Portfolio submitted in fulfillment of the requirements for the Professional Doctorate in Counselling Psychology

‘Experiences of the Self, Self-Injury and Shame in LGBTQ+ Adults’

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‘Integrative Compassion-Focused Therapy for

Experiences of Shame in LGBTQ+ Adults’

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THE FOLLOWING PARTS OF THIS THESIS HAS BEEN REDACTED FOR DATA PROTECTION REASONS:

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II. Acknowledgements

First and foremost I would like to express my sincere gratitude to those six individuals who volunteered to share with me their time and personal experiences for the purpose of this thesis, none of which would have been possible without their courageous willingness to contribute.

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III. Declaration of Power

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IV. Preface

This doctoral portfolio was formed as part of my three-year training as a counselling psychologist and consists of three distinct parts: a doctoral thesis, a publishable paper, as well as a combined case study and process report. The three parts of this portfolio are connected by a common theme which is woven throughout all three parts: LGBTQ+ mental health. More specifically, this portfolio focuses on issues relating to experiences of self-injury and shame in LGBTQ+ adults. The doctoral thesis uses interpretative phenomenological analysis to explore these complex experiences of self-injury in LGBTQ+ individuals and how self-injury and sexuality impact on one another. The publishable paper is derived from my thesis and focuses on experiences of the self in LGBTQ+ adults who self-injure. The combined case study and process report offers an example of my clinical work with an LGBTQ+ identifying client demonstrating high levels of self-criticism and shame, using integrative compassion-focused therapy. The complex and idiosyncratic process by which individuals come to identify as LGBTQ+ in a society dominated by heteronormativity, as well as the resulting impact on their mental health in general and more specifically on their sense of self, can be seen in each of the three parts. This portfolio gives prominence to the challenges which LGBTQ+ individuals face in relation to their sexuality, as well as to the challenges faced by professionals working to treat those identifying as LGBTQ+. Furthermore, this portfolio represents my own journey through the doctoral training, both personal and professional.

I will now offer a brief description of each three parts to this portfolio, highlighting how themes of experiences of the self and shame in LGBTQ+ identities emerge in each part.

Part I: Doctoral Thesis

The doctoral thesis aims to explore experiences of self-injury in adults identifying as LGBTQ+ using an interpretative phenomenological analysis (IPA) approach. Research has provided an abundance of literature regarding self-injury, yet the phenomenological experience of self-injury in LGBTQ+ adults (a community with significantly high prevalence of self-injury) has been under-researched. Given that self-injury is a highly idiosyncratic, complex and changeable phenomenon with a developmental trajectory similar to that of sexual development during adolescence, it seemed fitting to explore the two within the context of each other. I was particularly interested to explore how experiences of self-injury and experiences of sexuality impacted on each other, and how LGBTQ+ individuals made subjective sense of this interplay.

IPA was deemed the most appropriate methodology to address my research question for several reasons. First, IPA is more suitably aligned to my critical realist ontological perspective, where multiple and differing 'realities' are valid and are able to be held with equal importance. Given the subjective and complex nature of both self-injury and sexuality, adopting IPA with a critical realist ontology was therefore suitable and appropriate. Super-ordinate themes emerging from analysis of the data were: experiences of the self, experiences of the other, the act itself and recovery. 'Experiences of the self' emerged as complex and changeable, both with regard to self-injury and to LGBTQ+ identity. Internalised homophobia came up, and interestingly so did an internalisation of stigma associated with self-injury. In identifying as self-injurer and LGBTQ+, experiences of both at times were fraught with conflict and shame, and this is explored within the context of a pride-shame dichotomy. 'Experiences of others' captured experiences of participants' social worlds including discrimination, prejudice and stigma relating to both self-injury (or general mental health) and sexuality, as well as how individuals negotiated these experiences. The third emerging theme captures experiences specifically relating to the act of self-injury,

including emotional and behavioural processes before, during and after. The final theme captured narratives of recovery (i.e. cessation of self-injury) and a move towards feeling more accepting of ones' LGBTQ+ identity and a less fragmented sense of self. The intersectionality between experiences of self-injury and experiences of sexual and/or gender identity are explored and are a unique contribution of this research.

Part II: Publishable Paper

The publishable paper represents an important part of the portfolio as it offers practitioners an insight into the experiences of the self for those who self-injure and identify as LGBTQ+. The decision to present the theme of *experiences of the self* and not others, was made on the basis of wanting to capture the most phenomenologically significant findings, from which practitioners may benefit. If clinicians are able to better understand lived experiences of the self with regard to self-injury and sexuality among LGBTQ+ individuals, they can be better equipped to work in ways which reduce shame and fear of discrimination, an incredibly valuable experience for those who self-injure and/or identify as LGBTQ+ and who often experience high levels of self-criticism and shame, which can be exacerbated when seeking professional support.

Part III: Combined Case Study and Process Report

As a counselling psychologist, humanistic principles have been at the core of my training and indeed a personal ethos regarding my role as therapist. Humanistic, and more specifically Person-centered values emphasise personal agency, growth and actualisation for the client, with my role as therapist as being to facilitate the latter through use of Carl Rogers' core conditions. My doctoral training allowed me to develop, understand and value this approach and as my training progressed I was able to see the benefits for both clients and myself in terms of the overall therapeutic experience. Person-centered principles are at the core of my work with all clients, and

within the case presented here I also draw on two other approaches: compassion-focused therapy (CFT) and psychodynamic principles. This integrative stance was adopted on the basis of the client's presentation, suitability as well as my own personal intuition. CFT was deemed suitable due to its' focus on targeting shame and self-criticism in treatment, while aiming to increase self-soothing and self-compassion, which was particularly relevant for the client presented. Psychodynamic principles are also woven into my work much like person-centered principles, where I integrate a focus on childhood experiences and work with transference and countertransference within a containing environment.

The client presented in this part of the portfolio shared similarities with those who participated in the thesis; he identified as LGBTQ+, he reported difficulties with accepting and integrating sexuality into his sense of self, and he often reflected on the resulting sense of shame he experienced not only about his sexuality, but also about other aspects of his self. While the client presented reported no experiences of self-injury, his experiences of the self mirrored those of the research participants in part I.

Conclusion

In summary, the aim of this portfolio is to evidence the breadth and depth of my research and clinical skills throughout the course of my doctoral training, with a focus on exploring lived experiences of the self and shame, as well as the meaning making around them within the context of self-injury and LGBTQ+ identities.

Over the course of my training I developed my interest in LGBTQ+ psychology; an area which holds personal relevance in my life and which I felt keen to develop my skills in as a counselling psychologist. I embarked on this portfolio with a sense of personal and professional responsibility to give voice to those identifying as LGBTQ+ and who struggle with their mental health. In addition, I was able to develop my

understanding of the theory and phenomenology of self-injury which is something I had felt was lacking from my academic and professional experience. In completing this portfolio, I hope to demonstrate my commitment to exploring a topic which holds direct and important clinical relevance for clients identifying as LGBTQ+. A commitment to giving voice and meaning to underrepresented individuals' experiences is something I expect to continue throughout my career as a counselling psychologist.

Part I – Doctoral Thesis

Abstract

Non-suicidal self-injury continues to present a significant challenge for mental health services as the number of those engaging in it increases. LGBTQ+ individuals are at

significantly higher risk of mental health difficulties including self-injury, due to identifying as members of a sexual minority and due to the associated stigma. This qualitative research explores the lived experience of and meaning attributed to self-injury in six adults identifying as LGBTQ+. Semi-structured interviews were conducted, and the resulting data was analysed using Interpretative Phenomenological Analysis.

Four super-ordinate themes emerged from the analysis: 'Experiences of the self', 'Experiences of the other', 'The act itself' and 'Recovery'. The interplay between experiences of self-injury and experiences of sexual identity is discussed, focusing both on the difficulties and strengths of LGBTQ+ individuals engaging in the act. Findings contribute not only to the field of LGBTQ+ psychology, but also to the developing body qualitative research into self-injury. Their implications for mental health professionals working with LGBTQ+ populations are reviewed.

Initial Reflections

Over the course of my career in mental health I frequently witnessed self-injury and the resulting impact on the client, their loved ones and professionals alike. Having worked on inpatient wards, in community and crisis teams as well as one a one to one basis with clients engaging in self-injury, I was often struck the intentional harm clients would

inflict on themselves. I was also struck by how self-injury was responded to by professionals. The incident was indeed always contained, reported and a risk management plan put was in place, however little time or space seemed to remain for psychological and emotional exploration of the act which had taken place.

Over time I felt in myself a desensitisation to self-injury taking place, which was accompanied by a growing discomfort. I became proficient and professional in responding to and reporting risk as indeed is necessary, however I had little understanding of the complex processes actually occurring when an individual engages in self-injury. By embarking on this thesis I hoped to gain a more psychological and therapeutically useful understanding of experiences of self-injury and the meaning making around them.

My professional experience had left me with the above noted impressions and assumptions which I was aware would present within me as I embarked on my research and I acknowledged the importance of attending to them and reflecting on how they might impact on my role as researcher. For example, my discontent with organisational procedures for risk management may result in a tendency to overlook or interpret with more skepticism, literature around professional attitudes or tend to focus more on negative participant experiences with professionals.

I had initially began thinking about my research as being focused on adolescents, given the typical onset for self-injury during this time. Upon reflection and some engagement with the abundance of existing adolescent self-injury literature, and also considering practicalities such as gaining ethical approval for working with minors with high risk, I began exploring alternative areas of self-injury research which interested me. I had also began to focus my clinical experience on LGBTQ+ mental health and was becoming increasingly interested in combining my research focus of self-injury with my developing

clinical interest in psychosexual and LGBTQ+ psychology. While societal attitudes over the course of my career thus far had undoubtedly reflected a positive shift towards inclusion and acceptance of gender and sexual minorities, this did not seem to be reflected in my academic and clinical training, thus I sought clinical placements, supervision and external training which would enable me to develop my understanding. In identifying as LGBTQ+ as well as an ethnic minority myself, I was also intrigued to consider how occupying a minority status (e.g. gender, sexuality, race, ethnicity, mental and physical disability) might impact on ones sense of self and how occupying multiple minority statuses is experienced by an individual. As with my professional assumptions, it was important to attend to and reflect on my own personal identity and how resulting assumptions would impact on the research process. I considered how there may be a risk of over-identifying and therefore making assumptions, perhaps favoring certain literature over others. Given this, I embarked on this stage of the research process with an open awareness of these assumptions hoping it would reduce their impact on the process as far as possible. At the same time, I was aware and comforted of how the IPA process involves accounting for and attending to these kinds of researcher assumptions and reflections, thus there would be some space for them.

I was aware that embarking on this research process I would inevitably be bringing my own assumptions based on my personal and professional experiences. I had a sense of complexity and confusion about self injury as well as a sense that it was something clients were reluctant to discuss openly. I also held an idea about how professionals, myself included, tended to be very capable at recording risk and following service procedures (as was often the focus of supervision), but that an avoidance of in depth explorations about the clients' self-injury remained. The stigma attached to self-injury was something I suspected was contributing to both clients and my own ability to discuss it more openly and comfortably with clients; I often feared this was compounding the stigma, which was regrettable and something I wanted to address

through this research.

In adopting a phenomenological approach to this thesis, I was aware of the importance of attending to these assumptions and experiences, noting how they would invariably impact the research process. As I approached my literature review and indeed my portfolio as a whole, I aimed to pay due attention to my own assumptions and expectations around the experiences of self-injury in sexual minorities. I was aware that my clinical experience had led me to develop an assumption about how abuse and neglect were predisposing factors for self-injury, that all LGBTQ+ individuals struggle at some point with the development with their sexual minority status and that professionals were clinically often astute but emotionally avoidant when working with self-injury. These assumptions and expectations were important to reflect upon for me to be aware of how they might be invariably affecting the research process. In relation to my literature review, I began by feeling somewhat overwhelmed by the vast amounts of research into self-injury and how I might begin the task of focusing my review on the most relevant areas to my research question. This felt a grand task and one which required bracketing and noting my assumptions and reflections often, in order to make space for more clarity and focus on my research question. I began my review feeling intrigued by what direction the research may take me in and how my expectations and assumptions develop within that process.

1. Literature Review

1.1. Overview of the Chapter

I begin this chapter by outlining my aims for the current literature review. I will then offer a review of how existing literature defines self-injury and the implications of these varying definitions for research and practitioners alike. This is followed by a review of epidemiology, diagnoses and co-morbidities associated with self-injury within the

general population and more specifically within the lesbian, gay, bisexual, transgender and queer (LGBTQ+) population. I will go on to review predisposing factors for self-injury and consider how these may be associated with the higher prevalence of self-injury within the LGBTQ+ population. I then present a review of the existing literature around the functions of self-injury and qualitative studies exploring the subjective experience of self-injury, followed by a review of relevant theoretical models and their implications for treatment. I will conclude by offering the reader a summary of this chapter, framing the rationale for my research and presenting my research question.

1.2. Aims of Literature Review

The following chapter aims to review and evaluate existing literature around self-injury and more specifically around self-injury within the LGBTQ+ population in order to gain a better understanding of my chosen topic, as is suggested by Smith, Flowers and Larkin (2009) for interpretative phenomenological research. I aim to offer a critique of the existing literature, identifying the strengths and limitations as well as identifying any gaps in the literature which warrant further attention. In doing so, I hope to allow the reader to understand the context and justification for this research.

Regarding my search strategy for identifying and selecting studies to be reviewed in this chapter, I used a variety of online databases to conduct generalised and more specific searches around self-injury. The three main online databases I used were PsycInfo, the City University database CityLibrary, and the EBSCO database which is available to members of the British Psychological Society. Occasionally I would also rely on other databases (e.g. Google Scholar) when searching for specific journal articles. Focusing on functions, prevalence, comorbidities and predisposing factors for self-injury I searched databases using combinations of the following terms: self-injury/self-harm/non-suicidal self-injury, LGB/LGBT/LGBTQ+, sexual orientation, sexuality. Beginning with no time brackets, I would review the search results and then

narrow results down to focus on more recent publications (i.e. within the last five years). I specifically searched for recently published systematic reviews and meta-analyses as these would offer me an up-to-date general overview of the topics they covered from which to develop the review.

My search strategy led me in multiple and interesting directions, however for the second half of my literature review I focused on studies which spoke directly to the phenomenology of self-injury. In deciding which studies to retain and evaluate for the purpose of this review, I favored those (but not exclusively) employing qualitative approaches and focusing on lived experiences of self-injury in LGBTQ+ adults. My search for qualitative studies to review was more specific and I narrowed down search results using criteria such as subject terms and discipline of publication, in addition to combining the following search terms with those stated above: qualitative, phenomenological, non-clinical, adults. While the above outlines my search strategy offering readers an idea of how I decided on selecting studies to review for this chapter, it is by no means exhaustive. At times I also relied on other strategies to build on my understanding of literature around the topic, such as using the reference lists of studies focusing on particular areas of interest to explore and guide my reading and choice of studies to review.

1.3. Terminology

For the purpose of this research I chose to adopt the term ‘self-injury’. In choosing to omit terms such as ‘deliberate’ and ‘non-suicidal’ I hoped to maintain a somewhat open terminology, thus allowing ample space for exploration and interpretation of individual meaning-making around the act. It is of importance to note that where cited research has used different terminology referring to self-injury, I will adopt the terminology used by those authors. Outside of citing existing research, I will revert to and continue to adopt the term self-injury. It is also important to note here my choices of terminology

regarding sexuality and sexual orientation. I chose to adopt the term LGBTQ+ (lesbian, gay, bisexual, transgender and queer) in order to use a broad and inclusive term which would refer to those individuals who identify as non-heterosexual and/or gender non-binary. It felt important to include the 'Q' referring to 'queer' which is an increasingly popular term referring to all gender and sexual identities which are non-heterosexual or non-binary, and which has been reclaimed by the LGBTQ+ community, (Valocchi, 2005). LGBTQ+ research sometimes focuses on one identity within the LGBTQ+ umbrella term such as gay men, lesbian women or individuals identifying as transgender however, for the purpose of this research I aimed not to focus on the experiences of any one LGBTQ+ identity, but on the experiences of this community as a whole. I also wanted to include the experiences of individuals identifying as transgender and gender non-binary who are known to be at increased for mental health difficulties in comparison to other LGBTQ+ identities (Grossman & D'augelli, 2005; Rodriguez et al., 2018; Kuehn, 2019). As with use of the term self-injury, when citing research using differing terminology for LGBTQ+ status, I will adopt the terminology of those authors and revert back to using LGTBQ+ outside of citing existing research. A final consideration of terminology was necessary with regard to the distinction between sexual orientation and sexuality. Sexual orientation refers to who an individual is sexually attracted to (Argyriou et al., 2020) while sexuality is a broader term referring to how one's sexuality is experienced, expressed and practiced (Scott et al., 2017). Thus, when specifically referring to sexual attraction I will adopt the term 'sexual orientation', while outside of those circumstances when using the term 'sexuality', I will be referring to the variety of factors related to sexual expression, identity, practice and experience.

1.4. Defining Self-Injury

Definitions of self-injury vary enormously within the existing literature and these varying definitions have important implications for researchers, clinicians and therefore for

those who engage in self-injury. Despite an increase in this phenomenon, which has been accompanied by an increased interest by researchers and clinicians over the last ten years, there is still no clear and consensual definition of self-injury and the behaviours it includes or excludes. Consequently, terminology for self-injury in the literature reviewed does vary a lot, but may sometimes refer to the same set of behaviours (i.e. the terminology can be overlapping) using terms such as self-harm, self-injury, non-suicidal self-injury, self-mutilation, self-cutting, suicidal behaviour and deliberate self-harm.

One important distinction in defining self-injury is use of the term 'deliberate' (i.e. deliberate self-harm or deliberate self-injury). It seems important to differentiate between those who self-injure with a deliberate intention and willingness to do so, from those who injure themselves accidently or without a distinct will to do so. However, use of the term 'deliberate' has also be criticised for connoting a sense of blame towards the individual (Garisch & Wilson, 2015; Pembroke, 2004) which may exacerbate feelings of shame or isolation in an already stigmatised population (Burke el al., 2019). Furthermore, the idea of a distinctly willful act of self-injury may also be problematic in that, it implies an acute willfulness and therefore a consciousness about engaging in the act itself. Pembroke (2004) argue that self-injury can be carried out willfully but not necessarily with a full awareness given that individuals engaging in it often report dissociative states while doing so, which this definition would unduly excluded.

Another important factor that distinguishes between types of self-injury is the presence or absence of a suicidal intent. Some definitions of self-injury therefore include the term 'non-suicidal', clearly distinguishing self-injurious behaviours from behaviours with a specifically suicidal intent. Non-suicidal self-injury has thus been defined by some as the deliberate and direct destruction of body tissue in the absence of suicidal intent (Klonsky, 2007; Nock & Prinstein, 2005). However, this distinction is complicated by

the fact that individuals may carry out the act in the absence of suicidal intent but which may still lead to (accidental) death. Conversely, suicide may indeed be the intention but may not be the end result, for example if thwarted by the intervention of others, thus preventing death (Allen, 2001). The specification of the direct destruction of body tissue however, does not include many forms of self-injury that are in fact non-suicidal but may not involve the direct destruction of body tissue, for example ingesting harmful substances or inserting harmful objects. Additionally, this definition does not account for self-injury occurring through indirect means, such as those methods which result in harm to self through omission (e.g. not eating or not adhering to medical advice for serious health conditions).

Turp (2003) defines self-injury incorporating the concept of self-neglect Neglecting oneself through a lack of care may be purported as self-injury by omission, for example by failing to seek medical attention for health conditions, self-imposed sleep deprivation or overworking. Turp (2003, p.36) defines self-harm as 'avoidable physical harm to self either by omission or commission and that breaches the limits of acceptable behavior as applied in the time and place of enactment and leads to a strong emotional reaction from others'. This definition is useful in that it incorporates subtle but important factors such as omission versus commission, a breach of acceptability in context and also a social aspect regarding the reaction of others. In defining self-injury in this way, Turp therefore frames certain characteristics of self-harm as significant, without specifically stating what they must or must not be. The emphasis on acceptability in the context of time and place seems very relevant, as societal acceptability changes greatly over time and across different parts of the world, (Bhugra, 2013). Furthermore, Turp includes a social element in her definition, highlighting the emotional reaction of others as important, which also seems useful and appropriate.

