to be known. This is a structural relationship situated in the particular organisation of power and knowledge and may therefore allow psychiatrists and psychologists to judge, and positions women as service users to be judged and cured (Ussher, 2003). For as Rose (1996) maintains, the psy complex grants powers to 'some to speak the truth and others to acknowledge its authority and embrace it, aspire to it, or submit to it' (p.175). Eve's account demonstrated that she appeared to accept the diagnosis of 'BPD' unquestioningly whilst Maddy and Megan appeared to embrace or accept the other diagnostic labels that they had been given.

So, as a result of this assemblage, if a woman wishes to understand her experiences she might be expected to turn to the experts for answers; to the regimes of objectified knowledge that provide the 'truth' about her experience. The present study has demonstrated It could be maintained from this research that within women's mental health it would be useful to develop new languages, practices and concepts for the way professionals assess and plan services for women. However, these changes should not necessarily be developed by professionals alone rather it would be useful for professionals and women to work together, actively, and in partnership. By working with women services may be changed so that they become in line with what women say they want support with.

Based upon the accounts given in phase two the present study demonstrates that it might be useful for professionals to create opportunities for user power (Nelson and Walsh-Bowers, 1994; Williams and Lindley, 1996) and the user movement. Within the mental health system, the user movement has started to make some progress for example by groups like Survivors Speak Out (SSO) and the National Hearing Voices Network. Both of these groups attempt to democratise the assemblages in the mental health system, especially in terms of rights in relation to the choice of alternative services. However, in relation to the present study there were no user groups specifically for women who 'self-harm' and have the diagnosis of 'BPD' within the locality. It would be useful for the mental health care arena to develop a dialogical relationship between professionals and women, which incorporates more than mere talk (Sampson, 1993). Sampson (1993) distinguishes between an 'accommodative voice' (in which the participation of oppressed groups is simply added to the discussion defined by those in power) and a 'transformative' voice (where oppressed speak in their own voice and are heard in a manner that allows the nature of discourse to be transformed). The present study has demonstrated that any future changes in women's mental health would benefit from the incorporation of a transformative voice whereby women are largely responsible for, or at least involved in, the planning and delivery of services within the locality. Furthermore, there could be joint training involving women, carers and health care professionals within the locality.

Moreover, the present study has shown that it might be useful for the mental health profession to examine the professional code of conducts that guide health care professionals' practice particularly with regard to the notions of autonomy and non-maleficence. Drawing upon the analysis of chapter five, which explored the health care professionals' accounts of providing information to women about the diagnosis of 'BPD' it

could be seen that they viewed women as being unable to understand or comprehend the whole truth. Based upon these accounts it would appear useful for a movement towards autonomy. There are several reasons for this proposed action.

The first reason is to do with moral issues and involves respecting the women's 'right to know'. It is important that women's values and beliefs are respected and that they are involved in all aspects of decision making that involve their care and treatment. By not telling them or omitting certain aspects of knowledge about what is being written about them in their case records, particularly with regard to the diagnosis of 'BPD', it might be suggested that their autonomy as an individual is not being respected. In this statement I would like to make it clear that the present study is not arguing that autonomy should override other moral issues such as doing no harm, or doing good these principles are just as important. However, it must be noted that no research has been undertaken that has examined the possible short or long-term psychological damage through the disclosure of 'BPD' to women. From the analysis of the present study it might suggested that informing women about the diagnosis of 'BPD' might have a positive impact and give a sense of relief as it may serve to give them both an explanation for their behaviour and a reason for it.

The second reason is to do with maintaining trust. If health care professionals wish to maintain a sense of trust with women in the health care interaction then it is important that they tell them explicitly what is being written in their case notes. Indeed the present study shows that women do eventually find out what has been written about them and finding out in this manner appears to disrupt the women's relationship with the mental health profession causing mistrust and tension due to the lack of honesty. As a result, the present study has shown that the woman may then feel that they cannot discuss

their concerns or anxieties about this condition with the professional who ought to be available for such discussion (Atkinson, 1987). The present study therefore demonstrates that it might be useful for professionals to communicate with women in a reciprocal relationship. It may also be useful for active steps to be taken whereby women may actively write in the case records so the focus moves away from the objectification of their symptoms (Thomas, 1995).