Babiker and Arnold (1997) offer a comprehensive review in which they classify self-injury according to the function of the behaviour where *self-injury* refers to cutting, scratching, hitting and burning acts and *self-harm* refers to more suicidal or para-suicidal acts such as overdosing and poisoning oneself. Furthermore, Babiker and Arnold define other acts of self-injury under the following terms: *self-destructive behaviours* such as eating disorders, sexual risk taking and substance abuse; *somatic expression of feeling* such as accident proneness, pain and skin conditions; *factitious disorders* such as Munchausen's syndrome and polysurgery; *body enhancement* such as cosmetic surgery, body modification, tattooing, piercing; and finally other marginal and self-injurious behaviours such as smoking, danger sports and reckless driving. Classifying according to function allows for a more nuanced conceptualisation of self-injury, which perhaps reflects more accurately the variation in self-injurious acts and in their functions. Importantly, Babiker and Arnold conceive the act of self-injury as an attempt at *self-preservation* and not simply an act of self-destruction. The paradox of self-injuring in order to self-preserve has been explored by more recent publications (Creswell, 2005; Oktan, 2017) and can be difficult for an individual's social circle as well as for professionals to grasp. It does however, suggest that a phenomenological approach focusing on the lived experience and meaning attached to the act by those who self-injure is necessary and useful.

The lack of consensus around definitions of self-injury perhaps contributes to a confusion and lack of clarity for those individuals who engage in it and also for professionals working with it. Motz (2001, p.152) responds to the difficulty in defining self-injury by avoiding a definition which states specific parameters altogether instead refering to it as 'a complex set of behaviours, with different meanings in different contexts'. The difficulty in defining and categorising self-injury reflects the complex and variable nature of the act itself. Self-injury is a highly complex and multi-faceted phenomenon where the method, function, experience of and meaning attached to it,

are changeable both between individuals and across time and context for the same individual.

Research has also shown that an individual's' self-injurious behaviour typically combines a variety of methods and that the frequency, severity and resulting impairment vary over time and between individuals (Gratz, 2001; Sutton, 2007). Self-injury is a very idiosyncratic behaviour, which is not easy to make sense of for those engaging in it or for those researching it. This places counselling psychology and phenomenological research in a good position to explore self-injury given their integrative, relational and flexible stance.

For the purpose of this research it seemed important to use a definition which allowed for a broad range of behaviours (e.g. rather than only destruction of body tissue), included a social and contextual aspect, and did not imply a heavily medicalised approach, as this would have conflicted with my own attitudes towards self-injury as well as the epistemological stance of my research. Therefore the definition of self-injury that was used in this research was as follows: **'Avoidable physical harm to self either by omission or commission and that breaches the limits of acceptable behavior as applied in the time and place of enactment and leads to a strong emotional reaction from others'** (Turp 2003, p.36).

1.5. Functions of Self-injury

Defining self-injury remains contentious, however there does exist more empirical consistency regarding the functions of it. It is generally accepted that affect regulation is an important function of self-injury (Josselin, 2013; Klonsky, 2007, Di Pierro et al., 2014; Hamza and Willoughby, 2015). However, it is also accepted that this phenomenon serves multiple and varying functions, often simultaneously, with affect-regulation being a powerful and common function, but by no means the only function

(Tantum & Husband, 2009). Substantial support for the affect-regulation function of self-injury comes from Klonsky (2007) who conducted a review of existing literature, which highlighted the psychological characteristics of those prone to engaging in it as negative emotionality, self-derogation and a deficit in emotional skills. Thus, the review went on to name the functions of self-injury as affect-regulation, self-punishment, interpersonal influence and boundary setting, reduction of dissociative states and anti-suicide.

By contrast, the four-factor model developed by Nock & Prinstein (2004) regarding the psychological and social functions of self-mutilative behaviour, states four functions as follows: automatic negative reinforcement (reduction, removal or distraction from aversive thoughts or feelings), automatic positive reinforcement (feeling generation), social positive reinforcement (self-mutilation as a favourable social response) and social negative reinforcement (reduction, removal or distraction from external events).

As outlined above, research suggests there are multiple and varied psychosocial functions of self-injury for those who engage in it, which can occur simultaneously, with or without conscious attention. Importantly, the functions of self-injury can vary greatly between individuals and indeed within the same individual across time.

Given the multi-functionality and idiosyncratic nature of self-injury, a qualitative phenomenological approach seems well suited to the study of this phenomenon. NICE guidelines (2004) suggest qualitative research as not only suitable but as a necessary approach to understanding self-injury.

1.6. Prevalence of Self-Injury

Collecting and reporting statistics regarding the prevalence of self-injury is complicated by several factors. As noted above, the lack of a clear definition and the use of

overlapping terminologies hinder attempts to gain an accurate idea of its epidemiology. It is commonly accepted that research most likely under-estimates the prevalence of self-injury as it is usually based on data collected from hospitals, general practitioners and other medical services which does not account for the vast number of individuals who self-injure and do not seek help or report to services (i.e. non-clinical prevalence).

In the UK around 150,000 visits are made to accident and emergency departments each year, with self-harm being among the five top causes of acute medical admission (Nixon, 2011). Rates of self-injury in the UK have rapidly increased over the past decade and are now among the highest in Europe, particularly for children and adolescents (Madge et al., 2008). The difficulty in establishing the prevalence of self-injury is reflected in the range of prevalence figures reported by research. For example, research has shown that rates of non-suicidal self-injury in adolescents are between 5.5% and 30.7% (Muehlenkamp et al., 2012; You et al., 2013). Hawton, Saunders and O'Connor (2012) found that the persistence of self-injury from adolescence into adulthood has been associated with frequent and repeated self-harm during adolescence. The high prevalence and typical onset of self-injury during adolescence may reflect the developmental trajectory of complex psychological, emotional and social processes with which adolescence is associated; the majority of the literature on self-injury focuses on this adolescent population.

Less attention has been given to adult self-injury, despite significance in being one of the strongest predictors of suicide (Gunnell et al., 2004; Hawton et al., 2016). Epidemiological studies are typically confined to data collected from single locations (Hawton et al., 1997; McEvedy, 1997) or are restricted to hospital admissions, i.e. clinical samples (Wilkinson et al., 2011) or inpatients who typically exhibit serious psychopathology, thus running the risk of inflated estimates of associations between self-injury and psychiatric disorder, as well as of prevalence of self-injury (Klonsky,

Oltmanns & Turheimer, 2003). It is therefore not possible to confidently generalise findings from inpatient or single-location studies, which might risk further obscuring the picture of prevalence regarding self-injury.

Bebbington and colleagues (2010) conducted a study using a large and diverse community-based sample of 8580 adults found rates of self-harm at 2.2%. Briere and Gil (1998) reported on prevalence of self-mutilation in a non-clinical population and found a prevalence of 4%, as did Klonsky and colleagues (2003). Long (2017) argues that while the reported prevalence of self-injury in adults is significantly lower than that reported in adolescent populations, the likelihood is that the often hidden nature of this phenomenon means that prevalence in adults is much under-reported.

Klonsky (2011) contributed important findings regarding self-injury in the adult population by conducting research into the prevalence and nature of non-suicidal self-injury using a random-digit dialing sample of 439 adults. This study provided evidence to dispel the stereotypical notion that women engage in self-injury more so than men do. Interestingly, it also found that there was no association between self-injury and ethnicity, educational history or household income. This contradicts previous findings based on those presenting to emergency services, which found a strong relationship between self-harm and socio-economic deprivation (Ayton, Rasool & Cottrell 2003).

Minority groups within the adult population have been identified as being disproportionately affected by self-harm, including those incarcerated in forensic facilities (Hawton et al., 2014; Vinokur & Levine, 2019), young Asian women (Cooper et al., 2006), those with learning disabilities (Luiselli, 2009), those with chronic physical health conditions (Churruca, Draper & Mitchell, 2018) and those identifying as LGBTQ+ (Cawley et al., 2019; McDermott et al., 2018; Whitlock et al., 2006).

1.7. Prevalence of Self-Injury Within the LGBTQ+ Population

The prevalence of self-injury within the LGBTQ+ population is significantly higher than within the heterosexual population. Several studies conducted in different parts of the world have confirmed this by finding higher rates of suicidal behaviour, self-injurious behaviours and mental illness in those belonging to sexual minorities (Hatzenbuehler, 2011; Herek & Garnets 2007; Mortier et al., 2018).

A study by O'Hara (2013) reported finding that 46.9% of LGBTQ+ people had contemplated suicide and 35% had self-harmed, while 25% had attempted suicide at least once. These figures are alarmingly high as compared to the heterosexual population and therefore warrant further investigation. The age of onset for self-injury is not always but generally understood to be during adolescence and this is typically (but not always) the time of sexual development when individuals may become aware of and attend to their sexual orientation/identity. Difficulties in coming to terms with one's sexuality may lead to adverse experiences during this time, for example the experience of actual or feared rejection from others, social isolation, stigmatisation, discrimination, bullying etc. Thus, suicidal behaviours and self-harm have been shown to be associated with exposure to such adversities during childhood and adolescence (Bruffaerts et al., 2010; McLafferty et al., 2016).

O'Neill and colleagues (2018) conducted a study in Northern Ireland where same-sex marriage was not legal at the time of publication and where studies have found that more discriminatory views are held than in other regions of the UK (McAlister, Carr & Neill, 2014), found an increased likelihood of all queried self-harm and suicidal behaviours in those who did not identify as heterosexual. These results are consistent with research into suicidality and self-harm in gender and sexual minorities, identifying them as a high-risk group for self-harm (Cawley et al., 2018; O'Hara 2013). However it is important to note some of the methodological limitations of this study. A sample of

university students was used, thus limiting generalisability. In addition, cross-sectional causality cannot be inferred. Furthermore, the self-report approach used means that the accuracy of the data gathered should be treated with caution, and indeed the authors acknowledge that self-reporting varies depending on how the question is asked. Nevertheless, O'Neill and colleagues contribute important findings that highlight the impact that identifying as a member of a sexual minority can have on one's mental heath and proneness to self-harm.

Studies focusing on the prevalence of self-injury in the LGBTQ+ population face difficulties not dissimilar to those identified for self-injury research within the general population. Identifying as belonging to a sexual minority is not a clear-cut or linear process one goes through, which makes it difficult to research. Indeed, there are many fluid and changeable factors, which are heavily influenced by internal coping strategies (emotional and psychological) as well as external influences (familial and social). Stigma towards LGBTQ+ individuals is still present, in the same way that it is present for those who self-injure (Gower et al., 2019; Kaniuka et al., 2019). Thus, individuals identifying as LGBTQ+ who also self-injure, may perceive and/or experience increased feelings of distress and adversity. Kool and colleagues (2014) suggest that when research participants or therapeutic patients are asked to articulate experiences of their self-injury, their sexuality, or both, they may struggle with verbalising the complicated and changeable processes they have been through or are still going through. Additionally, they may have experienced negative reactions, a lack of understanding, criticism or prejudice from social circles or from professionals in the past, thus making them reluctant to seek help or participate in research. All of the above make researching self-injury within the LGBTQ+ population difficult, but necessary.

1.8. Self-Injury and the DSM

During the last decades a discussion regarding the conceptualisation and diagnostic organisation of non-suicidal self-injury has been ongoing, and it has been most commonly seen as a symptom of borderline personality disorder (BPD). The Diagnostic and Statistical Manual of Mental Disorders-4 (DSM-IV; American Psychiatric Association, 2013) relates only one criterion for BPD directly to self-injury: *'recurrent suicidal behaviour, gestures or threats, or self-mutilating behaviour'.* The strength of the association between self-injury and BPD has been criticised by some. Herpetz, Sass and Favazza (1997) reported finding that if the above stated diagnostic criterion was removed, only 28% of their sample of individuals who self-mutilate would meet the criteria for BPD, thus leaving a majority of the sample without a primary diagnosis. From my own clinical experience of working within the field, I would concur that in my experience, those who self-injure often would not meet the required five categorical descriptions for BPD. Other researchers have also expressed disagreement about the usefulness of the categorisations used in the DSM-IV and the pejorative nature of the terms 'personality disorder' (Roth & Fonagy, 1996, p.200). For those who self-injure but do not meet the criteria for BPD, it seems essential to carry out an individual formulation or conceptualisation to help determine the function of their self-injury as well as any potential relationship to other psycho-pathological features (Sidley, 1998).

Given the prevalence of non-suicidal self-injury and findings showing that it is often present in those who do not meet the criteria for BPD, several attempts have been made to include non-suicidal self-injury in the DSM, which now includes it as a condition for further study. Perhaps the most important justification for including self-injury in the DSM is the potential benefit that a distinct diagnosis may lead to further research, better understanding, management and treatment (Muehlenkamp, 2005). In addition, further benefits of the classification might include better communication between professionals and improved chances of a shared understanding of the phenomena.

The DSM has historically been subject to much criticism for the way in which it conceptualises and classifies mental disorders. Some may argue that the classification of non-suicidal self-injury in the DSM-V may serve to further stigmatise those who engage in it, and that despite the benefits of a diagnosis we must also be aware of the risk of pathologising what many individuals see as an adaptive and protective behaviour for them.

1.9. Sexual Orientation and the DSM

Homosexuality has had a contentious history within psychiatry and was only de-classified as a mental disorder in 1973 following years of activism and protest, for example following the Stonewall Riots. 2019 marked the fiftieth anniversary of the Stonewall riots, and while huge advances in equality and acceptability have been made, a recent survey found that 40% of LGBT people in England and Wales have experienced a homophobic incident of some sort within the last year (National LGBT Survey, 2019). While societal attitudes are indeed changing over time, homophobia is still a significant problem for those identifying as LGBTQ+.

Diagnoses which categorise highly idiosyncratic phenomena such as self-injury and sexual orientation should be treated with caution, and adopting a phenomenological research approach, perhaps allows for such phenomena to be explored more appropriately.

1.10. Co-Morbidity and Predisposing Factors

1.10.1. Co-morbidity and Self-Injury

People who self-injure appear to have a number of possible and common co-morbid disorders present. Borderline personality disorder, post-traumatic stress disorder, eating disorders, anxiety and depression are all common in those who engage in self-harm (Haw et al., 2001). Svirko and Hawton, (2007) found that within those who have

been diagnosed with an eating disorder, between 25% and 55% also presented with self-injury, while between 54% and 61% of those who self-injured, also had an eating disorder.

Cloitre et al., (2002) report that over 50% of a sample with post-traumatic stress disorder also reported self-injury, while intrusive memories, flashbacks and the associated anxiety have also been shown to precipitate self-injury amongst these individuals (Chu, 1998; Herman, 1998). Anxiety and depression are also very commonly found in those who self-injure. Haw and colleagues (2001) found that 70% of participants they interviewed regarding self-injury suffered from depression, and that 14% also had anxiety difficulties. The high comorbidity of self-injury with other psychiatric diagnoses appears logical in that, those experiencing psychological and/or emotional distress use self-injury as a means of coping, i.e. self-injury is conceptualised as a symptom of an underlying distress rather than the actual problem. This presents a problem for current diagnostic systems within which self-injury is classified as a distinct diagnosis, rather than a symptom of distress.

1.10.2. Significance of Self-Injury Co-Morbidities Within the Context of LGBTQ+ Identities

Considering the above co-morbidities within the LGBTQ+ population may help shed light on the high incidence of self-injury within this population. A large-scale systematic review and meta-analysis conducted by King and colleagues (2008) reported the lifetime risk of depression in lesbian, gay and bisexual participants to be at least twice that of heterosexual control participants. The lifetime risk of anxiety was also found to be significantly elevated within lesbian, gay and bisexual participants. All studies used in this analysis were of good quality and were based upon samples from the general population with high participation rates, allowing a high degree of confidence in the findings. Findings reported an elevated risk of lifetime and 12 month prevalence of

depression and anxiety disorders in all LGB groups compared to heterosexual controls. The review took multiple sophisticated steps in order to maximise methodological reliability and provides a valuable overview of existing research, however its limitations highlight some of the difficulties in researching LGBTQ+ populations in general. In selecting studies to include in the review, differing definitions of sexual orientation and sexual identity meant that many studies were excluded. This is similar to the difficulties in reviewing research regarding self-injury where a wide range of definitions exist, increasing the risk of overlapping and repetitive findings as well as discrepant or contradictory findings due to definitional variation. The definitions and terminology used to articulate sexual orientation and gender identity are changeable and often this is in an attempt to be more inclusive. As with self-injury research, sexuality research struggles with evolving terminology, which means different things to different people. Another limitation of the review that warrants attention here is the authors finding a lower than expected prevalence of LGB people in several of the population surveys included in analysis. Some studies were found to report results based upon very few responses from LGB people, indicating these studies struggled to recruit a representative sample. Thus, it is likely that some LGB people were reluctant to participate. A lack of willingness to participate in research around both self-injury and sexuality is not uncommon. With regard to sexuality, the lack of willingness is perhaps related to a fear of disclosure and engaging with psychiatry, which has historically pathologised non-heterosexuals. It is important to give these methodological issues attention and reflection when embarking on research around highly stigmatised groups of people such as those who self-injure and those who identify as LGBTQ+, so as to try and avoid replicating the same methodological limitations.

1.10.3. Predisposing Factors for Self-Injury

The complexity of self-harm is reflected in the multitude of predisposing factors associated with it (Hawton, Saunders & O'Connor, 2012) such as, childhood adversity

(O'Neill et al., 2018), suicidal intent (Muelhenkamp & Gutierrez, 2004; O'Neill et al., 2018), social rejection (Cawley et al., 2019) trauma (Allen, 2003; Chu, 2011), low self-esteem (Fergusson, Woodward & Horwood, 2000; O'Connor et al., 2012) and having been bullied (Hinduja & Patchin, 2010). The multiple causal factors associated with the act of self-injury highlight its equifinality, (Josellin, 2013).

1.10.4. Predisposing Factors for Self-Injury Within the Context of LGBTQ+ Identities

The above stated predisposing factors for self-harm are common in sexual minorities (King et al, 2008) as well as in other minority groups. Those identifying as LGBTQ+ are more likely to have experienced childhood adversity and suicidal intent (O'Neill et al., 2018). One study found that 47% of LGBTQ+ people had contemplated suicide (O'Hara, 2013). Suicidal thoughts and behaviour in LGBTQ+ people were also found to be more frequent and longer lasting than for the general population (O'Doherty, 2016).

Social rejection is a common experience for minority groups and specifically for LGBTQ+ people, which often occurs alongside social exclusion, victimisation, bullying and stigma (Karlsen and Nazroo, 2002). Not all people who identify as LGBTQ+ will experience social rejection and/or exclusion, however at some point in their process of identifying as LGBTQ+ and coming out, it is very common to fear perceived social rejection, even if this does not occur and social acceptance is instead the actual result. The threat of perceived or actual social rejection and associated shame has the potential to be internalised for LGBTQ+ individuals (Moody, Starks, Grov, & Parsons, 2017; Okutan, Buyuksahin, & Sakalli, 2016). This internalised homophobia is well documented as being associated with self-injury (Igartua, Gill & Montoro, 2014; Scott, Pringle & Lumsdaine, 2004). Self-punishment is also well documented as being associated with self-harm (Gratz, 2003) and when this is considered alongside

internalised homophobia and shame occurring in this minority, it is easy to understand how LGBTQ+ individuals are more predisposed towards self-injury than those who identify as heterosexual.

Both self-injury and sexuality are highly idiosyncratic and multifaceted, as demonstrated by the above reviewed literature. Research methods aiming to explore the experience rather than the incidence of self-injury (which can be argued to be more clinically relevant for those who engage in it) must allow individuals to voice the uniqueness of their experiences, however contradictory and confusing they may be. While there is of course value in the insights which quantitative research offers, qualitative methods are essential in addressing the continuing disparity between experiences of and treatments for self-injury.

1.11. Qualitative Research into Self-Injury

An abundance of research exists using quantitative methods to explore the prevalence and functions of self-injury. Qualitative studies investigating self-injury are less abundant but do shed light on the phenomenon from a more personal and lived experience perspective, which allows for consideration of the meaning making around the experience of those who engage in it.

The role of emotions and more specifically of emotion regulation is widely accepted as playing a significant role in self-injury. Qualitative studies focusing on the emotional experience of self-injury allow for a more nuanced picture of the behaviour. Morris and colleagues (2015) conducted a qualitative study of individual experiences of self-injury in those who had been referred to a personality disorder service and they employed a narrative analysis methodology. Findings highlighted five key themes referring to emotional processes around self-harm. Firstly, authors found that all participants reported early experiences of not feeling able to express their emotions and of being

chastised by caregivers for having done so. Secondly, the emotional release experienced through self-harming was significant for all participants as a means of ridding themselves of negative emotion, as well as of generating some kind of emotions in response to an overwhelming feeling of apathy or numbness. Thirdly, participants reported becoming trapped in a cycle of managing their emotions through self-harming which they reported as difficult to abstain from or effectively replace. Finally, all participants reported that while their self-harming was effective in managing their emotions, it also generated another set of negative emotions (shame, fear, isolation) as a direct result of engaging in self-harm. While participants reported experiencing self-injury as a means of regulating, generating and ridding themselves of emotional states, it is of relevance for this research to also note that in engaging in self-injury, participants also reported increased generation of shame, fear and isolation as a consequence of having self-injured. It could be assumed that if individuals who self-injure experience such negative emotion generation as a result of their self-injury, that those who self-injury and also identify as belonging to a minority group may experience an exacerbated sense of these shame, fear and isolation not only due to their self-injury but also due to their minority status.