Overall, the present study suggests that it would be useful to challenge the governing and controlling models of mental health by professionals and women but also to the services as they actually operate. Language and concepts may then be developed that do not individualise women's mental health problems. The present study demonstrates that strong alliances need to be built with women accessing services so that power and resources are shared and women have their say. However, it must be noted that there are hazards with undertaking the steps and individuals need to be aware of these. For example, McLean (1995) has identified that when service users become 'professionals' new imbalances of power might emerge. Also as service users build an affiliation and an alliance with health care professionals there is a risk of loss of independence and as service users become more involved in service planning there is a possibility of tokenism (Harper, 1999).

Changes at a material level

The present study has shown that at a material level it may be useful to provide provision for an alternative means of solving problems, which will make 'self-harm' one option amongst many, and make it easier for it to be rejected as the option of choice. Specifically, in relation to 'self-harm', it appears that it might be useful to provide for the

provision of facilities for interventions that do not blame individual women. A central issue here is trust. Thorne and Robinson (1988) coined the term 'reciprocal trust' to describe a situation in which, '...trust from health care professionals fosters trust in health care professionals...[Reciprocal trust] serves as a foundation for the kind of relationship that permits collaboration and co-operation...' (p. 786) From the present study the women's accounts have demonstrated that a foundation of trust might provide a different, and potentially more therapeutic, milieu for the delivery of mental health treatment. Thus, at an individual level, it might be maintained from this research that the women's accounts need to be heard when they attempt to express distress or concern about 'living with self-harm and BPD'.

Another crucial implication of the present study that needs to be taken into account at this level is that the symptoms that women come forward with and which the mental health profession observe are connected to contradictions of *gender* in late modern culture (Wirth-Cauchon, 2001). Moreover, the present study had shown that when women are seeking support and are expressing extreme intrapsychic pain they might be responding to the erasures, denials and suppression of self, powerlessness, and often vicitmisation of abuse, in a world of gender and power (Wirth-Cauchon, 2001). There is evidence from the women's accounts in the present study of incidents of abuse and feelings of powerlessness. Might it be that if the mental health care system could understand this positioning of women then it might significantly affect the ways in which women are understood and treated? Hence, from the present study it seems that it may be useful to situate women's symptoms within the larger context of gender. Several feminist treatment models have attempted to do this such as Judith Herman (1992) and Dana Becker (1997) and Marcia Linehan (1993).

For Herman (1992), the experience of abuse is an important factor to which health professionals must focus upon in the overall assessment process. In 1982 Herman carried out research on post-traumatic stress disorder and this work provides a framework for understanding a woman's behaviour as a replication of past abuse, rather than as a presentation of the woman's 'presumed underlying psychopathology' (p.116). It could be argued that this has the effect of 'rehumanising the potentially dehumanising and pejorative connotations' (Wirth-Cauchon, 2001, p 205) of the 'BPD' diagnosis.

I would therefore argue that Herman's position is a start but from the accounts gathered in the present study this research I would maintain that more is required within mental health for women who 'self-harm' and have been given a diagnosis of 'BPD'. In agreement with Becker (1997) the present study suggests that, *what would contribute substantially toward improved treatment of women would be the increasing ability of clinicians to understand the relationship between 'borderline' symptoms and female socialisation.' (p. 159)* In her work Becker (1997) centres upon how women's construction of self develops in adolescence and she argues that the social environment for women negatively affects their self-esteem and overall mental well being. She argues,

'Overall, it would appear, coming of age in our culture poses more risks for adolescent girls than for adolescent boys. Since low self-esteem paves the way for emotional and behavioural problems – eating disorders, suicide attempts and higher levels of emotional stress than boys experience'. (p. 96)

Evidence from the women's accounts in the present study gives further support to Becker's (1997) arguments in particular the account given by Megan who had an eating disorder. Becker (1997) moves on to argue that one of the key conditions of this female socialisation is the emphasis placed upon the capacity to nurture, the needs of others and relatedness. Further, because of the high value placed in the culture at large upon autonomy and separateness, as signs of a healthy self, women are being indoctrinated and socialised into a self that is viewed as unhealthy and over-dependent on others (Wirth-Cauchon, 2001). Thus, as women reach adulthood because of their experiences of early socialisation they rely on others for the validation of the self and they develop a,

'...magnified self-consciousness and consequent increase in fear of displeasing others. This results in a greater sensitivity to criticism or disapproval, generally, than exists in boys...Uncertainty in women may have its origins in the dependence on others for validation of self-worth' (p.96)

In the present study support for this position can be seen from the women's accounts when they talked about how the 'self-harm' had affected them her by the scars that it left upon their her bodies. Furthermore, in their accounts their sense of being depended upon the reactions that they received from others on occasions. Their sense of who they are was based upon developing a situation consciousness, as they must assess in advance the impression their scars will make in various contexts and situations (Ashbring and Narvanen, 2002.

Thus, the present study demonstrates that it may be useful if health care professionals understood the influence of female socialisation in shaping women's behaviours. They might also be less inclined to perceive women as 'manipulative' or 'attention-seeking',

phrases that are intrinsically pejorative and that have been frequently used to describe female service (Becker, 1997; Wirth-Cauchon, 2001).

Further women considered, as having 'BPD' might desire to set up groups with other women with similar difficulties in order to support each other. For example, there could be the development of support groups or user-controlled alternatives to official services for women like crisis houses and drop-in centres. However, I would suggest that caution must be expressed to the individuals who lead these developments so that they do not simply become 'mini-institutions'. Interestingly, however, the present study has illustrated that there are no support groups for women who have been given a diagnosis of 'BPD' at a local or national level. One of the few services that does exist is an on-line support message board with Borderline UK that has been operating successfully for the last five years and has approximately 300 members around the United Kingdom.

Lastly, the present study the women's accounts has highlighted that family and friends may find it difficult to help women and rather than avoiding it, ignoring it, or maintaining silence or secrecy, it needs to be emphasised that they may be able to help. There is a vast amount of research available on social support that illustrates how key this is in both physical and psychological health. Drawing upon the women's accounts the women did highlight a lack of understanding within their families.

Further, in much of the critical writing about mental health difficulties family members are often classified with an array of powerful interests that aim to individualise and pathologise those who become diagnosed by the psychiatric system. For example SANE, a charitable organisation, which was established in 1986 initially for people suffering from schizophrenia but now it is concerned with all mental illnesses, is largely run by relatives of service users and they are seen as instinctively conservative (Harper,

1999). There are relatively few, if any, progressive groups that include relatives. Furthermore, Harper (1999b) maintains that family and relatives are often placed in a position where pathologising their relation is the only way to secure support from services.

The present study therefore shows that in order to address these possible issues it may be useful for those who are close to women to understand the difficulties they might be going through. It might also be useful for relatives to view 'self-harm' and 'BPD' as an expansion of an essentially normal process: women who access services with these problems are not categorically different from the rest of us. Classifying and identifying a relative should not be experienced as the only way to get help and there is an obligation here on services to ensure that they do not become inaccessible.

Changes at an intrapsychic level

The present study demonstrates that at an intrapsychic level women must be encouraged to become more empowered and assertive in themselves so they do not continue to self-blame. Equally, if those who turn to 'self-harm' to solve their problems can find alternative means of resolving their distress, they may be less likely to harm themselves. The present study suggests that this might be a step forward for many women if more counselling or therapy were to become available. However it must be remembered that a large amount of treatment for mental health focuses on hospitals and medication.

Harper (1999) maintains that there is a necessity to offer service users more choice and information about the various treatment options offered. Within the research literature,

and from evidence in the present study, it has been illustrated that women would like easier access to psychological treatment (Rogers, 1993) as well as complimentary therapies (Brindle, 1997). However, medication is still a first choice of treatment by many GPs and psychiatrists for mental health difficulties (Warner, 1985).

The present study therefore suggests that it would be useful for professionals to give, in this case women, more control over the treatment options that are available. Engagement between the professionals and women about alternative treatment options may be more successful in order to meet their problems. The present study demonstrates that it would be useful to focus on talking to women rather than on administrative, ancillary and medically focussed duties (Harper, 1999).

With regard to the women in this research study one particular treatment approach that has been hailed by all the women as successful is the Dialectical Behavioural Therapy, developed by Marcia Linehan in 1993 at the University of Washington DC in America. This approach is aimed directly at women's self-destructive thoughts and behaviours, teaching them skills too intervene in negative feelings and replace them with alternatives. Linehan (1993) argues that women who express the behaviours that are grouped under the notion of 'BPD' may have had invalidating, and sometimes abusive, childhood family and social environments, which disrupt their creation of a positive sense of identity. Linehan (1993) points at a sexist society as a major source of invalidation because the diagnosis of 'BPD' is more frequent for women. It must be noted that she also incorporates other factors including abuse, parental rearing techniques and the overt sexism in which girls are punished for displaying 'unfeminine' behaviours or skills. She also identifies a biological predisposition in women to sensitivity and emotional vulnerability.