While Morris and colleagues provide valuable insights about the emotional experience of self-injury, their research design and methodology are subject to some limitations which need to be taken into consideration. Narrative analysis focuses on the individual life chronology and how this has led them to their current state. Much contextual data is collected about the participant and researchers need to have a clear understanding of the participant's life, which can of course be subject to misinterpretation. Thus, in contrast to phenomenological methods, narrative methods move away from focusing on the subjective experience of self-injury and individual meaning-making around it. The authors' methodology allows them to address this limitation to a certain degree. The inclusion of participant involvement in validating the accuracy of *restorying* and

subsequent analysis within which their experiences will be viewed, does ensure a degree of reliability, however, it is inherent in narrative analysis that the subjective experience of the individual and their meaning-making around experiences is not the focus. Some sampling limitations also need to be taken into account here. The researchers specifically note that due to issues of reliability, validity, and a desire not to attach a stigmatising label to participants, that they did not restrict inclusion to those only holding a personality disorder diagnosis. Rather, they recruited those who were being seen by a personality disorder service and who had engaged in cutting for a minimum of five times for at least a duration of one year. While this approach did indeed enable researchers to avoid association to a potentially stigmatising label, it meant that they employed other inclusion criteria such as having had at least two admissions to psychiatric hospital and involvement with crisis/community services. In implementing these criteria researchers were able to ensure the homogeneity of their sample which is necessary for qualitative research, but it also meant that they therefore focused on a purely and heavily clinical sample, excluding the experiences of non-clinical populations who remain under-researched. Furthermore, in recruiting a predominantly female sample (seven females and one male) gender may have significantly impacted on the way emotions were experienced and expressed (Brebner, 2003; Power, 2010). Participants all identified as White British, thus excluding any ethnic minority perspectives in the results. Finally, researchers acknowledge that in sampling a majority of participants from an 'expert-by-experience' service user group influenced participant's narratives through emphasising recovery rather than difficult experiences.

This research provides valuable data for clinicians working with self-injury, specifically within the context of other symptomology associated with personality disorders. It does not however, provide insights about the subjective experiences of those who self-injure and how they make sense of their experiences. In addition, it does not address the experiences of individuals belonging to a minority groups who are known to be at

increased risk for self-injury, or those who self-injure and are not receiving any mental health support (i.e. non-clinical individuals).

Another study which focused on lived experiences and meaning-making around self-injury was that conducted by Adams, Rodham and Gavin (2005). This study focused on the participant experiences of self in deliberate self harm employing an IPA methodology. Research shows that the concept of self for those who engage in self-injury is often conflicting and paradoxical (Josselin, 2013) and these findings support this notion. Researchers report one super-ordinate theme of 'Validation' and three sub-themes as 'Intrinsic self versus extrinsic self', 'Accepted or denied self' and 'Notion of normality'. The authors employed an online approach, gathering data through conducting focus groups online and email interviews with participants. Results highlight the defective and conflicting nature in experiences of the self for those who self-harm.

The overall concept of 'validation' (that is, the self-harmer's desire to maintain a sense of self that is legitimate, defensible and acceptable to themselves as well as to others) was the most prominent theme across the group in relation to the concept of self. Participants demonstrated an awareness of their self-injury and therefore themselves as abnormal or unacceptable and therefore illegitimate, but report not being able to stop, leaving (at least) a part of the self as being experienced as defective. This is important for the current research, in that it highlights the difficulty that those who self-injure experience with regard to feeling invalidated, unacceptable and illegitimate in some way.

While the study provides helpful insights into the experience of self-injury, there are some limitations which need to be taken into consideration. The researchers used online forums to recruit participants and conduct focus groups as well as email interviews. On the one hand this online communication may have enabled participants

to speak more openly and comfortably given the digital format which potentially reduced any discomfort about discussing this sensitive topic by offering a kind of barrier or distance between participants and researchers, perhaps allowing them to express themselves more easily. Conversely, it may be that recruiting and gathering data online meant that researchers were not able to attend to the many subtle and nuanced expressions in communication which are revealing and within the scope of IPA analysis procedure. In addition, the online format is acknowledged by researchers as being complicated by non-participants interfering with forum discussions in unhelpful ways (e.g. posting 'flaming' messages of anger or insult). This limitation emphasises what seems to be lost by online approaches; researchers are not able to control for many interfering factors such as unhelpful posts from non-participants, the emotional impact of these 'flaming' messages on participants, not being able to attend to participant's tone, pace, body language, and not receiving replies to email interview questions thus inhibiting the depth of communication and connection between researcher and participant, all of which can be argued are of paramount importance when researching stigmatised populations about sensitive topics such as self-injury, and when using IPA methodology.

Despite the above limitations, the study does provide valuable data about how those identifying as self-injurers report struggling with the concept of self in that, they experience the self (at least at times) as unacceptable, abnormal and illegitimate in some way as a result of their self-injury. Given this, we might assume that for those identifying as self-injurers in addition to identifying as belonging to a minority group, these experiences of the self as unacceptable, abnormal and illegitimate are amplified by another layer of the self which is potentially also experienced as abnormal or unacceptable. For example, if the concept of self for self-injurers is characterised by unacceptability, abnormality and illegitimacy, those self-injurers also identifying as LGBTQ+ might experience an amplification of the self as unacceptable and abnormal

not only due to their self-injurious identify but also due to their LGBTQ+ identity, and this warrants further investigation.

1.12. Qualitative Research into Self-Injury Within LGBTQ+ Populations

In 2015 Batejan, Jarvi and Swenson conducted the first meta-analysis comparing the risk of non-suicidal self-injury between sexual minority and heterosexual persons. Fifteen studies were reviewed which focused on the association between sexual orientation and non-suicidal self-injury, including over 7000 sexual minority and over 61000 heterosexual participants. Findings indicate medium to large effect sizes for the relationship between sexual orientation and non-suicidal self-injury. Adolescents belonging to a sexual minority and bisexuals were found to be particularly high-risk and the authors go on to highlight the need to examine the mechanisms linking sexual orientation and non-suicidal self-injury, which can be addressed by adopting qualitative methods.

Alexander and Clare (2004) conducted one such qualitative study using interpretative phenomenological analysis to explore the experience and meaning-making around self-injury in sixteen lesbian and bisexual women. Six major themes emerged from the authors analysis of the data as follows: ‘Bad experiences’, ‘Invisibility and invalidation’, ‘Feeling different’, ‘Just doing it’, ‘It helps me cope’ and ‘Moving on’. While some of the experiences reported may be applicable to all women, the authors focused on those factors which were specific to the experience of women belonging to this sexual minority, arguing that self-injury can be understood as a coping response arising within a social context characterised by abuse, invalidation and the experience of being perceived as different or unacceptable due to their sexual orientation, thus increasing already held negative views of the self. While feelings of confusion and shame regarding the women’s sexual orientation as well as their self-injury were reported, the authors also report that for some women sexual orientation eventually became a source

of pride and offered a sense of belonging, resulting in their sexuality being a positive source of self-esteem but that for others, negative feelings about their sexual orientation persisted due to the dominance of heterosexism and homophobia within society. The authors conclude by asserting that self-injury must be understood as a coping response arising within a social context which is complicated and fraught with difficult processes for women who identify as lesbian and bisexual, rather than as a symptom of a more isolated intrapsychic disorder. The authors report that abuse, invalidation and the experience of being regarded as different or unacceptable in some way are central and salient in the development of self-injury for those women who identify as lesbian or bisexual. This study points to the specific factors which individuals who identify as belonging to a sexual minority might experience and which increase the risk of engaging in self-injury.

Alexander and Clare provide helpful insights into the experience of self-injury within women who identify as a belonging to a sexual minority, however there are several limitations which need to be take into consideration. The researchers were able to recruit a large sample for conducting a qualitative study (sixteen) giving their findings significant validity. In addition, they were able to recruit a relatively diverse sample in terms of ethnicity with half of participants identifying as non White-British (the study was conducted in London) as well as age, with participants ranging from age 18-50 years old. However, inclusion criteria specified the number of times participants should have engaged in self-injury as only being once, which may have left their sample open to including those who perhaps had little experience of self-injury, for it to be the focus of an depth of interview about the phenomenon. An inclusion criteria of having engaged in self-injured at least three times would have ensured all those taking part had sufficient experience of self-injury to be able to explore and reflect upon their experience and the meaning-making around it in more depth. A second limitation of this study is that authors recruited a female sample only, thus excluding the experiences of

men who identify as a sexual minority. While self-injury is a phenomenon occurring in women more than in men, (and this may be why the researchers chose to exclude men from recruitment, although they do not explicitly state this as their reason for doing so) it seems important explore the experiences of both men and women who self-injure and identify as belonging to a sexual minority. Furthermore, the researchers recruitment criteria made no specifications about whether participants were receiving any kind of mental health treatment at the time of taking part, thus their sample included individuals who were in the process of having various forms of treatment including psychiatry, residing in therapeutic communities, having counselling and attending support groups. The inclusion of those who were receiving mental health support meant that the results were derived from a clinical sample, excluding those who were not in receipt of mental health support and who are often overlooked or not the focus of research around self-injury. As outlined above in this chapter, the experiences of those who self-injure are characterised by feelings of shame, isolation, fear, abnormality and illegitimacy which are also experiences of those who identify as LGBTQ+. Given that these negative emotions are experienced by both those who self-injury as well as those who identify as LGBTQ+, it may be inferred that seeking support for LGBTQ+ individuals who self-injure is not an easy process resulting in hiding self-injury, not seeking support and further exacerbating negative feelings about themselves. Those who identify as LGBTQ+, self-injure and are not in receipt of mental health support (i.e. a non-clinical individuals) seem to therefore be at increased risk and warrant further investigation, which was not within the scope the study outlined above.

Another study conducted by McDermott, Roen and Piela (2015) adopted qualitative virtual methods, examining data from online forums to explore how LGBT youth's cyber-talk about emotional distress, self-harming, and how they explained the relationship between self-harm, sexuality and gender. In employing an qualitative virtual method the researchers aimed to access marginalised LGBT youth and to generate rich

‘immediate’ data (i.e. data that is unmediated by researcher/participants and is therefore nonreactive) which was initiated, motivated and therefore determined by the young people themselves. In employing this virtual qualitative method, researchers sourced data from over twenty websites and estimated 290 contributors. They utilised thematic analysis using cross-sectional indexing to create categories. Reliability and credibility was improved by having all three authors devise and apply the coding schema as opposed to only one. Also of importance is that researchers approach to analysis was from a non-pathologising view of self-harm, which drew upon queer theory (Butler, 2011; Sedgwick, 1991).

Findings suggest that while some participants articulated contradictory, ambiguous or multiple accounts of the relationship between self-harm, sexuality and gender, three strong explanations dominated: self-harm due to homophobia and transphobia, self-harm due to self-hatred, fear and shame, and self-harm emphatically not related to sexuality or gender. Furthermore, in line with the majority of findings in the field of self-harm (Nielsen, Sayal, & Townsend, 2017; Christian, & McCabe, 2011; Sornberger, Smith, Toste, & Heath, 2013) this study also highlighted self-harm as essentially being a way of coping. It is important to note that in the absence of any direction, prompt or involvement by researchers, that themes of self-harm directly due to homophobia or transphobia, self-hatred, fear and shame were found. This study provides evidence of a nonreactive (i.e. not prompted by the researcher or by an awareness of taking part in research focusing on these factors) and direct link made by contributors, between self-harm and LGBT identity in a way in which other qualitative methods are not able to, suggesting it is a particularly salient and pertinent experience.

This study offers a unique and valuable insight which is important given the increasingly virtual lives of young people today (Rodham, Gavin & Miles, 2007). While the unique perspective that employing a virtual qualitative method offers is important, there are

several limitations which warrant attention. The lack of co-creation resulting in an at least somewhat controlled data gathering process in terms of the focus of content, means that there are many variables which the researchers were unable to account for or even be aware of. For example, the anonymous nature of being able to post in online forums means that no real demographic data is available for the study. Therefore, while the researchers specifically targeted forums for young people, in fact they had no way of knowing if those contributing were actually aged between 16-25, or indeed if they had any experience of self-harming. While the researchers specifically focused data gathering from websites targeting LGBTQ+ youth and those who self-harm, the ability of anyone and everyone to participants in these forums means that only a partial perspective is offered and what can be inferred from data analysis, is quite limited. In addition, the perquisite of linguistic competency necessary to contribute to forums and of access to technology for accessing the internet means that the online method used was only able to reach a skewed sample.

McDermott, Roen and Scourfield (2008) conducted another qualitative study seeking to explore the connections between minority sexual identities (LGBT) and self-destructive behaviours (suicide, self-harm and risky behaviours) in young people aged 16-25 years old. Interviews and focus groups were conducted with a large sample of 69 participants taking part who were found to be diverse in terms of ethnicity, socio-economic status and geographical location. Data was analysed using Foucauldian discourse analysis and suggested a strong link between homophobia and self-destructive behaviours. The authors argue that homophobia works to punish at a deep individual level and requires LGBT youth to manage being positioned (due to their sexual orientation or gender identity) as abnormal, dirty and disgusting. Furthermore, the authors found that central to the multiple and complex ways in which LGBT individuals negotiate homophobia are ‘modalities of shame-avoidance’. These modalities of shame-avoidance were processes such as routinisation and minimisation

of homophobia, maintaining individual 'adult' responsibilities and constructing 'proud' identities. The authors exploration of these shame-avoidance strategies argues that LGBT individuals manage experiences of homophobia individually, without an expectation of support from professionals, familial or social relationships. This argument is supported by research finding that LGBT individuals do struggle with seeking help for mental health difficulties, and in particular for self-harm (McDermott, 2014). These difficulties in seeking and the lack of expectation of support, leaves LGBT individuals more vulnerable to self-destructive behaviours.

Findings from the above study suggesting that homophobia is strongly linked to self-harm and that idiosyncratic shame-avoidance strategies are employed by LGBT individuals in order to negotiate homophobia, reinforce the notion that LGBT individuals struggle to seek help due to fear of further discrimination, suggesting that a significant number of LGBT individuals who self-harm do not seek support. Indeed, the researchers acknowledge that their own study's recruitment techniques meant their sample was not representative due to that fact that they recruited via LGBT support groups and LGBT professional networks (mental health, social services and education). Thus, their finding that LGBT individuals struggle to seek help for self destructive behaviours is further emphasised as it emerged from data collected from individuals who had eventually found a way to seek support. This research highlights the need for research to focus on those not in receipt of any mental health support, despite the difficulties which exist in recruiting these individuals. Another limitation of the above research is that only a small portion of those taking part actually had experience of suicide or self-harm. The researchers conducted 11 focus groups but only 3 were targeted at LGBT individuals and their findings therefore draw on a subset of data consisting of interviews and focus groups specifically with LGBT participants reducing the number of participants from 69 to 27. Furthermore, of this sub-sample only 14 participants had attempted suicide or self-harmed. While these findings do offer

valuable and relevant implications for LGBT individuals who self-harm, they do not directly address the phenomenology of self-harm for those who engage in it.

Despite the outlined limitations, a particularly important aspect of the above research is that it shed light on LGBTQ+ individuals' experiences regarding help-seeking behaviours and highlights the importance of these experiences in accessing care and perceived acceptability of their gender or sexual identity within this process. Those who seek help report the same fears around stigma and discrimination from health care providers as they do within their social circles and society in general (Munt, 2000; Sedgwick, 2003). This fear of institutional stigma has been found to contribute to concealment of sexual or gender identity (Maycock, Carr & Kitching, 2009). Furthermore, research has also found those identifying as LGBTQ+ reported a range of negative responses from health care staff including, embarrassment, hostility, suspicion, pity, condescension, ostracism and even treatment refusal (Sell & Gorin, 2006; McCann & Sharek, 2014).

In order to begin addressing this difficulty of LGBTQ+ individuals seeking help for self-harm and suicidality, the Department of Health Policy Research Program commissioned a research study in 2017 comprising of three distinct but interconnected studies, one of which was focused on mental health staff perceptions and practices regarding LGBTQ+ individuals seeking help for self-harm or suicidality which was conducted by Hughes and colleagues (2018). The study employed a mixed-method approach sampling a large and diverse group of LGBTQ+ young people (aged under 25 years old) who were interviewed about their experiences of self-harm, suicidality and help-seeking behaviours. Using this qualitative data, a survey was developed to examine whether staff views concurred with individual experiences of accessing care, as well as how staff viewed the intersection between mental distress (with a focus on self-harm and suicidality), sexual orientation and gender identity. The survey was

distributed to three NHS Trusts and 113 professionals took part, representing the first survey in the UK exploring mental health staff perceptions of working with self-injury and suicidality specifically with regard to LGBTQ young people. Several important findings emerged from the study which hold particular relevance for this research. Mental health staff demonstrated a good level of understanding around experiences of LGBTQ youth being more fraught with emotional distress due to feeling isolated by sexual or gender identities, and that self-injury was a way of coping with such isolation (rather than as an 'attention seeking' behaviour). In addition there was a perception that awareness of services was a barrier to accessing care, as was fear of disclosure of both sexual or gender identity, as well as disclosure of self-harm. This finding is significant in that it points to staffs awareness of an intersectionality experienced by LGBTQ youth who also self-harm, as formed by multiple layers of minority status. Mental health staff understanding this intersectionality is encouraging, however it was also reported that only 33% of staff routinely felt able to discuss sexual and gender identity with their clients. This discrepancy between recognising the complexity and distress associated with LGBTQ youths' experiences of self-harm and suicidality against ability to discuss openly seems crucial. Reasons for not feeling able to routinely discuss sexuality and gender identity with clients were identified primarily as a lack of prior LGBTQ awareness training, as well as not feeling supported by their organisation or supervision to do so adequately. Hence, two thirds of staff who took part in the survey report an avoidance of discussing sexual and gender identity, which could be argued as perpetuating feelings of isolation and amplifying awareness of minority status. These findings suggest that institutional stigma can be best addressed by professionals and organisations alike by focusing on providing and requesting specific LGBTQ+ training. In order to be able to work with such client populations better, professionals need to make direct and specific attempts to equip themselves with the skills and organisational support structures to do so adequately.

The study offers important insights into experiences of mental health staff perceptions of working with LGBTQ+ youth who self-injure in the UK. The mixed method approach meant that authors were able to focus the staff survey on aspects which were derived as being significant from qualitative interviews from a large, diverse and representative sample of LGBTQ+ youth, offering a good degree of validity to results. Some limitations of this study also need to be taken into account here. Firstly, the survey employed 'opt in' participation on a very specific topic, hence it was likely to attract those staff members with a particular interest in LGBTQ+ issues, who it may be argued hold more favourable attitudes towards the topic. Indeed, authors found an overrepresentation of 'non-heterosexuals' in the staff sample of nearly half, which is significantly higher than general population estimates (Mercer et al., 2014). This notion is supported by similar research conducted by Hou et al., (2006) in Taiwan which found that those staff members who identified as LGBT themselves, who had friends or family members identifying as LGBT were also more likely to have positive attitudes towards sexual minorities they worked with. This finding further supports the notion that organisational efforts to train and provide supervision for LGBTQ specific issues for all staff members, not only those seeking it out is necessary since those staff members not seeking it out, may also potentially hold negative attitudes or biases.

As is evident in the above reviewed studies, research tends to focus on self-injury in young people (aged between 16-25), as does a significant body of the research regarding self-injury (D'Augelli et al., 2005; Fenaughty & Harre, 2003; Grossman & D'Augelli, 2007; King et al., 2007; Nickels, Walls, Laser & Wisneski, 2011; Rivers & Cowie, 2006; Skegg, 2005; Hegna, & Wichstrøm, 2007). Given the developmental trajectory of sexuality as well as the typical onset of self-injury during adolescence (Scourfield, Roen, & McDermott, 2008; Rivers, 2000), it is understandable that research regarding self-injury is often focused around adolescents and young people.

Nevertheless, research regarding self-injury during adulthood, particularly amongst non-clinical individuals who identify as LGBTQ+, appears to be lacking.

Bautista and colleagues (2017) employed qualitative phenomenological methods to explore experiences of suicidality (including self-destructive behaviours involved in suicidality) in a sample of nine adult (18+) Filipino lesbian women and gay men who were currently receiving psychotherapy. Researchers analysed data through a process of reduction, description and conceptualisation in order to capture the essence of participant experiences. While this study focused on experiences of suicidality rather than self-injury per se, it yields important findings relating to lived experiences of sexual minorities regarding self-destructive behaviours and which hold particular relevance for the context of this research. Three main themes emerged from data analysis regarding suicidality which authors explain by use of the soda bottle metaphor; the unshaken bottle, the shaken bottle and the uncapped bottle. These three distinct but interrelated states are said to represent psychological states experienced prior, leading to and following suicidality.

The first is described as a state of 'effervescing dilemma' during which the individual tentatively and often unwillingly acknowledges their sexuality, and is subsequently conflicted by this confrontation and the resulting dilemma of negotiating outness. Hence, the soda bottle is said to be unshaken, but that an effervescence is occurring. During this first state, authors highlight the social context within which experiences of the individual are placed. Fears of familial and wider social reactions to ones sexuality were at the forefront of participant experiences. Fears were not yet experienced, but an anticipation of discrimination played a crucial role in the effervescing dilemma. This finding supports previous research reporting that anticipated (rather than actual) discrimination and rejection due to sexual minority status is a significant contributing factor to self-destructive behaviours (Bruffaerts et al., 2010; McLafferty et al., 2016;

O'Hara, 2013). In addition, authors note the significant role of cultural attitudes and acceptability regarding sexual and gender minorities as being embedded within the culture of a society. Within the context of Filipino culture where homosexuality is less accepted than in Western societies, participants in this study focused heavily on experiences of their own self-loathing as a result of being aware of the pronounced unacceptability of their sexuality within their culture. The authors note the important relevance of Meyer's (2003) minority stress theory here, which will be explored further in the following section and which emphasises the excess stress and psychological burden felt by minority groups. It is important to highlight the authors non-pathologising approach to analysis regarding this first theme in that, they emphasise being lesbian or gay is neither inevitably 'suicidal' nor does it lead to mental health problems. Sexuality cannot be regarded as the sole or sufficient cause of suicidality, but that coming out within the context of anticipated unacceptability is a significant risk factor for suicidality. Minority stressors experienced in the family or community pointed out a sense of failed belongingness and a lack of mutually supportive and meaningful relationships, which also contributed to feelings of suicidality.

'Pressurizing turmoil' was the second state represented by the authors metaphor of the shaken bottle, during which various emotions begin to feel overwhelming and thus difficult to contain or hide, particularly when participants social environment was overtly discriminating and stigmatising. The impact of such pent up emotion was found to be unbearable for participants to manage alone and a sense of impending outburst accompanied narratives within this theme. Again, authors highlight that this growing sense of pressure was not only related to issues resulting from sexuality, but also to general life events such as relationship breakdown, financial pressures and employment stress. Authors argue that when such life events are experienced by sexual minorities, the psychological turmoil is increased by a sense of isolation and excess stress already being experienced, thus issues relating to sexuality are brought

to the surface by such life events making them more poignant and harder to manage for sexual minorities.

Authors report their final theme as ‘the state of fizzing explosion’ relating to the uncapped bottle where a self-destructive acts and suicide attempts occur. Participant experiences reflected a short-lived ‘explosion’ followed by a rapid decline (like that of a soda bottle). Participants communicated a desire to end the pain that they were enduring, sometimes (but not always) not really wanting to end their life. Furthermore, suicidality was accompanied by moral reflections about the suicide attempt, regret and shame within which self-loathing and isolation were perpetuated.

While this study focuses on suicidality, rather than self-injury it does allow for some important observations which are useful within the context of exploring the experiences self-destructive behaviours in LGBTQ+ individuals. The phenomenological approach adopted allows for an in depth analysis of the lived experiences of suicidality in sexual minorities, focusing on the emotional and social processes occurring prior during and after a suicide attempt, which mirrors earlier research findings regarding the process leading up to self-injury, where an intolerable internal state becomes too intense to contain, resulting in self-injury as a means of ridding onself of such emotional states, rather than a sole attempt to harm onself (Nock & Prinstein, 2004). Instead, the act represents a much more complex picture where self-injury and suicidality act as coping mechanisms from which an individual seeks to manage emotional and psychological distress. The valuable insights offered by this study are important to consider again within the context of sampling limitations similar to those outlined previously in this section. Researchers rely on sampling from clinical populations, hence all participants are in receipt of psychotherapy and indeed were monitored by their therapists throughout participation. As a result, those taking part may be said to be somewhat well versed in talking about their psychological difficulties, suicidality and sexuality. They

were all within the sphere of accessing support, thus they do not represent the experiences of those who are not in receipt of any professional support. Furthermore, all participants in this study were classified as adults but also 'young people' ranging in age from 18-25 years old, thus excluding the experiences of adults over the age of 25, much like a majority of research regarding self-injury and sexuality.

One recent study which focuses on a specific aspect of self-injury in sexual minorities and which also highlights the complex intersectionality which may occur, is that by Jackman and colleagues (2018) who explored perspectives of transmasculine spectrum people (i.e. individuals identifying as male, transgender male, genderqueer or gender non-binary and who were assigned female at birth) who engage in non-suicidal self-injury (NSSI). A sample of 18 participants were recruited from an existing longitudinal study of transgender identity development across life span, from a variety of settings such as health care clinics, LGBTQ+ charities, social media and LGBTQ+ social events. Interview data was analysed by researchers using web-based qualitative software and directed content analysis, allowing researchers to frame research questions and aims to further develop knowledge based on particular theories, a useful approach for focusing on NSSI amongst transgender people, given a lack of existing theoretical foundation. Nock's theoretical model of NSSI (2009) and Meyer's minority stress theory (2003) were used to frame the research, aiming to allow for a focus on both experiences of vulnerability as well as resilience. In employing this method of analysis, researchers aimed to maintain a non-pathologising approach, as did Bautista and colleagues (2017), which seems crucial when researching minority groups in general.

Analysis revealed most participants described multiple motivations for engaging in NSSI with the most common being to cope with intense or overwhelming feelings of anger, sadness or anxiety. Other commonly reported motivations included feeling

generation (reducing feeling ‘numb’ or ‘detached’), self-punishment and suicide avoidance, similarly to previous research outlined in this section (Nock, 2009; Nock and Prinstein 2004; Muehlenkamp & Gutierrez, 2004; 2007). In addition to replicating these findings of previous research into the experiences of self-injury in sexual minorities, this study also offers some novel and useful findings for the field of NSSI research in general, but more specifically for the current research. Firstly, participants narratives reflected experiencing their gender identity as placing them as a minority within a minority, in that they belonged to the LGBTQ+ community, but that feelings of isolation, discrimination and prejudice were felt from within the LGBTQ+ community also. Furthermore, participants felt that simultaneously negotiating these multiple aspects of themselves (sexual identity, gender identity and NSSI) significantly increased their stress and contributed to further isolation, despite having eventually found social contact with other LGBTQ+ individuals, which was experienced as particularly poignant. Researchers suggest this reflects a stress inherent to tasks of the transgender identity development process, particularly during coming out and exploration stages. Similarly, seeking out and eventually finding spaces of support for NSSI (usually online), was not always associated with feeling less distressed or a reduction in self-injury either. Indeed, the authors report that finding peer support based on self-injurious identity sometimes exacerbated NSSI behaviours through reinforcement, validation and normalisation. Thus, a curious interaction exists between peer support for LGBTQ+ issues and peer support for NSSI. According to Jackman and colleagues, transmasculine individuals seeking peer support for related difficulties often felt further isolated when accessing such support and NSSI often increased when related peer support was accessed. Results seem to suggest that while social isolation is an important contributor to NSSI, when LGBTQ+ individuals who self-injure do find peer support related to any one aspect of their intersecting identities that it is still a struggle to negotiate their way into those support systems, and that a counterproductive stage of identifying with peer groups may occur in some. It may be that in finding a peer

group to identify minority status with, individuals may be disappointed at a lack of connection felt or similarity of experiences shared as they may have expected to. Conversely, individuals may well identify with peers but feel overwhelmed by this, or feel pressured to adopt norms associated with their new peers which they do would not otherwise.

This notion is supported by research, historically focusing on bisexual identities as being experienced as a minority within a minority (Tavarez, 2020; Molina et al., 2015) and more recently on such experiences of transgender individuals (Raynor, nation & Outlaw, 2019; Levitt & Ippolito, 2013). The intersectionality at play for those sexual minorities who also identify as belonging to another minority group (such as identifying as self-injurer) are complex and idiosyncratic, being affected by culture, access to support, navigation of accessing this support amongst other factors, as outlined by the research in this section. These findings will be important for the current research focusing on individuals who may identify with multiple minority statuses.

In summary, existing research as outlined above tends to focus on clinical populations, perhaps reflecting the difficulty in recruitment which researchers face when focusing on individuals who experience stigmatisation (due to self-injury) and who also identify as a sexual minority facing discrimination (LGBTQ+). In choosing to recruit individuals from clinical settings, researchers are able to access more easily the individuals satisfying their inclusion and exclusion criteria, however in doing so the experiences of those who are not receiving any clinical input are excluded. Given the difficulty which LGBTQ+ individuals who self-injure experience in seeking support (McDermott, 2015), it seems of paramount importance to focus on those who are not receiving treatment, despite the difficulties in recruitment.

Another way researchers seem to try and overcome recruitment difficulties here is by employing online methods of data gathering. As outlined above, while this does allow for some helpful insights to be derived from such nonreactive data, in employing this strategy researchers sacrifice what seem crucial to elements of qualitative research; a lack of direct communication with participants allowing them to attend to the subtle but important aspects of data gathered as well as a reduced ability to make inferences from analysis and perhaps most importantly, not being able to enquire and explore the actual lived experience of those who self-injure and identify as LGBTQ+. The idea of providing a space for individuals to willingly volunteer (rather than passively consent due to the public nature of online data) and chose to share their narrative, given the difficulties they face, seems essential. Thus, in comparison to the narrative and thematic analyses employed in the studies reviewed above, IPA allows for an in depth focus on the individual's lived experience and their meaning making around those experiences which is particularly appropriate for researching SI and sexuality.

In addition to focusing on clinical participants, qualitative research into LGBTQ+ experiences of self-injury also tend to focus on adolescents, youth or young people which is generally defined as between the aged of 16-25. As outlined above, given the developmental trajectory of sexuality during this life stage, as well as adolescence being the typical age of onset for self-injury, it is understandable why research focuses on this age range. However, there exists little research into the experiences of LGBTQ+ adults who self-injure.

This research aims to address this gap in the literature by exploring the lived experience of self-injury in adult individuals identifying as LGBTQ+ and who are not receiving any mental health support.

1.13. Theoretical Models of Self-Injury

Theoretical models of self-injury are subject to the same difficulties as defining and researching self-injury outlined in the previous section, given the variability and complexity of the phenomenon. Nevertheless, there are a number of theoretical models which hold particular relevance for this research and which will be considered here in order to offer the reader some contextual information within which to situate self-injury theory.

I shall begin by offering an overview of the psychodynamic perspective regarding self-injury given its potential to shed light on the paradoxical and conflicting nature of the experience of self-injury, through consideration of unconscious drives and repressed emotional states. I will go on to offer an overview of cognitive-behavioural models given their current popularity and NICE guidelines specifically recommending their applicability for working with self-injury. I will also consider two third-wave cognitive behavioural approaches which hold particular relevance; dialectical behaviour therapy and compassion focused therapy both of which are increasingly popular approaches for working with self-injury. I will conclude this section by exploring minority stress theory and its relevance in highlighting the potential intersectionality at play for individuals identifying as both LGBTQ+ and self-injurer.

1.13.1. Psychodynamic Theory

Psychodynamic theory emphasises the ‘self’ and the ego in self-injury. Self-injury is seen as a destructive act aimed at the ‘self’ and which represents a manifestation of internal and unconscious conflict within the psyche. Freud (1923) proposed the development of mind as arising from the body and the derivation of the ego as being from bodily sensations, particularly those bodily sensations occurring from the surface of the body, i.e. the skin. Early psychoanalytic theories were then developed by Anzieu (1974) who theorised that in early years the ego is constructed as a ‘skin ego’ where

the infant's body experiences a developing relationship with the mother's body and a communication of emotions through tactile sensation (as well as other senses). The skin is said to have a containing function, being the boundary between what the body and mind experience internally, and the external world (Bick 1968). As such, early experiences of the body and sense of self are characterised by a modulation of affective states through physical exchange and consequently one's earliest sense of self is inextricably embedded in and regulated through bodily sensations. Recent research has substantiated some of these early psychoanalytic ideas by showing the importance of tactile interaction for infants brain growth, stress and immune function, as well as for cognitive and affective awareness of the body (Lemma, 2010).

Anzieu suggested that given the importance of development of the 'self', ego and affective modulation through bodily sensations in early years and that according to psychodynamic theory self-injury represents a conflicting relationship between the body and the 'self'. If a lack of attunement and containing relationship in early years is experienced, the infant is said to internalise negative representations of significant others and develops an impaired capacity to regulate affective states. Healthy development of the self has been impeded and unhealthy internalisation of abusive or neglectful others is incorporated into one's sense of self, causing a conflict which results in harm or injury aimed at 'bad' parts of the self. Self-injury is seen as an act with unconscious meaning, communicating through action repressed thoughts, feelings and fantasies which are too distressing for the conscious mind, or indeed for words (Yakeley & Burbridge-James, 2018).

From the psychodynamic perspective, acts of aggression in later life represent a continuation of distressing and unconscious fantasies to attack another. Freud (1917) hypothesised that his patients' verbal and physical attacks on themselves were perhaps representative of an, albeit unconscious, desire to exercise vengeance (for example,

someone with whom there was an interpersonal conflict). These unacceptable desires combined with a tendency to internalise feelings of anger or hate towards another, means that attacking the self allows for a an expression of one's affect without harming another, which is perceived as more acceptable for the individual's psyche. Nathan (2004) suggests that psychodynamic theory is useful in understanding the paradoxical nature of self-injury whereby the individual wishes to protect the self by getting rid of unacceptable or disturbing feelings on a conscious level, but on an unconscious level is perhaps playing out self-criticism by attacking their dependent, vulnerable and needy self.

Psychodynamic theory of the self in self-injury also hold relevance for LGBTQ+ individuals who self injure, in that the perceived or actual rejection from others regarding sexuality (a fundamental part of the self) may also be internalised and develop into an internalised homophobia, where attacking the self (i.e. the 'defective' or unacceptable part of the self) through self-injury, mimics the rejection of others and punishes the non-heterosexual part of self, responsible for this rejection (Cabaj, 2000; Mitchell, 2000).

Psychodynamic conceptualisations of sadomasochism may also shed light on self-injury. Sadomasochism is defined as the derivation of pleasure (often but not always involving sexual arousal) from the infliction or receipt of physical pain, humiliation and degradation either on another person or on oneself. Freud's (1905) early writings considered sadomasochism as a sexual perversion dominated by the pleasure principle while his later writings (1961) developed this notion further as form of collaboration between the death drive and the libido, said to be responsible for sadistic and masochistic tendencies. Freud purported that the death drive is subdued by the libido and that in the service of survival, the libido must neutralise and tame the death drive. The libido imposes life processes on the death drive by attaching to it, thus forcing an integration of the two which is directed outwards in the form of the sadistic inflictor,

while the remaining part is directed inwards in the form of the masochistic receiver, (Kaplinsky & Geller, 2015), and where both become sources of pleasure. From the psychodynamic perspective, sadomasochism therefore allows for an enactment of such conflict within the psyche.

Neuroscience may help shed some light on Freud's conceptualisations of sadomasochism in that, pain produces endorphins which the individual engaging in self-injury may welcome as a means of affect regulation, generation or distraction. Furthermore, pain enhances our attention thus increasing the intensity and enhancing the processing of all sensory signals (including sexual arousal), not only those subverting pain (Bain, 2014). It is important to note here that while sadism and masochism remain in the DSM-V under paraphilias, researchers exploring the psychology of BDSM practices have more recently moved away from pathologising these practices as, perverse, pathological or as simply 'kinky sex', instead conceptualise them (when practiced safely and consensually) as healthy 'serious leisure' practices (Newmahr, 2010). Researchers go on to suggest conceptualising BDSM as distinct 'non-pathological sexual identities' in their own right (Langdridge & Barker, 2007) which are self-preserving rather than self-destructive, as is often the experience of self-injury for those who engage in it.

While psychodynamic theory provides interesting approaches for theorising about self-injury, it is not possible to falsify theories of unconsciously driven desires (Shedler, 2010). Nevertheless, the notion that unconscious paradoxical motives can become symbolically represented through self-injurious acts is useful when theorising about self-injury.

While the emphasis on unconscious and repressed processes inherent in psychodynamic theory around self-injury can criticised for its lack falsifiability, it does

offer an in depth consideration of emotion, early attachments and relationship with the 'self', which other theoretical models lack. Gardener (2001) suggests that the aim of a psychodynamic therapist working with self-injury would be to provide the client with the stable containment which they lacked as an infant or child, using the therapeutic and transference relationship to shed light on and reduce reliance on defense mechanisms. If the therapist is able to contain the clients' unbearable affect and work with the client to assimilate affective states, they may no longer need to be aggressively acted out in the form of self-injury. Eventually, a new sense of self might emerge where the 'good' and the 'bad' parts of self (or psyche) are finally assimilated, eliminating the need to exert destructive control over the body.

1.13.2. Mentalisation-Based Theory

Mentalisation-based theory integrates aspects of psychodynamic and cognitive-behavioural principles to focus on the ability to understand one's own as well as other people's mental states. Mentalisation is seen as a form of 'social cognition' thought to depend on positive social childhood experiences (Allen & Fonagy 2006). In describing an individuals' ability to understand their own and other peoples' mental states, Bateman and Fonagy (2012) suggests that a lack of ability to mentalise can have profound negative consequences, such as an inability to contain the self when distressed and to maintain stable relationships. Allen (2001) links early trauma and insecure attachment as a causal factor for the development of mental disorder, specifically for self-injury. This inability to tolerate and manage distressing affective states (e.g. rage, anxiety, despair, numbness) is linked to a poor ability to mentalise effectively, resulting in a perceived need to self-injure as a means of affect regulation, (Hamza & Willoughby, 2015).

Mentalisation-based treatment is also a cornerstone of Marsha Linehan's Dialectical Behaviour Therapy for borderline personality disorder (BPD). BPD is said to be

characterised by disorganised early attachments, poor affect regulation, poor intentional capacity and impulsivity. For these clients, when their attachment style is triggered they are not able to mentalise and distorted modes of thinking take over, resulting in a distorted perception of reality and making them more likely to resort to self-injure as a result of emotional distress.

The aim of mentalisation-based therapy is to gradually introduce or restore the individual capacity to contain the self by emphasising a focus on people's 'in the moment' state of mind. Bateman and Fonagy (2009) suggest that the mentalisation-focused therapist uses the transference relationship to enable the client to attend to and recognise their affective states and thoughts, while validating and exploring them within the context of a safe and nurturing relationship. Together the therapist and client work towards developing collaborative interpretations and generating alternative perspectives which enable the client to negotiate their inner and outer worlds with less distress and disruption.

1.13.3. Cognitive-Behavioural Approaches

Cognitive behavioural approaches emphasise the direct role of maladaptive cognitions and associated behaviours with self-injury. Kennerley (2004) conceptualised a theory of self-injury which focused on four types of maladaptive cognitions driving the behaviour as: 'I am bad and deserve it' (fundamental belief); 'This is the only way to show how I really feel' (facilitating beliefs); 'This is the only way I can cope' (reactions to self-injury; as well as flashbacks or other intrusive memories about trauma or painful events which trigger self-injury as a means of distraction or dissociation. Kennerley's approach benefits from being free of any associated diagnostic classification, but it is arguable that it's approach lacks the depth to adequately address the complex and maladaptive schemas those who self-injure demonstrate.

Nock and Prinstein's (2004) four function model conceptualises self-injurious behaviour as a result of interaction between the positive or negative reinforcement with interpersonal or social contingencies. For example, attention linked to self-injury may act as a kind of positive reinforcement, as may the 'high' reported by some individuals who self-injure (Walsh & Rosen, 1988). Thus their approach emphasises the role of reinforcement in shaping and maintaining the behaviour.

While the cognitive-behavioural approaches outlined above benefit from being free of any associated diagnostic classification, it is questionable whether or not they alone are able to account for the depth and complexity of the experiences of those who self-injure. While traditional cognitive-behavioural approaches focus on cognition and behaviour, the lack of emphasis on emotional experiences, which is know to be central in self-injury, as outlined earlier in this chapter, is neglected and this is problematic for cognitive-behavioural therapy (CBT). Somoilov & Goldfried (2000) note that the role of emotional arousal in both CBT research and practice is lacking, despite it's clearly addressing the role of emotions, it fails to focus on them in a way which seems comprehensive for those who self-injure. Primacy is given to cognitions and behaviours in CBT, with the resulting impact on emotions as being a by-product.

Third wave cognitive-behavioural perspectives have attempted to offer more multifaceted approaches which are relevant to self-injury and which have been popularised in recent years. The role of emotions and particularly of self-injury as a means of emotion regulation has been incorporated into integrative cognitive-behavioural approaches such as dialectical-behaviour therapy and compassion-focused therapy.