The treatment approach for this model is based upon a dialectical approach whereby there is 'the necessity of accepting patients just as they are within a context of trying to teach them to change' (Linehan, 1993, p. 19). So although the treatment is aimed at the cognition and behaviours that women can learn in order to develop new, less self-destructive responses to their psychological pain there is also an emphasis in treatment to both the necessity of change and the acceptance of what is. Furthermore, because Linehan's (1993) model focuses upon ongoing change it means that 'truth' is never absolute; it,

'...evolves, develops, and is constructed over time. From the dialectical perspective, nothing is self-evident, and nothing stands apart from anything else as unrelated knowledge. The spirit of a dialectical point of view is never to accept a final truth or an undisputable fact. Thus, the question addressed by both patient and therapist is 'What is being left out of our understanding?' (p.35)

Although Linehan's (1993) model in mental health has been praised not every woman has easy access to this form of treatment and in the case of the women in the present study only one had had access to such a treatment approach. Furthermore some feminist writers (Flax, 1996) argue that it does not go far enough at looking into women's psychic divisions.

Flax (1992) maintains that there should be a move away from a language of self in therapy towards one of multiple and shifting subjectivities (Wirth-Cauchon, 2001). Rather than motivating women to find fixed meaning in their lives, she declares that women must be encouraged to embrace its elusive quality. This is notion is explained in the following paragraph,

'The patient learns that she can live with multiple, often contradictory stories and develops the capacity to revise them as necessary in ongoing life struggles. At least as important, the patient learns to tolerate the absence of meaning, the limits of narrative organisation, and the ineradicable persistence of unintelligibility. The capacity to construct meaning or story lines, like all human powers, is finite. Some event or experiences happen randomly or are too horrible to comprehend. Sometimes we confront experiences that simply are; we cannot make sense of them, can only register their existence and some of their effects on us.' (p.589)

It could be argued that Flax's (1992) position is in line with the narrative, social constructionist or post-modern forms of treatment that have been developing within psychology in recent years. Narrative therapy was initially developed in 1989 by Michael White (Adelaide, Australia) and David Epston (Auckland, New Zealand) and basically it has started to turn the `gaze' back on itself and to decentre the professional so the person is at the centre of their own therapy. The language that is used in narrative therapy is deliberately non-sexist, ethnically neutral, and avoids medical model terms that many mental health professionals use that unthinkingly objectify and pathologise people, for example, referrals, case notes, and clinical work.

In the therapeutic conversation narrative therapy uses a variety of techniques to de-construct, expose and subvert the dominant patterns of relating; patterns that the person often finds problematic (Payne, 2000). This process opens up spaces for possible change. The conversation is based on shared contributions because the narrative therapist does not present themselves as distant, objectively neutral experts who diagnose problems and prescribe solutions and treatments, but as curious, interested and partial participants in the person's story (White, 1995). The narrative therapist

respects that the person has personal or local knowledge, skills and ability that they can tap to solve their problems.

Thus, the narrative therapist asks creative, curious, persistent questions, yet this is nothing like an interrogation but is part of a dialogue. The questions aim to learn about the meanings of the person's world, to examine socio-politico-cultural assumptions in that world and to find sub-plots that are richer and closer to actual experience and to facilitate co-authoring the person's unique story (White, 1995). Empowerment is seen in a general sense of `teaching' people ways to understand the discursive conditions and power relations of their lives, how they might `re-author' their lives and to find and use their own voice and to work on the problem to find their own solutions (Drewery & Winslade, 1997). According to Speedy (2000) accepting the equal validity of each voice but acknowledging that `some voices have more meaning-making power than others' (p.365) impacts on power relations for the person as well as on counsellor practices. The aim is to avoid the unintentional objectifying professional gaze that can occur when the therapist is unaware of their role as professional expert in constructing a therapeutic dialogue.

Therefore, the present study suggests that women need to be encouraged to engage in this treatment so that their perspective on the world may be taken seriously, on their own terms. The position of the professional is also reoriented so they are able to give greater attention to the woman's voice. Furthermore when difficult feelings and emotions occur health professionals need to encourage women to express them, feel them and to be with them rather than the women splitting them off or repressing them.   It must be noted that the present study is not demonstrating a passive acceptance of these emotions and feelings rather it is suggesting that this is the first step of action. After acknowledging

the pain, distress or anger that women feel the next step that health professionals need to take is to work on the diverse causes or making changes to their life to deal with issues that are analogous with the problem.

Thus, the present study therefore asserts that women who 'self-harm' and have been given a diagnosis of 'BPD' cannot acquit themselves of emotions and feelings, but that what mental health care can do is we can comprehend and understand them, learn to decrease them, or to help women to live with them. They become part and parcel of us, rather than a feared or undesired 'other' that mental health care wishes to medicalise or even 'cut out' (Ussher, 2003).