1.13.4. Dialectical Behaviour Therapy

While more traditional CBT approaches rely on Beckian formulations focusing on cognition and behaviour as the primary targets for treatment, Marsha Linehan's

dialectical-behaviour therapy (DBT) firmly emphasises emotion regulation (Beck et al., 2004). DBT was developed as an approach for treating borderline personality disorder (BPD), which the DSM-V outlines as being characterised by emotional instability, marked reactive mood, intense anger or difficulty controlling anger and chronic feelings of emptiness (American Psychiatric Association, 2013). Given that emotion regulation is purported as a primary difficulty in BPD, it follows that recurrent suicidal and/or self-injurious behaviours, gestures or threats are also common in those meeting the criteria for this diagnosis and DBT has a strong evidence base for the treatment of BPD including a reduction in self-injurious behaviours (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Verheul et al., 2003; van den Bosch, Koeter, Stijnen, Verheul, & van den Brink, 2005; Priebe et al., 2012).

Linehan (1993a) proposes a biosocial model of emotion regulation which is particularly relevant for self-injury, where an interaction between biological predispositions and environmental experiences, including a lack of validation from others when experiencing distress and painful emotions. The model proposes self-injury as a means of regulating emotional states when the individual is overwhelmed by distressing emotions. DBT treatment therefore focuses on supporting the individual to modulate these extreme emotions, reduce maladaptive mood-dependent behaviours as well as to trust and validate their own thoughts, emotions and behaviours through a range of cognitive-behavioural techniques but also through mentalisation, mindfulness, interpersonal training and distress tolerance. Linehan (1993b) goes on to emphasise that the dynamic between the dialectical behaviour therapist and the borderline patient is also of great importance and the therapist is tasked with finding the balance between encouraging and fostering change while simultaneously accepting and validating the client.

While Linehan's DBT has received wide utility and holds a strong evidence base, the

model may be said to contribute to pathologisation of self-injury, in that self-injury is seen as an underlying symptoms of a personality disorder. Another third-wave CBT approach which holds relevance for self-injury and which avoids this participation in pathologisation is Paul Gilbert's compassion-focused therapy.

1.13.5. Compassion-Focused Theory

Compassion-Focused Therapy (CFT) is a third-wave cognitive behavioural approach developed by Paul Gilbert and colleagues (Gilbert & Irons, 2005; Gilbert & Procter, 2006) which aims to treat individuals with mental health difficulties characterised by high levels of shame and self-directed hostility (Van Vilet & Kalnins, 2011). Traditional cognitive behavioural strategies seek to identify and challenge 'faulty' cognitions which may inadvertently reinforce self perceptions as defective, 'wrong' or 'bad', particularly in people such as those who self-injure who struggle with high levels of self-criticism. CFT instead works on adjusting the way individuals relate to themselves through generating warmth, understanding, non-judgment and compassion towards the self. As a consequence this increases self-soothing, self-acceptance and feelings of connectedness with others, which is what CFT aims to encourage and develop within the individual. For those who self-injure, CFT has therefore been presented as a particularly well-suited approach.

CFT is rooted in evolutionary psychology, neuroscience and Buddhist philosophy (Gilbert, 2009). Gilbert proposes that patterns of relating to others and oneself are created thorough neurobiological activation of the affect regulation systems in the brain, which can be activated by external signals (i.e. other people and environment) or by internal signals (own cognitions or emotions). When threatened, the safety-seeking threat protection system is activated, which is thought to involve the neurotransmitter serotonin (Gilbert, 2005). As the threat system is activated it also generates the evolutionary response of fight, flight, submit or freeze and this in turn is associated with

feelings of shame, fear, anger and disgust. Chronic overstimulation of the threat system may therefore lead to a mentality characterised by extreme over concern with how one compares with others in terms of status, value and power. Research has shown that individuals who are highly sensitive to social comparison and rejection may be more susceptible to depression, anxiety, shame and self-criticism (Allan & Gilbert, 1995; Cheung, Gilbert & Irons, 2004) which are known to be prevalent in those who self-injure and in those who identify as LGBTQ+.

In contrast, when an individual receives compassion from others or generates compassion for themselves the self-soothing system is activated which is characterised by warmth, care, safety and affiliation as well as by a release of opiates and oxytocin (Gilbert, 2005). Furthermore, when the self-soothing system is activated, it in turn calms the threat system. For those who engage in self-injury, this compassionate approach targeting shame and self-criticism highlights its usefulness for those who self-injure, as well as for those who identify as LGBTQ+.

1.13.6. Minority Stress Theory

There is a substantial body of research reporting on how stress in various forms has a negative effect on physical and mental health (Carr & Friedman, 2006; Gee et al., 2007; Sehmi et al., 2019; Solberg et al., 2020) and more specifically on how members minority groups are additionally burdened by discrimination stress, which damages physical and mental health (Thoits, 2010). Minority stress theory suggests that individuals who belong to minority groups (racial and ethnic minorities, sexual minorities, physically or mentally disabled individuals, religious minorities) are at greater risk for health problems than those who do not belong to a minority group because they face greater exposure to social stressors related to experiences such as stigma and prejudice (Conron, Mimiaga & Landers, 2010).

Minority stress theory suggests that sexual minority individuals (those who identify as LGBTQ+) are exposed to excess stress related to a variety of stigma-related experiences that stem from their sexual minority status such as prejudice-related stressful life events (e.g. being attacked or fired), micro-aggressions and slights in the form of everyday discrimination, expected rejection regardless of actual discriminatory circumstances, cognitive burden associated with negotiating outness and self devaluation inherent to internalised homophobia (Frost & Meyer, 2017; Meyer & Frost, 2012; Meyer, Schwartz & Frost, 2008). Meyer (1995) suggests that the excess stressors faced by sexual minorities can present as both proximal and distal stressors, and that individuals may or may not be consciously aware of the stressors they encounter or the resulting impact on their mental health. A tendency to minimise experienced stressors is common in order to also minimise one's minority status, in attempt to reduce feelings of otherness and increase feelings of 'normality'. With regard to sexual minorities, a minimisation (i.e. hiding or denying one's LGBTQ+ status) is more possible than when belonging to other minorities where visibility does not allow for concealing of that part of one's identity (e.g. with regard to race, ethnicity, physical disability). Thus, Frost, Lehavot and Meyer (2015) highlight how some forms of minority stress relate to any socially stigmatised minority group, while concealment of sexual minority status (i.e. outness) and the potential for resulting internalised homophobia are experiences unique to those belonging to sexual minorities.

Minority stress theory is also useful in theorising more directly about self-injury in that, stigma related to self-injury (and to a lesser extent to mental health difficulties in general) may also be subject to similar discrimination and prejudice as other minorities. In the same way that gender and sexual minorities are subject to excess stress, individuals who self-injure are also subject to specific stressors resulting from stigma, actual and perceived discrimination directly due to their engaging in self-injury. In the same way as sexual minorities negotiate outness, those who self-injure may also

experience a similar negotiation around disclosing and concealing their self-injury. As a consequence, the self-injurious part of one's identity has potential to be associated with high levels of distress and feelings of shame, much like internalised homophobia in sexual minorities. It is possible that individuals identifying as LGBTQ+ who also self-injure experience a unique stress as a result of their intersecting minority identities. Other examples of intersectionality between sexual minorities and other minorities include LGBTQ+ people who also identify as a person of colour, as having physical disabilities and as belonging to religious minorities. As a result of these kinds of intersecting identities, research suggests that stress and identity difficulties are higher and are uniquely experienced by those identifying as belonging to multiple minorities (Ramirez & Galupo, 2019; Miller, 2018; Alvi & Zaidi, 2019).

Research into minority stress and the impact on physical health for sexual minorities has its limitations. Cross-sectional data that relies exclusively on subjective reports has implications for conceptual and methodological reasons. Firstly, these subjective reports are unable to account for the effects of minority stress where individuals do not see discrimination or prejudice as the cause of an adverse life event. Secondly, self-report measures are vulnerable to reporting bias of stressful life events as reporting may be correlated with individual and situational characteristics (Dohrenwend, 2006). Individuals may (perhaps unconsciously) attribute causes of negative life events to prejudice and discrimination in order to avoid self blame (Major, Kaiser & McCoy, 2003) or may be reluctant to attribute negative life events to prejudice and discrimination in order to minimise psychosocial disruption (such as distrust for others, anxiety and stress, social or workplace conflicts) which can occur as a result of falsely attributing events to prejudice (Barrett & Swim, 1998).

Frost and colleagues (2015) conducted a study which sought to overcome the above limitations of relying on self-report data alone. The study sampled a diverse and

ethnically representative group of adults from community settings. Participants completed a set of self-reports measures of minority stress as well as externally rated forms of minority stress, using a narrative life event interview and rating method. Interviews were then rated by two external raters on several different dimensions regarding whether or not prejudice was involved in the events participants shared during interview. Researchers also gathered data regarding self-appraised reports and externally rated reports of physical health. Results reported that the odds of experiencing a physical health problem during the one-year follow-up were three times higher among sexual minorities who had experienced prejudice events, as compared to those who did not. This result was found to remain robust and statistically significant even after adjusting for externally rated non-prejudice life events.

In summary, minority stress theory suggests that those identifying as LGBTQ+ and who self-injure experience an increased psychological burden as compared to those identifying as cis-gender heterosexual who do not self-injure as a result of their intersecting minority identities. Given that prevalence of not only mental health difficulties in general, but more specifically of self-injury is significantly higher in LGBTQ+ people, minority stress theory may help account for this increased incidence and be useful in conceptualising about the experiences of those individuals.

1.14. Relevance to Counseling Psychology

Research into self-injury is vast and has focused on factors such as prevalence, functions, co-morbidities, risk factors and theoretical models. However a lack of consensus and understanding still exists in terms of both research and treatment and this may be attributed to the complexity, multi-functionality and variable nature of self-injury. An integrative approach, with a focus on interpersonal aspects and

phenomenology, requires clinicians to conceptualise and practice flexibly when working with the changeable presentations of those who self-injure. Kasket (1012) argues that the pluralistic orientation of counselling psychology, especially the relational focus and the flexibly integrative stance of the therapist, lend themselves well to practice within this field.

This research focuses on the experience of self-injury in LGBTQ+ adults who are not receiving any clinical input. Thus, there exist multiple layers of sensitivity which counseling psychologists are particularly well trained and equipped to manage. The stigma associated with both self-injury and LGBTQ+ identities, as well as the potential hesitation of those identifying as LGBTQ+ to engage with mental health, (especially for the sought 'non-clinical' individuals for this research) due to risk of encountering professionals as pathologising (Welch et al., 2000), means that researchers and clinicians working with such individuals who are marginalised in multiple ways and who struggle with seeking help (McDermott, 2015) can be difficult to engage. A sensitive, relational and validating approach is essential for working with such individuals, which counselling psychologists are able to provide.

The HCPC's (2015) Revision of the Standards of Proficiency for Practitioner psychologists specifically emphasises the counseling psychologist's ability to implement therapeutic interventions based on a range of evidence-based models of formal psychological therapy. The pluralistic orientation of counselling psychology (Kasket, 2012) combined with its Rogerian conditions and focus on phenomenology rather than categorisation, suggests that this research is particularly appropriate for counseling psychologists to engage with both in terms of research and practice. Finally, the IPA methodology employed in this research is also particularly suited for counseling psychologists to engage with. While IPA considers the theoretical background relevant to the topic of exploration (as outlined in this chapter), it

approaches the research question with an open mindedness, making no assumptions or attempting generalisations, instead recognising the highly idiographic nature of the experience.

1.15. Summary of Rationale and Research Question

This literature review outlines how self-injury is a vastly researched and theorised phenomenon; nevertheless it remains a major health concern globally and lacks consensus. The experience of self-injury within the adult LGBTQ+ population has received less attention, perhaps in part due to difficulties with sampling, nevertheless the need to develop a better understanding of lived experiences calls for further investigation.

While there is a significant body of research exploring self-injury in those identifying as LGBTQ+, the vast majority of this research is quantitative or reviews existing quantitative research (Smalley, Warren & Barefoot, 2016; Jackman et al., 2019), focuses on adolescent populations (Fraser et al., 2018; DeCamp & Bakken, 2016) due to the typical onset of self-injury during this developmental stage, or focuses on clinical adult populations (Hawton et al., 2014; Creswell, 2005). A phenomenological understanding adult LGBTQ+ individual's experience of self-injury, remains under researched.

Existing qualitative studies around the experience of self-injury in LGBTQ+ individuals highlight that self-injury can be understood as a coping response arising within a social context characterised by abuse, invalidation and the experience of being perceived as different or unacceptable in some way due to one's sexual orientation (Alexander and Clare, 2004) thus increasing already held negative views of the self. Other qualitative research focusing on LGBTQ+ youth's cyber-talk found that individuals directly linked their self-injury to experiences of homophobia (McDermott, Roen and Piela, 2015).

While these studies suggest that individuals identifying as belonging to multiple minority groups (due to self-injurious and LGBTQ+ identities) experience an emphasised sense of struggle relating to their minority status, research focusing on LGBTQ+ adults rather than youth, remains under researched. The experience of homophobic discrimination and stigmatization for LGBTQ+ individuals is known to continue into adulthood (van Beusekom et al., 2018; Wandrey, Mosack & Moore, 2015), and warrants further attention.

In addition, researchers exploring self-injury in LGBTQ+ people, face difficulties in recruitment which have led to researchers relying on clinical samples, which limits the amount of inferences that can be made from emerging results. Given the high number of individuals who self-injure and do not seek help, finding ways to reach these individuals seems of paramount importance, especially given the risks associated with self-injury, and the significantly higher likelihood of mental health problems for LGBTQ+ individuals.

To my knowledge, there are no studies adopting a qualitative phenomenological approach to explore self-injury within a sample of non-clinical LGBTQ+ adults, as is the aim of this research. As such, my research question is as follows: **How does an LGBTQ+ individual experience and make sense of their self-injury?**

1.16. Reflexivity

My interest in self-injury stemmed from clinical experience of having worked with a diverse range of individuals who self-injure in a variety of clinical settings. As a nursing assistant I worked on an adolescent psychiatric unit where trying to prevent and manage self-injury was a daily task for the team. I recall being often shocked by the lengths to which individuals would go to engage in self-injury, as well as the severity of the ways in which they would self-injure. With hindsight, as I recall working in this

setting I am again struck by the severity of the self-injury I witnessed there and only now, with more years of experiences behind me am I able to reflect on how those acts I witnessed must have been accompanied by such emotional turmoil. Being exposed to severe self-injury at that early stage in my career on a daily basis evoked in me strong emotional reactions, yet there was a disconnect between my observing those acts and meaningfully connecting them with the emotional distress of those engaging in self-injury. I felt frustrated that my understanding of and ability to respond therapeutically to this phenomenon was lacking.

As my career developed and I worked within a crisis resolution team as well as a community mental health team my exposure to self-injury in the clinical population increased. Working with self-injury outside of an inpatient unit was daunting and I was able to recognise just how common it is in community metal health settings. I was also able to see the impact on services where risk management was paramount, and much training was delivered to address this with staff. Training equipped me to assess, record and communicate about risk, but it did not address my desire to really *understand* self-injury.

When I began working on a one-to-one therapeutic basis with clients, first within IAPT settings and then within a variety of other clinical settings, I was able to explore more first hand accounts of my clients' experiences of self-injury. Within NHS settings I often felt frustrated by high case loads and supervisory emphasis on assessing and documenting, which I felt prevented me from actually understanding and working *with* self-injury. I recall many times leaving work after having conducted 5-6 risk assessments per day and knowing that I had followed all procedures, documented accurately, liaised with relevant other services and put everything in place which my job role and supervisors required, but feeling as if I did not have the time or skills to

attend to the individual behind the risk. This repeatedly left me with a sense of anxiety and frustration.

The high prevalence of self injury amongst LGBTQ+ individuals was something which held my attention and I felt a growing desire and sense of responsibility as both a counselling psychologist and an LGBTQ+ person, to try and improve my ability to understand and work with self-injury within this population. Being introduced to qualitative research methods and in particular to phenomenology during my doctoral teaching, I felt I had found an approach which would address my desire to explore the subjective experience of and meaning making around self-injury by those engaging in it.

1.17. Conclusion

This chapter provides a review of the existing literature around self-injury and more specifically self-injury in individuals identifying as LGBTQ+. The emergent research question aims to explore the experience of self-injury in non-clinical LGBTQ+ adults through employing an interpretative phenomenological analysis approach. The following chapter will provide an account of the process of my chosen methodology aiming to address my emergent research question.

2. Methodology

2.1. Overview of Chapter

This chapter will outline and discuss the rationale for adopting a qualitative phenomenological approach as well as the philosophical underpinnings associated with this approach. An account of my research design and procedures will be given in

order to ensure transparency of the steps taken during data collection and analysis. I discuss the strengths and limitations of my approach, and explain why it was chosen over others.. I will conclude by offering my reflections regarding the methodology used and my personal reflections as I undertook this research.

2.2. Rationale for Adopting a Qualitative Approach

As outlined in the preceding literature review, existing research into self-injury and more specifically into self-injury among those who identify as LGBTQ+ has largely relied on pre-designed self-report measures, which omit the meaning making process around these experiences for the individuals who engage in it. The rationale for this research was to examine the subjective experience of and the meaning making around self-injury among those with LGBTQ+ identities. Therefore, the use of a qualitative approach relying on in depth semi-structured interviews seemed appropriate (Robson, 1999; Smith, 1995)

It is of importance to note that quantitative research within the field of self-injury has yielding many important findings and contributions to the topic. Silverman (2010) reminds us that it is not that quantitative research is ‘wrong’ or ‘inappropriate’ for certain topics, but rather that one’s research method should be selected on the basis of the research aims. The aim of this research was not to explore a causal or explanatory relationship between identifying as LGBTQ+ and engaging in self-injury, as it was evident in the early stages of planning that self-injury research requires consideration of multiple and interacting etiological factors (Hawton, Saunders & O’Connor, 2012), as outlined in the literature review. Instead, the aim was to explore lived experiences of self-injury in LGBTQ+ adults.

2.3. Ontology, Epistemology and Methodology

The paradigm one adopts when engaging in psychological research is informed by a conceptual framework based on ontological, epistemological and methodological assumptions. When developing any given research strategy, Mason (2009) emphasises the importance of ontological meaningfulness and epistemological explainability. Ontology refers to beliefs about the nature of the world while epistemology refers to theory of knowledge. Thus, translating this to psychological research implies that ontology concerns the type of knowledge to be gained (i.e. what there is to know) and epistemology concerns how this knowledge can be gained (i.e. how can we know about this phenomenon?), (Willig, 2013; McLeod, 2011). The ontological stance one adopts therefore informs ones choice of epistemology and methodology.

2.3.1. Ontology

After some consideration about my research question and personal approach to both my research and clinical work, I felt that a critical realist ontological stance was suitable. Critical realism emerged in the 1970s and 1980s through the works of Bhaskar as a scientific alternative to positivism and constructivism (Denzin & Lincoln, 2011). As a philosophy of science, critical realism functions as a methodological framework for research but is not associated with any particular set of methods (Fletcher, 2017).

From a critical realist standpoint, multiple and differing experiences of both self-injury and sexuality may be conceptualized as ‘real’ and ‘valid’, without requiring adherence to any one objective ‘truth’. Thus, the complex and idiosyncratic aspects of participants’ experiences are able to be viewed as occupying multiple truths, all equally valid, without the need to conform to any kind of ‘external validity’ parameters (Willig, 2008). Critical realism would therefore allow me to consider multiple, differing and equally valid perspectives of reality, regarding participants’ accounts of both their self-injury

and sexuality. Given that the focus of this research was a naturally occurring phenomenon (self-injury), it was also important to consider the plethora of interacting causal factors which may (or may not) be at play during any given time (Pocock, 2013), and how this might sit within the framework of my ontological stance. To this extent, the suitability of critical realism was further evidenced as it was deemed to be a fitting framework from which to explore and understand the self-injury and sexuality within changeable contexts.

Furthermore, critical realism also allowed me to consider my role as both the interviewer gathering data and the analyst of this data as shaping reality through my own limitations and biases (McLeod, 2011), thus enabling me to recognise and reflect on my own role within the research, which felt of paramount importance to be able to do.

Finally, critical realism suited my role as a counselling psychologist in that, I would be able to see participants' experiences as 'true', focusing on the subjective and attempting to immerse myself in their reality rather than proceeding with any predetermined clinical models or theories in mind. The reflexivity inherent in counseling psychologists' tool kit as well as it being a fundamental aspect of critical realism, positioned me well to work within a critical realist framework and reflexively recognise my own role in the research process.

2.3.2. Epistemology

When reflecting on my epistemological stance it was necessary to consider how my qualitative approach would sit within the context of a scientific process which allowed for multiple (and subjective) realities. This seemed of particular significance given my role as a scientist-practitioner. Given my ontological stance, epistemic relativism was briefly considered, but did not chime well with my personal approach to the nature of knowledge and how it can be known. While I was aware that participant narratives

would represent their own varying versions of reality, I also felt it important to adopt an epistemological stance that would accept their subjective realities as 'true'. From a critical realism perspective, it is assumed that there is no way of knowing about things except for under transient and historical descriptions (Archer, 1982, 1995; Little, 2016; Sayer, 2000). Thus, individual experiences (and therefore realities) are seen as fallible where no real truth exists outside of the parameters of historical time (Sayer, 2000). Therefore, in addition to not chiming well with my personal stance as a scientist-practitioner, critical realism was also seen as risking an epistemology which might somehow negate the experiences and realities of participants. Given that this research would be exploring the experiences of individuals belonging to stigmatised groups and would be reflecting on intensely sensitive and private aspects of their lives, it felt of paramount importance to consider an epistemology which was more able to accept and value their experiences as (albeit, subjectively) 'real' and 'true'.

Contextual constructionism states that 'individuals are continually engaged in a process of appraising their environment and acting on the basis of this sense-making processes' (McLeod, 2011, p.52). Individuals' experiences of phenomena are seen as rooted in the contexts within which they are experienced, and within which reality is constructed. As such, it does not suggest that any specific methodology will enable the researcher to discover any one reality or truth, but instead that context and the process of continual subjective appraisal is what leads to meaning-making. Contextual constructionism would therefore allow space for participant accounts as well as my own subjectivity within the research process where our understandings, perceptions and interpretations were seen as part of the process, rather than a hindrance.

In adopting a contextual constructionism epistemology, there exists an assumption that knowledge is local, situational and often provisional, but that phenomena do indeed

exist (i.e. it does not assume non-reality), and that phenomena can be effectively explored using certain methodologies (Willig, 2013).

Importantly, contextual constructionism therefore felt coherent with my ontological stance of critical realism as neither positions assume any one reality or truth can be discovered through adopting any one particular methodology. Instead, contextual constructionism assumes multiple dimensions influence how an individual constructs and produces knowledge, which would also allow space for my own understanding and interpretations (constructed within and subject to my own context) throughout the research process (Pidgeon & Henwood, 1997).

Given the multiple contexts and realities which were to constitute the emergence of knowledge in this research it was also important for me to note that within contextual constructionism 'there is a desire to find some kind of grounding for results' (Madill, Shirley & Jordan, 2000, p.9). It was noted that this would ensure that getting lost in co-constructed versions of reality, which risk moving too far away from participants' narratives would be minimised. Given my qualitative method, emerging data would need to be firmly grounded in participants'' narratives and detailed descriptions, representing experiences of the phenomena of self-injury as individuals who identify as LGBTQ+.

2.3.3. Methodology

Interpretative phenomenological analysis (IPA) was deemed the most suitable and appropriate qualitative methodology for this research, given its consistency with my chosen ontology and epistemology, as well as its ability to enable me to focus on participants' lived experience and meaning-making.

IPA is a qualitative approach founded by Jonathan Smith in the 1990s, deriving its philosophical roots from the phenomenological writings of Edmund Husserl, Martin

Heidegger, Maurice Merleau-Ponty and Jean-Paul Sartre. Husserl determined this approach as striving to 'go back to the things themselves' and emphasised the importance of phenomena being explored through the here-and-now lived experience of those who experience them, albeit through the lens of the researcher and their interpretations (Smith, Flowers & Larkin, 2009). Thus, IPA positions itself as not claiming to provide either true or false statements about the world (Willig, 2008). Furthermore, given that this research aimed to make sense of participant experiences (rather than to simply describe them), an interpretative phenomenological approach was selected over a descriptive one. In adopting this interpretative phenomenological approach, participants' initial 'descriptions' are said to be able to be positioned within the context of wider social, cultural and perhaps even theoretical contexts, (Larkin, Watts & Clifton, 2006). IPA allows for a learning about phenomena through a commitment to exploring experiences in context, in keeping with my chosen contextual constructionism epistemology (Larkin et al., 2006).

Rather than building knowledge and understanding based upon theory, IPA emphasises the richness and depth of understanding that can arise from exploring subjective experiences, while allowing for multiple realities or truths. As such, IPA suited my critical realist ontology and contextual constructionism epistemology. IPA allows the researcher to conduct in depth exploration of life events described by participants through a process of interpretation and reflection, where the they engage closely and iteratively with the participants' words while paying attention to how her own biases and contexts influence these interpretations (Willig, 2013).

Smith (1996) recommends IPA for research in the fields of health and counselling psychology. It is also often applied to research exploring peoples' perceptions of illness, and has increasingly been adopted in the exploration of sexuality and identity development (Smith, 1999). As I considered qualitative approaches for addressing my

research question of ‘How does an LGBTQ+ individual experience and make sense of their self-injury?’ the methodology and philosophical underpinnings of IPA were appealing in that, the very purpose of IPA is to provide participants with an opportunity to express their lived experiences and for the researcher to conduct an interpretative investigation (Smith, Flowers & Larkin, 2009).

The phenomenological focus of IPA denotes the researcher suspends their natural attitude regarding taken-for-granted knowledge and scientific approach to understanding phenomena (Van Manen, 2014). In addition to this suspension of beliefs, Husserl advocated that a process of ‘reduction’ should take place. The notion of reduction in IPA is complex and has been interpreted in various ways. One interpretation of reduction sees it as representing a process of reflection on the most fundamental elements of individuals’ lived experiences (Van Manses, 2014). The suspension of beliefs in IPA is eloquently described by Merleau-Ponty as combining with reduction to ‘slacken the intentional threads which attach us to the world and thus brings them to our notice’ (Merleau-Ponty, 1962, p. xiii). Consequently, IPA encourages researchers to reflect on the nature of phenomena with ‘new’ eyes while also bracketing their own assumptions (both theoretical and emotional). With regard to this research, those IPA notions of suspending belief and reduction were seen as underlying an ability to explore the experiences and meaning-making around self-injury within the context of an LGBTQ+ identity.

In addition to phenomenology, IPA is underpinned by hermeneutics and idiography. Hermeneutics can be described as the theory of interpretation (Smith, Flowers & Larkin, 2009) and is concerned with the context of a text’s origin and the context of the interpretation. Hans-Georg Gadamer, a contributor to hermeneutic theory, suggests that researchers often come to understand their own biases and preconceptions around a research phenomenon through the process of interpreting data. For this

reason, IPA researchers acknowledge their biases and reactions to the data throughout the research process. Hermeneutics operate on many levels during the research process, where participants make sense of their experience, researchers make sense of the participant's making sense of their experience, and the reader makes sense of the researcher's making sense of the participant's making sense of their experience. This is referred to as the double hermeneutic. The so-called hermeneutic circle is concerned with the relationship between the part and the whole (Bontekoe, 1996), which presumes that neither the part nor the whole can be fully understood without looking at both in relation to each other. Within IPA research, the hermeneutic circle comes into effect when the participant's words can only be understood within the context of the whole interview, or when the interview adopts a meaning through interpretation within the context of the research project as a whole. The non-linear and iterative nature of IPA research is founded on the principle of the hermeneutic circle and offers IPA researchers a rich and relational means of making sense of data gathered.

Idiography is concerned with the particular (Smith, Flowers & Larkin, 2009) and its influence on IPA can be seen in the focus on understanding particular experiential phenomena from the perspective of particular people, in a particular context. In emphasising the particular, idiography sacrifices the ability to draw generalisations thus, generalisability is not the aim or within the remit of IPA research. Given the highly idiographic nature of the development and experience of both self-injury and sexual identity, this focus was seen as invaluable and necessary within the context of the present research. Idiography in IPA emphasises that researchers should recognise the limits of generalisability and instead make a commitment to the case (Brocki & Wearden, 2006). The participants' narrative is said to take center stage in IPA research (Smith 2011), and within the context of this study focusing on the very idiographic phenomenon of self-injury within the context of also very idiographic sexuality, it was

deemed that IPA would allow for the most important elements of this research and indeed of participants' experiences to be captured.

Finally, IPA also appealed to me as a clinician. Counselling psychologists seek to accompany others through subjective experiences (Raflin, 2010) and while my role as researcher is quite different to my role as practitioner (and was indeed something I aimed to bracket and separate as far as possible) immersing myself into the world of another was something I felt equipped to do as a counseling psychologist.

2.4. Limitations of IPA

It was important for me to consider the limitations of IPA in order to be aware of them throughout the research process. Giorgi (2011) offers a comprehensive critique of IPA in an 'open letter' published as a journal article in which he discusses with Jonathan Smith the methodological limitations of this approach. Giorgi states that Smith confuses Husserl and Heidegger's original phenomenological and hermeneutic theoretical framework and approaches the method with a reductionist view in comparison with the original set of ideas.

In addition, Giorgi critiques IPA as not being scientific enough as a method of enquiry as it cannot be replicated, thus reducing its reliability and scientific rigor. While IPA allows or an in depth accessing of participants' and researchers' interpretations, it has been critised for being theoretically insubstantial. As Willig states, IPA 'describes and documents the lived experience of participants but it des not attempt to explain it (Willig, 2008, p.68). With regard to this research as a doctoral thesis, I was aware that applicability to professional practice was essential and would need to be fully developed (Kasket, 2012). Thus, IPA was perhaps not the most suitable approach. Despite these limitations, IPA researchers of course strive to relate and situate research within the context of existing literature (Smith, 2011), as if evident for this

research in the previous chapter. While IPA does not allow for generalisations, it does instead open up a dialogue with extant theory (Larkin & Thompson, 2012).

Giorgi also argues that IPA's flexible approach is lacking a sufficient and necessary articulation of clear steps for application, and that this is detrimental to its scientific status (Giorgi, 2011). Smith has since defended IPA by stating that IPA does indeed prescribe a fixed procedure for researchers to follow, but acknowledges that these steps are not fixed in any particular order and that often researchers apply these steps in varied and flexible orders. As a consequence, the steps applied in IPA are carried out differently by different IPA researchers (Smith, 2010).

2.5. Consideration of Alternative Qualitative Approaches

Various other methods were considered before choosing IPA, including Grounded Theory (GT), which has been deemed comparable to IPA (Willig, 2013). The relationship between these two methods was explored in order to make sure that the methodological choice was informed and transparent.

Like IPA, GT offers a systematic approach to analysis within a qualitative research framework. Glazer and Straus (1967) developed GT as an inductive method with sociological research in mind, which locates itself within a constructivist-interpretivist paradigm. As Ponterotto (2005) notes, counselling psychology has historically been dominated by qualitative research adopting GT. While developing an explanatory model may have been suited to this research, with the potential for generating a framework allowing professionals to better understand self-injury within the context of LGBTQ+ identities, Willig's (2008) distinction that GT looks 'from the outside in' and IPA looks 'from the inside out' was important in that, it highlighted how my aim was to emphasise the individual experience of participants. I was concerned with the nature of experiences and the essence of self-injury, rather than focusing on social processes,

as GT might do. GT is epistemologically rooted in contextual constructionism (as is this research), yet its ontological assumptions are not coherent with the aims of this research and philosophical stance of the researcher.

Also similar to IPA, GT offers researchers a procedure by which to identify themes emerging from the data, with a focus on capturing the true nature of a phenomenon and the meaning attributed to it. However the ultimate aim of GT research is for the researcher to be able to develop a theory grounded in the data they have gathered (Willig, 2013; Charmaz, 2010), while IPA makes no such attempts. Instead, IPA focuses solely on the exploration of the lived experience of the individual, perhaps allowing researchers more freedom to immerse themselves in the data analysis and interpretation process.

One of the advantages of GT is that it allows the researcher to conceptualise the individual's behavior as being both embedded in societal and cultural contexts and as possibly independent of these contexts. Furthermore, the methodology can be adjusted to fit either a positivist or an interpretative approach to knowledge, thanks in part due to the contrasting views of its founders, Glaser and Straus (1967). However this flexibility in GT approaches has been subject to much criticism and there remains a lack of consensus around the best way to conduct GT research (Charmaz & Henwood, 2013; Willig, 2013).

GT approaches claim to produce theory, but they have been criticised for making this claim given that results often remain descriptive. In addition, the detachment from data gathered in GT approaches, may be argued as preventing researchers from conceptualising participant's experiences as a whole. Thus, analysis and interpretation may also remain inadequate. The analytical and procedural approaches of IPA and GT approaches are somewhat comparable, despite that notably GT uses theoretical

saturation and involves an overlap between data collection and data analysis, while IPA does not (Smith et al, 2009). However GT is embedded in sociology, focusing on social processes. In contrast, IPA extrapolates lived experiences with more of a focus on psychological processes. The societal context and influence may well prove to be significant but are not deemed central in the present study; instead the psychological processes around self-injury and identifying as LGBTQ+ are the main focus of exploration. Coming from a counselling psychology background and aiming to explore the experience and meaning of self-injury, it seemed more appropriate to adopt an approach focusing on the psychological aspects of human experience.

Narrative analysis (NA) was also considered as an alternative qualitative approach for this research. NA focuses on how a person's life chronology and by processing data across the life span, researchers aim to understand current states (Bruner, 1991; Schegloff, 1997). As such, NA research identifies the stories told about a specific phenomenon within a culture or society. NA is underpinned by ontological relativism and epistemological constructionism (Smith 2013a) and as such, it is accepted that while physical realities exist, psycho-social phenomena are seen as multiple and as being created and dependent on ourselves, rather than existing independently of conceptualisations and interpretations (Sparked & Smith, 2008). Hence, narratives are seen as conceptions of truth and experiences which are not absolute, but instead are relative to the individual or groups of individuals communicating them. This did not sit well the critical realism ontology of this research where multiple and differing experiences of both self-injury and sexuality are able to be conceptualised as both 'real' and 'valid', without requiring adherence to any one objective 'truth'. Therefore, the subjective focus of this research did not fit well with the ontological assumptions of NA.

Epistemologically, NA's constructionism stance was well suited to my own epistemology, however the ontological assumptions of NA as well as the analytic method, did not suit my research aims. In contrast, IPA aims to assess how the person themselves perceive and make sense of their own experiences. As such, inherent in the IPA approach is a valuing of the individual lived experience and the unique perspective held about those events, from which researchers attempt to make sense of the participant making sense, and through the process of hermeneutics outlined above. The subjective nature of the focus in IPA was deemed more suitable for this research given the minority status of those taking part in attempt to value and emphasise their own experiences, albeit within the context of the researchers interpretations. The aim of this research to focus on subjective experience per se, rather than the manner in which experiences are made sense of through encoding them in a narrative and seeking connections between events, meant that IPA was deemed significantly more appropriate than narrative analysis.

Finally, thematic analysis (TA) was also considered as an alternative qualitative method to IPA given the similarities between the two. Like IPA, TA allows for organised and richly described information about the data. TA suited well the phenomenological stance of this research in that, it gives importance to the participant's perceptions, experiences and feelings as the focus of study (Braun & Clarke, 2006). The main distinction between IPA and TA is in the analytic process. TA, like IPA, involves a process of familiarisation with the data, followed by coding and generating themes. However, in TA themes are generated across the group, rather than initially individually, as in IPA. Given the focus of this research was individual lived experiences, and that the aim was not to make generalisations from the data, IPA's focus on deriving themes from individual interviews thus allowing for more of a focus on the subjective and idiosyncratic aspects of experiences, was deemed more suitable.

2.6. Validity

Concerns about validity and reliability are most often associated with quantitative research. However validity must also be considered by qualitative researchers in order to ensure robustness of findings (Smith, Flowers & Larkin, 2009). In this section I will outline the four notions of validity offered by Yardley (2000), and how they informed the present study.

Yardley's suggestion for the first step in striving for qualitative methodological validity refers to 'sensitivity to context'. There are various ways in which the researcher should pay close attention to the wider context of the study. The researcher's ability to comprehensively position the research within a socio-cultural context by exploring thoroughly the existing literature around the topic is one. In relation to this research, the existing literature regarding self-injury and more specifically self-injury research in the LGBTQ+ population was reviewed and critiqued, in the preceding literature review. The aim was to provide a rationale for why the current research is necessary. In addition, sensitivity to context was also important here given the sensitive nature of what participants would be discussing in interviews. Throughout the process of recruitment and data collection, I aimed to provide participants with containment and comfort, employing my relational skills as a trainee counselling psychologist, but being mindful of my primary role as researcher. I carried out telephone screenings prior to inviting participants for interview not only to assess suitability in terms of my inclusion criteria, but also to use this initial contact as a means of beginning to build a comfortable rapport. In keeping a reflexive diary, I was able to note down my reflections about engaging with the research process and this helped me identify any biases and contexts of my own, which might be impacting on the research process. My interview schedule was carefully designed being mindful of how participants would feel when

asked about potentially triggering aspects of their life. I also sought external input on my interview schedule, revising it several times following feedback from peers and my research supervisor. Adopting an IPA approach and staying close to participants' subjective experiences also felt like it contributed to my being sensitive to context.

Yardley's second principle in striving towards validity in qualitative research is commitment to rigor (Yardley, 2000). In IPA research, commitment to rigor may be demonstrated by sampling a suitable group of participants in terms of number, inclusion/exclusion criteria and homogeneity. Given the sensitivity of researching self-injury in a minority group, I had concerns about whether or not I would be able to recruit enough participants. Despite some early difficulties, I remained committed to the boundaries drawn by my inclusion and exclusion criteria, often reminding myself of the rationale for them, and I was eventually able to recruit a suitable sample; I feel that this demonstrates a commitment to rigor. Throughout the research process my aim was to completely embed myself into the IPA framework. The analytic process in particular required me to immersing myself into the words and experiences of my participants and I aimed to do this as deeply and accurately as possible. IPA requires the researcher to engage in an iterative process staying close to participants words, but also acknowledging their own contexts and how these may be contributing to interpretations. While this aspect of IPA was at times difficult for me, allowing space for reflection and thus minimising my own personal and unconscious biases in the interpretation process, also felt like an example of commitment to rigour. You could also say something about your adherence to Smith and al.'s analytical stages here.

'Transparency and coherence' is the third notion suggested by Yardley (2000) for ensuring the validity of qualitative research. Qualitative research methods may be perceived as less transparent than quantitative approaches, however, IPA purports transparency at every stage of the process and I feel I was able to offer transparent

and logical accounts of my decision making and interpretations throughout the process. Each stage of the analytic process is clearly outlined in the appendices allowing for transparency and readability. In addition, I include personal reflections regarding each stage of the research process in each chapter of this portfolio.

Finally, Yardley (2000) identifies 'impact and importance' as the fourth notion to consider for qualitative research validity. Despite decades of investigation, self-injury remains a major and multi-professional health concern, the importance of which cannot be denied. Furthermore, the alarmingly high incidence of mental health difficulties in LGBTQ+ people (including and specifically of self-injury) highlight the importance of this research. In adopting a qualitative and phenomenological approach, this research hopes to contribute an understanding of the subjective experience of self-injury (given the very multifunctional and variable nature of it from person to person) within a non-clinical sexual minority sample, making this research both important and impactful.

2.7. Sampling and Recruitment

2.7.1. Recruitment Inclusion and Exclusion Criteria

To be included in this research, participants needed to be at least 18 years old and had to have self-injured (as per definition in literature review) three or more times over their lifetime. Including only those participants who reported a total number of three or more lifetime incidents of self-injury felt necessary in order to ensure participants had sufficient experience of self-injury to be able to discuss in depth their experiences and meaning-making around it. In addition, participants were required to self-identify as LGBTQ+.

Exclusion criteria were that participants should not be receiving inpatient or outpatient care from mental health services, to ensure sampling of a non-clinical group of individuals. While advertising did garner a fair amount of attention, several volunteers

for participation were excluded as they were currently in receipt of mental health input (therapy, psychiatry, care teams etc.). In addition participants who reported being actively psychotic or suicidal were excluded (although this was not the case for any individuals volunteering to participate). Given IPA's emphasis on language, those who were not fluent in speaking English were also excluded, to limit the risk of misinterpretations during interview and analysis. It was decided not to exclude participants who still engaged in self-injury as their recent or current experiences of self-injury may still have been relevant for the purpose of this research. However it was important to transparently discuss the potential triggering effects of taking part in the research, and to take steps to minimize any potential negative impact on participants mental health.

In order to ensure that potential participants met the inclusion and exclusion criteria outlined, an initial telephone screening was conducted for those who expressed an interest in taking part. Given the above inclusion and exclusion criteria, If potential participants did not recognise any reason for not being able to take part, the researcher then took them through a brief verbal screening to double-check suitability. The telephone screening was conducted with sensitivity, ensuring that those who may be excluded on the basis of their mental state and history (e.g. suicidality and psychosis) or sexuality (e.g. heterosexual individuals) would not be unduly stigmatised.

2.7.2. Purposive Sampling

Purposive sampling refers to the method of choosing participants on the basis of a common 'lived experience', to fit the research objectives or the phenomena being studied (Smith, Flowers & Larkin, 2009). Participants were purposively sampled to take part in this study. IPA does not set a preferred number of participants and is instead concerned with a sample that provides enough richness of data to examine similarities and differences between cases while maintaining sufficient homogeneity in terms of

experience (Smith, Flowers & Larkin, 2009). Smith, Flowers & Larkin, (2009) and Langdridge (2007) suggest the average sample size for doctoral students as anything between 4 to 10 participants. Considering this, the potential difficulties in sampling from a minority group and discussions with my research supervisor about the size of my sample, it was agreed that I would seek to interview 6-8 participants.