Discussion and concluding remarks

In this final chapter I have attempted to highlight how the present study could potentially influence women's mental health practices. Through the notion of 'usefulness' (Gergen cited in Misra, 1993; Harper, 1999) I have attempted to identify ideas about intervening so that a change may occur to the situation of women who 'self-harm' and have been given a diagnosis of 'BPD'. My aim therefore in this chapter was not to talk of 'true' but of *better* stories (Harper, 1999) and the present study has suggested that this might be possible to do this through the use of the MDI approach, which is grounded within a critical realist epistemological paradigm. This approach, as I hope to have shown, enables us to: (i) bring the biological body 'back in' as a crucial point of reference (i.e. real bodies, real needs); (ii) relate the individual to society in a challenging, non 'uni-directional' way, and; (iii) rethink questions of identity and difference through a commitment to real bodies, real selves and real lives. Women's experiences of 'self-harm' and 'BPD', from this viewpoint, is *neither* the sole product of an impaired mind or a

267

socially oppressive society. Rather, it is, as we have seen in the present study, an *emergent* property, one involving the interplay of material, discursive and intrapsychic factors. Moreover, within such a model, a critical view of agency is retained, as is the transformatory potential of embodied social praxis.

However, the critical realist paradigm, which the MDI approach is grounded within, attests to a reality beyond discourse and the likelihood of non-social relations with non-social reality, including an enduring non-linguistic sense of self based upon personal identity (Williams, 1999). The world according to critical realism is 'real' it is something that can be discovered and which in part operates at the level of the individual. However, as I indicated in chapter six, a tension exists here when applying this model within a post-modern perspective. As previously indicated, this position has no conception of the 'real' and cannot account for the 'felt' reality that women experience; in the case of the present study it cannot explain or explore anything about the intrapsychic experience of 'self-harm' and 'BPD'.

Upon reflection the model that I have utilised in phase two has allowed me to gain access to a 'reality' that is 'real' and is 'felt' by the women in the present study. However, I would like to highlight that although this model has allowed me to access this 'reality' we need to cautious. I am not claiming that the women's accounts constitute an inert, unambiguous body of truth; rather I am putting forward a version of 'reality' that is 'felt' to be real to them on an individual level. At the same time I am still alert to the material and discursive distortions that exist, and I am aware that the world is a complex place that is inescapably subject to interpretation. Further, critical realism as a theory of knowledge is also weak because it cannot describe how we know what we know. I therefore acknowledge, especially in the case of the present study, that we can never

understand the women's 'reality' perfectly. Nevertheless, what I would like to argue here is that by using this model we might understand it to a reasonable degree. This model allows an understanding of women who 'self-harm' and have been given a diagnosis of 'BPD' to be explored and attempts to understand the complex roots of the symptoms that women present with, yet also offers ideas and thoughts for amelioration and rectification. From the evidence presented in the present research study it could be suggested that the MDI approach based within a critical realist epistemology is more empowering than many others that are currently offered for women, as it attempts to reframe their symptoms outside of a pathological framework.

In conclusion, the present study illustrates that 'self-harm' and the so-called symptoms of 'BPD' emanate from a complex interaction of material, discursive and intrapsychic factors and that these ought to be taken into account when designing interventions to support women. As the women's accounts revealed in this study psychological treatment must be the first option offered to them for the treatment of their problems. If this was to occur then there might be a move away from a reductionist biomedical analysis of women's distress, to a multi-factorial approach that empowers women, increases coping skills, and abates many of the problems that are implicated in the aetiology of 'BPD'.

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271

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Appendices

Appendix 1: Interview guide for service providers

Study title: A study of women who self-harm and have a diagnosis of **borderline personality disorder** *(brief title)*

Purpose:

To facilitate a conversation with service providers of current mental health services within *****NHS Trust. Service providers will be invited to participate so that an understanding can be gained of how their service operates for women who self-harm and have a diagnosis of borderline personality disorder.

Aims of the Interviews:

- To gain an insight into the type of services and interventions currently available in the mental health area for women who self-harm and have a diagnosis of borderline personality disorder.
- To understand the ways in which women self-harm and other problems they may typically have.
- To gain an understanding of the working practices of these services.
- To explore with service providers any ideas for future developments of service provision in this area.

Consent:

Thank you for agreeing to take part in this research study and for seeing me today.

Firstly, could I please confirm a few details with you before we commence the interview?

- Have you read the service providers information sheet that outlines the aims of the research and the purpose of the interview?