2.7.3. Recruitment Strategy

Participants were recruited via advertising posters at various City, University of London campuses and via online support groups (e.g. 'Alumni', support group at selfharm.co.uk) and other online forums (e.g. DivaMag and PinkNews, both online magazines aimed predominately at LGBTQ+ individuals). Relevant permissions were of course sought from City, University of London and the relevant online groups and forums prior to advertising (see also the ethics section below). I was also open to recruiting participants through word of mouth, where if a peer, colleague or friend approached me with interest from a potential participant, I would send the individual relevant information about the research and invite them to contact me for a telephone screening. In appreciation for your time participants were given generic £10 vouchers valid for various high street outlets upon completion of the interview.

2.7.4. Sample

IPA prioritises the quality of the data gathered rather than quantity (Smith, Flowers & Larkin, 2009). With this in mind, I initially aimed to recruit eight participants. As stated in the previous section, while advertising did garner a fair amount of interest, upon further exploration it was clear that many were in receipt of mental health services and therefore did not meet criteria to take part. With the specificity of those individuals I was seeking to take part, as well as the further specificity with regard to non-clinical status it proved difficult to recruit eight participants. However after six participant interviews had been conducted, I felt that those interviews were rich enough for me to

address my research aims. My sample was also homogenous enough to satisfy IPAs methodological guidelines. Participants were aged between18 and 43 years old, all self-identified as LGBTQ+ and all had engaged in self-injury three or more times over their lifetime. All participants reported that self-injury was not currently something they engaged in (even if urges persisted) and that they would therefore be discussing retrospective experiences, nevertheless IPA can and has also been used to explore retrospective experiences (Van Parys, Smith & Rober, 2014) One participant reported frequently engaging in body modification and sadomasochistic practices, but she did not conceptualise these practices in the same way as her previous experiences of self-injury as defined in the more traditional sense. After reviewing her account and discussing this with my supervisor, I decided that including her would not compromise the homogeneity of the sample, and might even introduce an interesting variation. Given that participants had a history of self-injury, it was unsurprising that all reported a history of mental health difficulties ranging from (historical and current) anxiety and depression to borderline personality disorders and psychosis. None of the participants sampled were receiving mental health treatment of any kind. One participants reported receiving clinical supervision as part of her job role, and she queried whether this may be categorized as a 'kind of therapy'. However upon further exploration I was satisfied that while this did involve discussion of her personal circumstances and mental health, it was focused on her job role rather than personal life.

2.7.5. Initial Contact

Potential participants contacted me via email, text or phone call directly after hearing about the research via my various recruitment adverts, or through word-of-mouth. Following this initial contact, I emailed participants a copy of the participant information sheet (see appendix 1) which outlined the research aims and rationale, inclusion and exclusion criteria as well as basic information about what taking part would involve. If they still wanted to take part after having read the participant information sheet, I

scheduled a telephone screening in order to introduce myself properly and check that they met the inclusion criteria. During this phone call, which lasted 10-15 minutes, I reiterated the aims of the study and what taking part would involve.

I informed participants not only about the research, but about myself as the researcher, their rights to anonymity and rights to withdraw at any time, the level of involvement and the approximate length of the interviews. Importantly, I also raised the possibility of the interviews triggering difficult emotions, and emphasised that participants would be able to stop the interview or to take a break at any time. I also suggested that participants consider making plans with or arranging to have available to them someone whom they found supportive and would be able to talk to, if they found themselves feeling emotional in the hours following the interview. It was important for me at this stage to allow participants to feel at ease and to begin to build a rapport with them. Once participants had confirmed that they would like to go ahead and take part in the research, I arranged an interview time, date and location at their convenience.

Table I. Participant information

Participant (Pseudonym)	Age	Gender Identity	Sexual Orientation
Gene	20s	Non-binary	Bisexual
Helen	20s	Female	Bisexual
Sue	40s	Female	Lesbian
Anne	20s	Female	Bisexual
Toby	30s	Male	Gay
Erin	30s	Female	Lesbian

2.8. Data Collection

The data was collected via semi-structured interviews lasting between 60-90 minutes. Interview schedule (see appendix 2). I personally collected all data via individual and open-ended interviews. Interviews were recorded using 2 recording devices (one as a back up). All interviews were safely stored as encrypted files on an external hard drive.

2.9. Interview Schedule and Pilot

An interview schedule of 7 questions with prompts was developed. The decision to employ a semi-structured format was made in order to allow participants to be flexible guided rather than the interview being determined by my choice of questions and a rigid structure. The highly variable and idiosyncratic nature of individuals experiences of self-injury and their own sexuality meant that semi-structured interviews would allow participants to convey their own narrative and this was in keeping with my ontology, epistemology and methodology (Langdridge, 2007). Adopting a more flexible approach to interviewing also meant that I was able to establish a rapport more easily with my participants and gently probe for further exploration.

One question which I debated whether to include or not was question 6 of my interview schedule 'Do you feel that there is any association between your self-injury and your sexuality? And if so, in what way?' Initially I had felt that this question may be too leading and 'force' a connection. Smith, Flowers & Larkin (2009) state that researchers should not simply ask participants the research question and I was aware that this question may be too close to my research question, '*How does an LGBTQ+ individual make sense of their self-injury and how do they conceptualise it within the context of their sexual identity?'* I decided to include this question with the rationale that I would be able to establish a comfortable enough rapport and dialogue with participants, so that by the point in the interview where this question was asked, they would feel able to articulate agreement or disagreement and elaborate further, and this was indeed

the case. While some participants did indeed explain that for them there was a connection between their self-injury and sexuality (which I felt it was important to hear about in their own words), Three participants reported they did not perceive any direct relationship between the two and this allowed me to have confidence that the question was not too leading or forced. In fact, responses to this question proved to be quite insightful and rich and I was therefore glad to have included it, despite my initial concerns.

After having devised my interview schedule using my literature as a guide as well as Smith et al (2009) guidance, I conducted a pilot interview with a friend whom I knew had a history of self-injury. Although I had a familiarity with this individual which would of course not be the case with participants, it was a useful exercise in helping me to practice and reflect on my interview skills and schedule, prior to implementing it with participants. After conducting the pilot interview I asked my friend for feedback both in terms of my interview schedule and my interviewing skills. I also listened back to the recording of my pilot interview and was able to gain valuable insights and make some changes which I felt would improve the quality of interviews with participants, for example allowing the participant space and time to reflect during silences and waiting to see if they had anymore to add, before moving to the next question. I also had a tendency to give small acknowledgements such as 'Okay..' and 'Uh-huh…' while listening, which upon listening back to the recording felt somewhat disruptive to the participants train of thought. I noted that for future interviews it would be preferable for me to remain silent and rely on more visual and bodily signals to convey my understanding. I suspect this was due to my experience of engaging in therapeutic dialogue as a trainee counselling psychologist, which was spilling over into my role as researcher. I also found that I needed to have more prompts ready for each interview question in order to remind me to probe further instead of moving on to the next question, particularly when it felt as if there was more to be said. This technique of

moving from broader to narrower enquiry was very useful in later interviews. One interview question ('How has it felt for you to reflect on these experiences during this interview?') was eliminated after it was deemed to be irrelevant to the research aims. Having conducted the pilot interview I also decided that it would be helpful to state before beginning the interview that if the participants found they were repeating themselves, talking 'in circles' or not adhering to a linear timeline, that this was absolutely fine and not something to worry about but instead to simply talk as thoughts entered into their mind. For future interviews I found this to be very helpful in that, when participants revisited an aspect which they had previously talked about, the second time they accessed those memories they were often able to articulate the experience in a richer, more detailed and psychological manner.

2.10. Location

Five interviews were conducted at City, University of London, in a quiet, comfortable and private room. One interview was conducted in a private room within a local library. Each location was chosen according to participants needs for confidentiality, comfort and convenience. All locations also allowed for safeguarding precautions. Interview rooms were booked for 120 minutes and I made a point of informing participants of this, so that they did not feel preoccupied with the timeframe and in order to allow them time to settle, relax and make themselves comfortable before beginning the interview. Smith, Flowers & Larkin (2009) note that it is of paramount importance for the researcher to establish a rapport with participants prior to beginning. Given my clinical experience and training as a counselling psychologist, this was something I felt capable of doing. Booking rooms for 120 minutes also allowed for time to end the interview, debrief and say goodbye in a way that hopefully made them feel valued and not rushed. Two recording devices were used, one dictaphone and one recording application (Voice Recorder). Once recorded, all interviews were stored as encrypted files in an external hard drive.

2.11. Interview

Prior to commencing the interviews, participants were again talked through their right to withdraw at any time and anonymity, after which consent forms were signed and dated. I reminded participants that there were no 'right or wrong' answers and that I was not seeking specific responses from them but was instead interested in their personal experience and meaning making around these experiences.

Once the interview had been conducted, I stopped both recording devices, thanked participants for their time and began the debrief process by asking how they were feeling having taken part, allowing them time and space to reflect on the experience and thus encouraging them to attend to their emotional and mental state. No participants reported strong negative feelings after having taken part. Two participants reported feeling somewhat 'strange' and 'a bit weird' having reflected on their history of self-injury and their sexual orientation. Upon further exploration, neither reported that this strangeness was negative for them but simply that it was an unusual experience. Following my verbal debrief I also gave participants a debrief information sheet (see appendix 3) with some contacts for accessing support from various self-harm charities and services, should they feel the need to access them.

2.12. Ethical Considerations

Ethical considerations were of paramount importance for this research, given the sensitive and private nature of the material I was gathering (and also considering that there was a potential for this data to be published into the public domain). I made myself familiar with and mindful of BPS professional guidelines around informed consent, debriefing, confidentiality and protection of participants well-being (British Psychological Society, 2014). In order to ensure this was achieved, I was transparent with participants about the purpose and method of the research prior to them taking

part (during telephone screening and again prior to commencing the interview when I met with them), also enquiring if they had any questions or concerns before beginning the interview. In addition, a Participant Information Sheet and Consent Form were provided to participants by email after initial telephone contact, for them to read in their own time. Ethical approval was granted by the Psychology Department Research and Ethics Committee of City, University of London in May 2016 (see appendix 4).

I liaised closely with my research supervisor regarding safeguarding and lone working procedures when meeting with participants to conduct the interviews. To ensure participant confidentiality, I altered certain biographical details in the final write-up, being mindful to maintain the integrity of my interpretations.

There was also a possibility of participants disclosing emotional, psychological and physical health concerns to me. Emotional and psychological concerns are common in the sample population targeted, although my use of a non-clinical sample may have limited the severity of those concerns (as compared to a clinical sample). The risks arising from participants reflecting on potentially uncomfortable and distressing experiences was made clear during the telephone screening and prior to beginning the interview. Participants were reminded that the interview might trigger negative emotions, and that this might in turn trigger an urge to self-injure. I encouraged participants to be vigilant about either effect, and reminded them that they were able to stop the interview if needed. All written communication with participants made clear what steps to take if they were feeling distressed following the interview, i.e. contact details of professional support or emergency services, emotional support helplines and reminders of how to seek professional support if feeling at risk.

In order to monitor participants' well-being during and after the interview, I paid attention to any indication (verbal or non-verbal) that they might be becoming

distressed; if this occurred I would offer participants the opportunity to take a break, discontinue the interview until a later date, or simply discuss how they were currently feeling. If participants did disclose issues of concern regarding emotional and psychological health, I was prepared to support the participant by allowing them to voice concerns and offering to signpost to relevant specialist services who offer support for people who self-injure. In the unlikely event that during the interview I had serious concerns regarding participants' safety and de-escalation attempts were unsuccessful, I was ready to discuss this with participants and to contact the necessary emergency services, if appropriate. In addition, I was also aware that should I or the participants have any concerns regarding safety and well-being, I would encourage the participant to access support from their GP, who would be able to refer them on to psychological, social, medical support as necessary.

After having taken part in the interview, I reminded participants that they were able to contact me with any concerns or queries regarding their participation, keeping the lines of communication open. I had no major concerns about participants' well-being following the interview, and none of them contacted me.

I felt it was important to make clear from the onset that in taking part in this research, participants should not anticipate a therapeutic encounter. I was aware that my training and experience as a clinician were much more prominent and comfortable for me than my relatively new role as researcher. I therefore monitored myself closely during not only the interview process but during any interaction with participants, aiming to be empathic, containing and relaxed without shifting into my therapeutic mode, which risked generating emotional changes and interference within the subjective relating experience (Brinkmann & Kvale, 2008). During the first couple of interviews I conducted, I found my mind to be overly concerned with monitoring this shift into a more therapeutic mode. As participants spoke, I found it difficult to refrain from

attending to my own thoughts about what I was hearing, at times formulating around participants' narratives. I found this distracting and difficult to ignore initially, however, as I continued conducting interviews I found myself becoming more able to be present as a researcher and less distracted by such thoughts.

2.13. Analytic Procedure

2.13.1. Transcription

Smith and colleagues (2009) suggest that the transcription process should be undertaken verbatim, including breaks and pauses in sentences, overlaps in speech, repetitions, hesitancies and grammatical errors. Langdridge (2007) also suggests that transcribing data collected verbatim is important, but in contrast to Smith and colleagues, Langdridge asserts that paying overdue attention to the finer details of the data should not be the focal point when adopting a phenomenological approach. With this in mind, I proceeded to transcribe using Smith and colleagues' suggestions, while keeping in mind not to get too preoccupied. This proved difficult to do initially. However after transcribing the first two data sets I was able to negotiate this conflict within myself better and became more confident in feeling I was accurately capturing participants narratives during this phase of analysis.

The transcription phase was long and demanding, however I saw it as a crucial step in the analytic process of immersing myself in the data Once each data set had been transcribed, I listened to audio recordings again, while reading through my transcripts in order to ensure accuracy. Digital audio recording were stored in an external hard drive as encrypted files, and transcripts stored safely in a locked drawer.

2.13.2. IPA Analytic Strategy

Smith *et al.,* (2009) provide a thorough account of the stages of IPA analysis, which provided me with a sound step-by-step process to follow. I found this particularly useful given that this was my first time conducting qualitative research. I familiarised myself with the whole process of IPA analysis as outlined by Smith et al (2009) before beginning the initial coding stages, in order to ensure I began the analysis with a clear idea of what stage would be conducted next and what that would involve. Reminding myself of the so-called 'bigger picture' and entire process, helped me progress through the arduous task of analysis. Once all six transcriptions were complete. I was ready to begin focusing on analyzing each transcript individually.

Step one as suggested by Smith et al. (2009) involves the initial exploration of the data during which I carefully read and re-read the individual transcript, while listening to the audio recording. This step seemed repetitive but essential, in order to re-focus my mind on the transcript at hand and bracket off data from other interviews, with which I was very familiar at this stage. Once I was satisfied that I was able to focus my attention on the transcript at hand without too much interference, I began noting my initial observations and reflections in my reflective diary. This process is suggested by Pringle et al. (2011) as enabling the researcher to 'reduce the noise' around the transcript, and it enabled me to note down my initial thoughts and feelings about the data, which were often characterised by a therapeutic stance rather than a research stance. In completing step one and noting my initial observations I began to actively engage with the data in a way which felt as though I was entering into the participants world.

Step two of the analytic process according to Smith et al. (2009) involves concentrating on three different aspects; descriptive, linguistic and conceptual. I decided to conduct each of these three stages distinctly. Firstly focusing on descriptive noting, I found this somewhat overlapped with my initial noting from step one. Nevertheless, I read

through the transcript while listening to the audio recording and used blue ink to record descriptive commentary in the left hand margin. Next I moved on to linguistic commentary for which I used green ink, and I listened to the recording while reading the transcript once again. I paid attention not only to pauses, breaks and hesitations in the transcript but also to tone of voice, signs of participants becoming emotional or tearful, and any use of metaphor or language in a way which intrigued me. I also found it useful to underline or circle certain words or phrases in green ink within the actual transcript (rather than in the margins). Doing this allowed me to eye-ball sections of the data together which I saw as being associated linguistically (see appendix 5). One adaptation I found very useful during this linguistic commentary stage was to use a thesaurus to help me explore participants' choice of certain words. For example, when I came across a poignant or unusual word, I searched that word in a thesaurus and jotted down synonyms (and sometimes antonyms) associated to that word. I found this particularly helpful in exploring and grasping the essence of what was being said.

The final commentary to complete for step two was conceptual. Reading and listening to the data once again, I wrote down my conceptual notes in red ink, using the left margin as well as underlining and writing within the text itself (see appendix 5). The conceptual commentary stage was demanding and arduous but also satisfying. Having listened and read each transcript several times by now, I was enjoying being able to indulge my more pensive side and to explore the data in this way.

Step three of the analytic process involved developing and labeling emergent themes for each individual transcript in the right margin (see appendix 6). I struggled initially with this step of the process due to feeling quite overwhelmed by the amount of data I had and not wanting to exclude anything of importance. I read over sections of the transcript, often taking each paragraph at a time, reviewed my descriptive, linguistic and conceptual comments, and attempted to label each chunk of data with an

emergent theme which captured the essence of what I interpreted the participant was trying to communicate. During my first few attempts at developing emergent themes I was aware I was perhaps being too pedantic and I ended up with a large number of emergent themes for the first transcript. However, knowing that I would later be able to drop themes which held less weight or which were less relevant to my research question allowed me to progress. During this stage of analysis, I found that my circling and linking associated data with lines was very helpful and often my emergent themes reflected these visual associations I had noted. I still felt unease at 'chunking' or distinguishing between parts of the data in this way, given how interconnected whole interviews were. However, reminding myself that this process represented one manifestation of the hermeneutic cycle inherent in IPA analysis eased my anxieties. I also struggled on occasion with feeling like my conceptual commentary and emergent themes were too interpretative and were perhaps rooted more in my own reflections about the data, rather than what the participant actually said. Again I referred back to Smith and colleagues' (2009) guidelines for this stage, which highlight that with each stage of analysis the researcher will indeed be taken further away from the participant's words, but that this was part of the process and that the end result would be the product of a collaboration between myself and the participant. Given my anxiety about these issues, I double-checked and ensured my commentary and emergent themes were always rooted in the participants' words.

Having now completed initial noting, descriptive, linguistic and conceptual commentary as well as labeled emergent themes for one transcript, I created a table of emergent themes with corresponding associated quotes and page/line numbers for the entire transcript. An example of emergent themes with quotes can be found in appendix 7 .

Once I had finalised the emergent themes, I was ready to move on to Smith and colleagues' fourth step of the process, which is focused on searching for connections across emergent themes in order to develop super-ordinate themes for each individual

transcript. For this part of the process I trialed different methods until I found what worked best for me. Initially I used a whiteboard to list emergent themes, allowing me to see them all clearly and distinctly, move them around and begin attempting to meaningfully group them together. I employed abstraction, polarization, as well as grouping according to context and function, as suggested by Smith and colleagues (2009). Another method I trialed was moving themes around within the tables I had created on my laptop. Eventually I resorted to printing out a list of all emergent themes and cutting them up into small pieces of paper which I then laid down on a large clear surface, allowing me to eyeball them, repeatedly move them around while contemplating connections between them, and eventually group them into clusters which I labeled super-ordinate themes. During this process I kept referring to my table of emergent themes with quotes, in order to establish which emergent themes were prominent and which were not so prominent or relevant. In doing so, I began dropping emergent themes. When I was unsure about the importance or relevance of a particular emergent theme, I reminded myself of my research question and how the emergent theme would be relevant or not. This enabled me to have some clarity that I was not getting sidetracked by including themes which were perhaps interesting but less directly relevant. Once I was content with my list of super-ordinate themes, I added an extra column to my existing table of emergent themes with quotes, thus allowing me to include super-ordinate themes within the same table.

Step five as suggested by Smith et al. (2009) involves moving on to the next transcript and repeating the entire process for each of the six interviews. It was important to allow a period of time before moving on to the next case so as to ensure I was able to focus on the next case and its individuality, with minimal impact of the previous case interfering with my thinking. This was difficult but I found that noting down reflections into my diary helped, as did engaging in completely unrelated activities for some time before engaging with the next data set. This allowed me to view the next case with

'fresh' eyes as much as possible and ensured the idiographic commitment which is essential in IPA. A table of emergent themes and super-ordinate themes for all participants can be found in appendix 8.

The sixth and final step in the analytical process was to look for patterns across cases. I found that listing the emergent and superordinate themes for each interview on a large whiteboard on my wall allowed me to view the 'bigger picture' more easily. I found myself reconsidering things again and again over the course of a week, during which I relabeled and reconfigured them further. I reminded myself of the dual quality of IPA in that it captures and values individual participants' idiosyncrasies, who also share higher order qualities. At this stage, it was precisely these higher order qualities I was trying to recognise across all cases. During this process I was struck by just how much convergence there was between participants. Despite their experiences and narratives being quite different, there were undoubtedly similarities across all cases, which I found satisfying to explore. After much contemplation and repeated revision, I eventually felt confident enough to draw up a table of super-ordinate and major themes for the group, which can be found in Appendix 7.