- Do you have any questions about the information sheet, consent form or the research study?
- Are you willing to participate in the research study?

Thank you.

Topic areas to be discussed within the interview

1. Purpose of the service

- First of all can you tell me something about the type of service you provide and how your service operates?
  - o Service aims
  - o Service users accessing
  - o Referral process
  - o Criteria
  - o Delivery of service
  - o Service users who self-harm
  - o Forms of self-harm
  - o Prevalence of self-harm issues
  - o Diagnosis of service users
  - o Problems of service users.

2. Service providers understanding of self-harm

- Could you talk to me a little bit about what the notion of self-harm means to you?
  - o Emotions/personal feelings
  - o Views in the workplace
  - o Reasons for self-harm
  - o Ways of helping

3. Service providers understanding of the diagnosis 'borderline personality disorder'

- Can you tell me a little bit about what this diagnosis means to you?
  - Usage in the workplace
  - Awareness by service user
  - Process
  - Views of the diagnosis
  - Stereotypes
  - Emotions/personal feelings
  - Challenges

4. Service Provision and Interventions

- Can you tell me a little something about how your service works with these women?
  - Sources of support
  - Treatment approach
  - Specific interventions
  - Challenges

5. Service User Involvement

- Can you tell me a little bit about how services users are involved in the service, for example, giving them information, asking their views on the service, setting up self-help/support groups?
  - User empowerment
  - Independence

6. Working Practices

- Could you reflect a little bit on the working practices and possible procedures that have been formatted or agreed in anyway for service users who self-harm?
  - Effectiveness of your service
  - Views of service users
  - Involvement of service users in any review process

7. Staff education, training and support

- Can you tell me about the opportunities for training and professional development for staff?
    o Staff support.
    o Supervision

8. Future developments?

- Can you perceive any gaps in the services you currently provide?
    o Training needs,
    o Supervision
    o Support needs

Any suggestions for service development?

Any questions for me?

Thank you.

Appendix 2: Information sheet for service providers

An invitation to take part in a research study

Study title: A study of women who self-harm and have a diagnosis of borderline personality disorder *(brief title)*

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 following information and discuss it with others if you wish. The researcher, Tammi Walker, would be happy to explain anything that is not clear or that you have concerns with. Thank you for reading this.

Purpose of the research:

To study the response of services within the *****NHS Trust to self-harming behaviour and to explore the personal perspectives of women who self-harm and have a diagnosis of borderline personality disorder. As part of this investigation the research aims to map out the current mental health services and interventions within ****** in order to gain a picture of the existing service provision for women who self-harm. Included within this will be a review of the current service provision for women who self-harm and have a diagnosis of 'borderline personality disorder'. Women service users subjective experiences of these current services will also be explored in the second phase of the research.

Who will take part?

You will be asked to take part if you provide a service or a range of services where women currently or previously displaying self-harming behaviour may present for support, assistance and or treatment.

What will it involve?

If you agree to take part in the research, the researcher, Tammi Walker, will carry out a one-hour semi-structured interview, in order that you may discuss how the service(s) or provision that you currently provide for service users operates. It is anticipated that the interviews will explore the working practices of your service(s). Discussion in the interview may also highlight if there are any perceived gaps currently within the services and if there are how these may be filled or improved by future developments. Interviews will be tape recorded with your agreement and then transcribed by the researcher, Tammi Walker.

What are the benefits of taking part?

It is anticipated that the information generated may aid health services in refining and expanding their service provision and support for women who self-harm and in particular those with a diagnosis of borderline personality disorder.

Do I have to get involved?

You can decide not to participate in the interview without giving a reason and withdraw from the research at any time without giving reasons.

Will my taking part in this study be kept confidential?

All of the information that is collected from you during this research will be kept secure and any identifying material such as names and addresses will be removed in order to maximise the anonymity of participants involved.

What will happen to the results of the research study?

The research will tell us about the current service provision in the Wakefield area for women who self-harm and have a diagnosis of borderline personality disorder. The research forms part of the researchers doctoral studies and it is anticipated that the research may at some point be published in a journal or book.

Finally, if you agree, thank you for taking part in this research

Further information. If you wish to discuss this further before making a decision you may speak to Tammi Walker, Ph.D. Student, on 01484 473606 or at t.walker@hud.ac.uk

Appendix 3: Consent form for service providers

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and my legal rights will not be affected. ☐

3. I understand that all of the information collected in the study will be kept secure and that if it is presented or published every effort will be made to ensure my anonymity. I also give my permission for the research team to use my words from the interview in the presentation/publication of the study. ☐

4. I agree to take part in the above study. ☐

Name of Participant   Date   Signature

Name of Person taking consent   Date   Signature
(if passing it onto the researcher)

Name of Researcher   Date   Signature

1 for participant; 1 for researcher

Appendix 4: Key areas of enquiry with women

Consent

- Thank you for agreeing to take part in this research study and for seeing me today.
- Introductions.
- Sign the consent form.

  - Have you read the information sheet that the health professional gave you and which outlines the aims of the research and the purpose of the interview?
  - Do you have any questions about the information sheet, consent for or the research study?
  - Talk about confidentiality and anonymity.
  - Talk about when this will be breached in relation to the following critical incidents:
    - poor or unsafe practice
    - risk to self and/or others
    - child protection issues

- Firstly, could I please confirm a few details with you before we commence the interview?
- Are you willing to participate in the research study?

Thank you.

Briefing

Thanks again for talking to me today and I would like this time to be as relaxed and informal as possible. Therefore the interview will not involve me asking you a lot of

questions to answer I would like it if possible to be more like a conversation or chat between us as I am extremely interested in what you have to say.

I am aware that some of things that you may talk about may not be easy at times, but if you need a break or pause please let me know we have plenty of time.

If you wish me to repeat anything please let me know and if you do not mind I will be taking extra notes as you talk in case I would like to ask you anything later.

Have you any questions?

Key areas of enquiry

Can I ask you to think about the first time that you self-harmed; can you talk to me about it?

- What happened
- Why
- Feelings/emotions
- Type of self-harm
- Currently self-harming
- Differences over time?
- Effects on life

Can you talk to me about how you cope when you self-harm?

Can I ask you to think about your experiences when you have accessed health services for assistance/support when you have self-harmed.

Can you talk to me about how health professionals responded to you?

- Responses from doctors, nurses, other professionals
- Own feelings/thoughts in relation to this

- Interventions offered
- Continued support?

Can you talk to me about the first time that you were told you had BPD?

- Who by
- When
- What were you told
- Impact (if any) on life
- What does it mean to you

Can I ask you to think about your experiences when you have accessed health services for assistance/support since being diagnosed with BPD?

Can you talk to me about how health professionals responded to you?

- Responses from professionals
- Feelings/thoughts in relation to this
- Interventions offered
- Continued support?

Lastly, can you talk to me about how you think services may be developed in the future to support your needs?

Do you have any questions for me?

Thank you.

Appendix 5:   Information Sheet for Women

An invitation to take part in a research study

Information Sheet for Women

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 following information carefully and discuss it with others if you wish. The researcher, Tammi Walker, would be happy to explain anything that is not clear or provide you with more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

What is the purpose of the research?
To investigate the current mental health services and interventions within the ********
NHS Trust for women who self-harm and have a diagnosis of borderline personality disorder. As part of this work the research aims to hear in depth, the individual experiences of female service users who self-harm and have been diagnosed as having a borderline personality disorder. The purpose of the work is therefore to hear women's accounts of their experience, in their own words, by telling their own individual story.

Why have I been chosen?
You have been asked to take part because you are a female service user with the diagnosis of borderline personality disorder and you are accessing mental healthcare services. The researcher, Tammi Walker, will be interviewing approximately five female service users in the next few months as a part of this study.

Do I have to take part?
You do not have to take part if you do not wish to do so. If you decide to take part you will be asked to sign a form giving your agreement to take part in the study. If you decide to take part you are still free to withdraw at any time and without giving a reason. This includes your right to stop part way through the interview. A decision to withdraw at any time, or a decision not to take part, will not affect the help or treatment that you currently receive from services or in the future.

What do I have to do?
If you are interested in taking part, please tell the person who provided you with this sheet. The researcher, Tammi Walker, will collaborate with the key worker to arrange a date and place convenient to you for an interview. At the interview, you will be asked to discuss your personal experiences of living with a diagnosis of borderline personality disorder. Your personal experiences of self-harm and what it means to you will be explored and discussion in the interview will also centre on your views of the services that you believe you require to meet your health care needs and the helpfulness of the current service provision to meet these. It is important that you tell this in your own words, as if you were telling the researcher your story. Each interview should take no

more than an hour and a half and will be tailored to the amount of time you are able to give.

What happens to the information I give at the interview?
The interview will be tape recorded so that the researcher can listen to you without the need to take notes. Following the interview the story will be typed up from the tape. Your personal details, any names of people or places mentioned will remain confidential. Only the researcher, Tammi Walker, will have access to the written information and the tape.

If something is heard that raises serious concerns about poor or unsafe practice and /or there was a risk to you or others, including child protection concerns, the researcher will have to report the matter locally. In the unlikely situation of this happening, the interviewer will discuss this with you and will explain what will happen.

What will happen to the results of the study?
The research will tell us about the individual experiences of women who self-harm and have a diagnosis of borderline personality disorder in the *******. It is anticipated that information gained may assist health services in refining and expanding the services to provide further support for women who self-harm and in particular those with a diagnosis of borderline personality disorder. The research forms part of the researchers post-graduate studies and it is anticipated that the research may at some point be published.

Who is organising and funding the study?
The University of Huddersfield has provided the funding for the research study.

Who has approved the study?
The study has been approved by NHS Local Research Ethics Committee, who are authorised to give approval to research studies involved service users.

Contact for further information.
If you wish to discuss this further before making a decision you may speak to Tammi Walker, Ph.D. Student, on 01484 473606 or at t.walker@hud.ac.uk

Thank you for reading this information sheet and considering taking part.

Appendix 6: Consent form for Women

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and my medical care or legal rights will not be affected. ☐

3. I understand that all the information collected in the study will be kept secure and that if it is presented or published every effort will be made to ensure my anonymity. I also give my permission for the research team to use my words from the interview in the presentation/publication of the study. ☐

4. I understand that the information I give will be treated in the strictest confidence and information will only be passed on by the researcher, Tammi Walker, to other professionals if serious concerns are raised about poor or unsafe practice and/or there is any risk to myself or others, including child protection issues. ☐

5. I understand that the research forms part of the researchers (Tammi Walker) post-graduate studies. ☐

6. I agree to take part in the above study. ☐

_____   _____   _____
Name of Participant   Date   Signature

_____   _____   _____
Name of Person taking consent   Date   Signature
(if not researcher)

_____   _____   _____
Name of Researcher   Date   Signature
                    (1 for participant; 1 for researcher)

Appendix 7: Resource guide for women

Organisations for women who self-harm

Bristol Crisis Service for Women (BCSW)

This is a charity run organisation that responds to the needs of women in emotional distress. They have a particular focus on self-harm and provide a national help-line for women in distress.

Women can talk through their feelings and emotions in confidence. They also publish a wide range of literature and publications on women and self-harm.

Contact:

BCSW
P.O.Box 654
Bristol
BS99 1XH

Helpline: 0117 925 1119
Friday and Saturday evening 9pm-12.30am & Sundays 6pm-9pm

National Self-Harm Network (NSHN)

This is a survivor-led organisation that campaigns for the Rights and understanding of individuals who self-harm. They publish leaflets for health staff, supporters and people who self-harm.

Contact:

NSHN
34 Osnaburgh Street
London
NW1 3ND

42nd Street

This is a mental health service for people aged fifteen to twenty-five in Manchester. They offer individual support alongside a range of groups based at the resource.

Contact:

42nd Street
2nd Floor, Swan Buildings
20 Swan Street

Manchester
M4 5JW

Helpline: 0161 832 0170
Monday, Tuesday & Friday 9.30am-1.15pm/ Monday to Friday 1.30pm-5pm.

Self-Harm Alliance

This is a national survivor led voluntary group which support people affected by self-harm.

Contact:

Self-Harm Alliance
PO BOX 61
Cheltenham
Gloucestershire
GL51 8YB

Helpline: 01242 578820
Wednesdays to Sundays 7pm-8pm.

Hope

This is a self-help group where people can meet and talk together on equal terms.

Contact:

Hope
Leeds MIND Self Help Initiatives Project
3rd Floor
6-8 The Headrow
Leeds
LS1 6PT

0113 245 5151

SHOUT (Self-harm overcome by understanding and tolerance)

SHOUT is a bi-monthly newsletter that aims to provide support for women affected by self-harm. It is read and contributed to by women all over the country, by groups and by professionals who work with people affected by self-harm.

Contact:

SHOUT
c/o P.O. Box 654
Bristol
BS99 1XH

The Cutting Edge (Newsletter)

This is a forum for women who life with self-inflicted violence.

Contact:

The Cutting Edge
P.O.Box 20819
Cleveland
Ohio 44120
U.S.A.

SASH – Survivors of Abuse and Self-Harming

This is a pen-friend network that offers support and friendship on a one to one basis, in

writing.

Contact:

SASH
20 Lackmore Road
Enfield
Middlesex
EN1 4PB