2.14. Reflexivity

2.14.1. Methodological Reflexivity

The importance of methodological reflexivity when conducting IPA research is highlighted by many (Willig, 2013; Finlay, 2011; Frost, 2011. This position chimed well with my personal approach to research, and also with my research question which sought to explore the individual experience of self-injury among LGBTQ+ individuals.

During my masters degree many years ago, I recall being quite intrigued and fascinated by phenomenology as a concept but at that time I had no understanding of how phenomenology would translate into a research methodology in practice. I was

pleased to be able to develop my understanding of phenomenology within the context of counselling psychology, and over the course of my doctoral training this understanding grew greatly. I was aware that many of my peers were choosing to adopt an IPA approach but I was cautious to ensure that it really was suitable for my chosen research topic. During the early stages of planning my thesis (and indeed throughout the research itself), I considered carefully if and how IPA fitted within my epistemological and ontological stance.

I knew analysing text using IPA would be a demanding process. However, I also felt excited to be able to delve into so much detail for each participant.

Managing my ability to shift into a researcher role, as opposed to a clinician role with which I was far more experienced and comfortable, was not straightforward. While conducting interviews as well as in the analysis stages I felt as though I was frequently having to minimize my clinical stance. I found myself formulating and hypothesizing about what participants were telling me during the interviews, as well as during the transcription and analysis. While interviewing and transcribing it was necessary to stop, take breaks and use my reflexive diary often in order to allow my mind to settle down and bracket off thoughts which kept intruding but which were premature in the process or altogether irrelevant. However during analysis this was somewhat more manageable as even within my researcher role, IPA required me to interpret and analyse,

2.14.2. Personal Reflexivity

Personal reflexivity was important for me to consider throughout the process of conducting data gathering and analysis. I was aware that I needed to consider my own position in the world, with regard to self-injury and sexuality but also with regard to being a counselling psychologist and researcher embarking on a journey of exploration

around a topic which would potentially be highly sensitive for those participants taking part.

I felt an overwhelming admiration for those taking part in my research. I experienced them as brave simply for having taken part and being willing to share their story with me, a stranger. I reflected on my own openness about my sexuality and recall discussing with my research supervisor in the early stages how I would feel conducting a piece of LGBTQ+ research. I wondered if I was 'qualified enough' to conduct LGBTQ+ research, not from a professional or academic perspective, but from the perspective of my identifying as a member of the LGBTQ+ community and how I chose to express that outwardly or not, how much I knew about LGBTQ+ activism and LGBTQ+ mental health in general. I had friends who were very much involved in LGBTQ+ activism, academia, feminism and related fields, whom in comparison to I felt an amateur. This led me to consider how I would feel for the next few years discussing my research with other people. Indeed, I was advised by professors and peers to discuss my research with people in the field in order to broaden my thinking as much as possible. When I contemplated doing so, I wondered if people would assume my LGBTQ+ identity once they heard I was conducting this research. This caused an anxiety in me about having to negotiate my own outness to those who might otherwise assume my heterosexuality. I decided to remain transparent with participants who might ask about my own LGBTQ+ status, as I felt this transparency would be important. Once I made this decision, it no longer felt like a negotiation and instead felt like a part of my reflexivity and the research process as a whole. I discussed these anxieties with friends and peers throughout the planning and analytic process which helped in reducing them, simply by voicing them and also by receiving reassurance and advice in response. During this process I found myself reflecting on how self-care during the analytic process became essential for me, even at times when I was not focusing on my self-care, I was aware that I was not doing to so my own detriment. Seeking help,

support, reassurance and comfort was something I saw reflected in participants interviews and I was aware of that my understanding of the data was developing through my own experiences. Being cautious about how these experiences and reflections might impact on my assumptions about the data, I documented my reflections in my reflexive diary regularly. What motivated me through these personal reflections was my desire to contribute to better understanding the experiences of LGBTQ+ individuals who were struggling with their mental health.

I was somewhat surprised by how many participants directly asked about my sexuality. All except one asked if I identify or belong to the LGBTQ+ community. Whether or not I belonged to this community seemed important to them and when I reflected on how psychiatry/psychology has historically pathologised homosexuality, I was able to understand why they were interested in my identity. One participant directly stated that she did not want to feel 'like a guinea-pig being studied by a professional', and that given that I identified as LGBTQ+, she was reassured and willing to take part.

I was also struck by how affected I was hearing participants' experiences of their own sexuality and of coming out. Those in their 30s and 40s described more difficulties, while those in their 20s seemed to report less difficulty which I hypothesised was partly due to changes in societal attitudes. Nevertheless, all expressed confusion and distress at some point regarding their sexuality. When I was searching for patterns across cases I listed all emergent and super-ordinate themes on a large whiteboard in my bedroom and found myself often struck by a sadness and despair at the struggle which all participants had been through. Having been through similar processes myself around sexuality, I was aware that I was not alone and that many LGBTQ+ people have had similar experiences, but having delved into the world of six individuals and having their struggles printed on my walls for many days affected me; my abstract notion that everyone struggled with the process was brought to life and occupied a

very concrete space in my mind and in my environment. Several days into the process I decided to remove the whiteboard on my bedroom wall as it seemed to be contributing to a sense of 'heaviness' in my mind. I became acutely aware of how demanding the analytic process was and decided to limit the number of hours I spent analysing, before taking a break and physically removing myself away from my work desk. I made sure to interact with others during breaks by phone call, online or with flat mates which I found helped refresh and lighten my mind, allowing me to focus better when I returned to analysis. It became apparent that I needed to allow my mind to disconnect from the analytic process at regular intervals, despite feeling the urge to 'plough through' and not loose focus for the sake of taking breaks, which proved counterproductive in the early stages. Another particularly useful aspect of my self-care was using personal therapy to vent and express my anxieties, struggles and achievements also. I found my therapist to be incredibly empathic and understanding as to the difficulties inherent in writing a doctoral thesis, in a way that my family and friends (outside of the field of psychology) were not able to, and I valued this interaction each week.

In contrast, I also found it incredibly satisfying to hear about and reflect upon the positive aspects of participants experiences with regard to reaching a stage where they did not carry so much pain and struggle regarding their sexuality. Their narratives of pride, hope, belonging and acceptance were powerful and also impacted me.

While I have no direct experience of self-injury, I also found myself struck by some participants' accounts of violence towards themselves. More so than the actual physical act of harming themselves, I was struck by the feelings they reported around their self-injury and how self-critical their narratives were. This was something I was not prepared for but which I felt driven to attend to and focus on, despite my discomfort.

With regard to both self-injury and sexuality, whatever discomforts my personal reflexivity evoked in me, I had a growing sense of motivation and determination to capture my participants' experiences, doing them justice and producing a piece of research which would contribute to a better understanding of self-injury and LGBTQ+ mental health within the field of counselling psychology.

2.15. Conclusion

This chapter offers a discussion of my chosen ontology, epistemology and methodology, while providing the rationale for doing so, while rejecting other positions. Within this chapter I have also provided a detailed and transparent account of the methodological process undertaken, while offering an account of my personal reflexivity throughout the process. The following chapter will present an account of the super-ordinate and major themes emerging from the analytic process.

3. Analysis

3.1. Introduction

The aim of this chapter is to offer the reader an account of super-ordinate and sub-themes emerging from my analysis of data across cases. I will begin by briefly introducing each participant in order to establish relevant contextual factors. This will be followed by a table presenting super-ordinate and sub-themes, followed by a description of each theme, including quotes from participant interviews. It will also be possible for the reader to see a demonstration of how themes are in some cases converging or diverging, relaying participants' shared experiences as well as any differences in their experiences.

3.2. Introduction to Participants

The below summaries provide basic contextual information about participants at the time of interview regarding demographics, gender identity and sexual orientation as well as relationship status. Pseudonyms have been used and identifying details have been altered in order to preserve confidentiality of participants

Anne identifies as a bisexual woman and is aged in her twenties. Anne reported being single at the time of interview and of having a history of mental health difficulties since childhood, which is when her self-injury began in the form of cutting.

Sue identifies as a lesbian/queer woman and is aged in her forties. Sue reported being in a long term and monogamous relationship at the time of interview. Sue reported a history of self-injury through cutting, burning and hitting herself which began in childhood and continued into her thirties.

Erin identifies as a lesbian/queer woman and is aged in her thirties. Erin reported having experimented with her gender identity during adolescence and assumed the identity of male for a period of time, before later identifying again as female. Erin reported being in a long term and open relationship with her partner at the time of

interview. For Erin, Self-injury manifested as disordered eating, scratching and burning during adolescence.

Helen identifies as a bisexual/queer woman and is aged in her twenties. Helen reported being single at the time of interview. Helen's self-injury began during childhood and involved cutting herself. Helen described intermittent contact with health services over the years and at the time of interview, reported being on a waiting list for Dialectical Behaviour Therapy.

Toby identifies as a gay/non-heterosexual male and is aged in his thirties. At the time of interview, Toby reported being in a long term and monogamous relationship. During childhood Toby reported disordered eating for many years as well as an acute psychotic episode during his twenties. Toby reported self-injury through disordered eating, cutting and on one occasion through stabbing himself.

Gene identifies as gender non-binary (and will therefore be referred to using the pronouns 'they/them/their') bisexual person and is aged in their twenties. Gene reported being single at the time of interview. Gene reported a history of mental health difficulties including anxiety and depression during childhood and early adolescence. For Gene, self-injury occurred in the form of scratching and cutting.

It is important to note here that while all participants reported a history of mental health difficulties with some coming into contact with mental health services, no participants were receiving mental health services at the time of interview and none reported suicidality or psychosis, as per my exclusion criteria.

A significant challenge inherent within my research question was that it referred to two distinct yet connected phenomena: experiences of self-injury and experiences of

sexuality. Both experiences of self-injury and experiences of sexuality are equally complex and idiosyncratic, thus the themes emerging from the analysis represent their interconnectedness. Through description and explanation of themes emerging from the group, I will offer the reader an account of how experiences of self-injury and experiences of sexuality were often described as being experienced in similar ways by participants. A visual illustration of how experiences of self-injury and experiences of sexuality were often similar can be found in appendix 9 where quotes from transcripts are presented in different colours for self-injury (black) and sexuality (red) under the same theme.

It is also of importance to note that while the themes aim to capture the most salient and meaningful aspects of participants' experiences, as is the aim of IPA research, they do not offer a complete and total account of these experiences. A table of super-ordinate and sub-themes is presented below (Table A). A table of themes with recurrence across each interview can be found in appendix 10. Super-ordinate themes will be introduced, followed by related sub-themes which will be supported with quotes from interview transcripts. A table of super-ordinate and sub-themes with supporting quotes can be found in appendix 11.

Table II: Super-ordinate and sub-themes for the group

Super-Ordinate Themes	Experiences of the Self	Experiences of the Other	The Act Itself	Recovery

Sub-Themes	Conflicting self	Family	Intense emotions	A new perspective
	Otherness	It's hard to talk about	Anger	Taking control
	Defective self	Stigma	Effective self-injury	

3.3. Super-Ordinate Theme I: *Experiences of the Self*

On paper it looks fine, but of course that ugly beast is still there.

(Toby, 496)

The first super-ordinate theme of '*Experiences of the self*' emerged from participants' shared accounts of their own thoughts, feelings, actions, processes and beliefs about themselves, often positioned as being in contrast to alternative versions of themselves (e.g. past self, ideal self or desired self) or in relation to peers, family and their wider social contexts. Participants' experiences of the self were complex, fluid and often contradictory with regard to both self-injury and sexuality.

3.3.1. Sub-Theme I: *Conflicting Self*

The first sub-theme emerging under '*Experiences of the self'* is *'Conflicting self*'. The internal dialogue taking place within participants reflects a confusion and duality with regard to their self-injurious behaviours and the process leading up to it, as well as their feelings post self-injury. The conflict is focused around a desire to feel better or alleviate emotional distress but only feeling able to do so through self-injury, an act

which all participants acknowledged was effective but which they felt was also destructive for them. This paradox was reflected in participants' narratives:

> *And I don't know why I kept doing it for ages because afterwards I would always regret doing it but, at the same time I felt better for doing it so I was trapped in this spiral of needing to do it so that I could continue with what I was doing, but I hated that I was doing it as well. So… I couldn't win. (Gene, 295)*

The above quote from Gene exemplifies the confusion around their recurring urge to self-injure with *'I don't know why I kept doing it'* and their admission of *'regret'* after having done so. At the same time they acknowledge the motivation for doing so as *'I felt better… so that I could continue with what I was doing'* and therefore *'needing to do it*'. The quote implies a sense that there were no alternative options available to them and that if they were to function, self-injury was necessary. Gene then articulates how they felt *'trapped in this spiral'* and that they *'hated that I was doing it'* which implies another part of the self which does not like or approve of self-injury being the chosen means of coping. The simple and direct statement of '*I couldn't win'* captures well the conundrum they find themselves in. There is a sense that prior to self-injuring an intolerable state was being experienced which was perceived as only being alleviated by a solution which was also experienced as intolerable. Hence, the feelings of being trapped in a spiral are clear and understandable. Gene seems to connote a sense of feeling trapped in their confusion which may be perceived as contributing to a loss of agency which can be felt within this quote. The confusion within which they are trapped seems to 'need' self-injury in order to gain back a sense of control, despite the 'hate' of engaging in the act. Thus, it may be perceived that while self-injury seems to offer a sense of gaining control and agency over the moment, that this seems transient where the resulting regret and hatred of having self-injured seems to feed back into a

cycle of difficult and tumultuous emotions, hence their sense of '*I couldn't win'.* Gene's choice of language is interesting here and perhaps implies a sense of strategic game playing against ones self. By engaging in self-injury to manage one part of the self, another part of the self seems to have 'lost'. The conflict between these differing parts of the self is perhaps amplified by engaging in behaviours such as self-injury which emphasise the polarity between the parts.

Helen also expressed regret when describing the conflict between parts of herself:

> *I always regretted it. Yep. I always, I always regretted that I'd done it because I knew, knew that I shouldn't be doing it and I knew that it wasn't good for me. (Helen, 233)*

Helen's repetition of the word '*always'* in the above quote emphasises regret after each episode of self-injury. Helen expresses on a cognitive level *knowing* that she *'shouldn't be doing it'* and nevertheless reports doing it daily for a number of years. Thus, inevitably, different parts of the self struggle to accept and make sense of her experiences. Similarly to Gene, Helen also seems to *need* self-injury. The above seems to have a definitive tone where Helen is quite assertive in how she communicates her certainty that she should not have been self-injuring; it was not good for her. Her language may be said to reflect a kind of black or white thinking, where thoughts (I shouldn't be doing it) and emotions (regret) seem to be final. It may be interpreted that this reflects how Helen felt in those moments she is recalling where, similarly to Gene, a middle ground where different parts of the self are able to be considered, contained and satisfied without disrupting the other.

In addition to feeling conflicted about engaging in self-injury, Helen's sense of internal conflict extends further, to the meaning she attaches around her self-injurious identity:

> *… there was never a point where I felt like it was okay and that I wanted to do it but I kind of felt compelled… and yeah, it was really, really a struggle for me to sort of accept that that was who I was now. It was… that was one of my behaviors, one of my coping mechanisms. (Helen, 427)*

In her struggle to accept self-injury as one of her coping mechanisms, Helen seems to infer that her identity has somehow morphed into something else as a result and that this new identity (*'that was who I was now')* was not something she found easy to accept. Helen's reflections here are similar to how she and other participants speak about their identity regarding sexual orientation. It may be interpreted that while self-injury is seen as a necessary method for being able to function and cope with life, it is difficult to accept and integrate into their sense of self identity which is acceptable. Similarly, as will be explored later in this chapter, for some participants sexual orientation seems to be experienced as something innate and an aspect of their identity which they at some point in their lives have struggled to accept and integrate, albeit for differing reasons.

Toby also refers to a sense of conflict within himself:

> *So, I'm a big mess of contradictions to myself. (Toby, 655)*

While Toby's statement is short and pithy, his choice of language is poignant. He uses the word '*contradictions'* which is not precisely the same as 'conflicting' but connotes a very similar meaning. '*A big mess'* seems to imply that the contradictions within him are multiple and chaotic, perhaps resulting in a similar kind of confusion as communicated by Gene and Helen. It is noteworthy that Toby states he is a

contradiction *to himself.* Within this quote he seems to focus on how he himself cannot make sense of the mess within him. As such, we may infer that there are multiple selves within Toby where one self is observing the mess within him, and another *is* the mess within him. This interpretation can be further developed by considering the multiple selves as conflicting, or at least as being positioned as opposing one another. Toby continues to make references to what may be perceived as the differing and conflicting aspects of himself throughout his interview. Within the below quote he acknowledges both his sabotaging demonic side as well as his resourceful and resilient side:

> *It's a slap in the face reminder that I've got some demons that could ruin my life and have in many ways taken much of my life away from me. (Toby, 598)*
>
> *Yeah… It's definitely made me resilient and I'm industrious and resourceful and can make, make… the most out of anything really (Toby, 985)*

Toby offers us an insight into how he perceives and experiences himself as both demonic and capable of sabotaging himself, while at the same time having the ability to be resilient, industrious and resourceful. Toby's use of the phrase *'a slap in the face'* connotes a sense a sense of shock. The demonic parts of himself he speaks of seem to be experienced as suddenly and aggressively reminding him of how they could ruin his life. Inherent in this interpretation there is also a sense of loss of agency. Toby describes experiencing his *'demons'* as being able to *'take much of my life away from me'* evoking a sense of passivity where his demons dominate and he looses a sense of agency over them, and therefore also over his life. This presentation lies in stark contrast to the second quote above, in which Toby is able to confidently assert that his life experiences have not only made him resilient and resourceful but also

able to *'make… the most out of anything'.* Two interpretations are possible here. First, it could be perceived that in stark contrast to being taken over by his demons, Toby then speaks of being his resilience and resourcefulness in a very active way with a sense of overcoming. Upon further interpretation, an alternative perception is also possible. The tone and pausing within the second sentence of the above quote could also be interpreted as having a sense of resignation where the loss of agency is not regained or overcome, but instead is perhaps accepted and a passive resignation (albeit with an ability to continue) seems to taint the tone of his words. Both interpretations speak to an inherent conflicting sense of self.

Sue articulates a sense of conflicting selves within the following quote:

> *… 'cause I've gone in with this… Clearly an 'X' cut into my arm but… Uh… But I remember just feeling almost quite devious, feeling quite devious against myself. (Sue, 337)*

Here Sue's deviousness seems to be directed at herself in the form of self-injury and her choice of wording may be interpreted as connoting a sense of deception, dishonesty and a kind of strategic plotting against her own self. Within this quote there seems to be an additional level of complexity where two parts of the self are not only conflicting, but are also set against one another intentionally and willingly with a 'deviousness'. Post self-injury, the conflict appears to continue within Sue:

> *Afterwards I'd feel quite sad. I'd usually start crying and then I would feel guilty and think "Crickey, what a stupid thing to do. What am I going to do with that?" (Sue, 409)*

Sue's sad self seems to be quickly chastised by her critical self in the above quote. Later in the interview, another aspect of the self is also revealed with regard to Sue's self-injury:

> *I was always picking at scabs. Uhm, but then they'd bleed, then I'd have to wash it and put a bandage on it, look after it in a sensible sort of, almost, uhm… I think looking back at it maybe it was attending to myself where I possibly felt it wasn't getting it from my mother who was, uhm… In… In… In, a practical way a good mother but emotionally very... and still is very, uh… Detached from her own life and her own stuff and she can't deal with emotions and uhm… Uh… So… Yeah, so I think it was-… Yeah, it was definitely that sort of self-care, self-mothering sort of thing. (Sue, 232)*

Within this quote a '*sensible*' and *'mothering'* part of Sue is revealed. Sue's own interpretation insightfully suggests that this was possibly due to the lack of emotional mothering she was receiving at the time, perhaps also explaining why her sad self was so quickly chastised by her critical self; she may have been mirroring her mothers' perceived lack of empathy at the time. In describing her mother's inability to attend to the emotional, Sue perhaps also explains her own inability to attend to her emotional self without criticism and the sensible mothering side of Sue lies in contrast to the devious inflictor of cuts as well as the sad and guilty self (or selves) she refers to in the previous quote.

The theme of 'conflicting self' appears to represent within participants not only their experience of multiple and fragmented selves, but also how these different parts of the self often adopt opposing positions, thus exemplifying the paradoxical nature of the self-injurious act itself.

3.3.2. Sub-theme II: *'Otherness'*

The second sub-theme emerging under the super-ordinate theme of '*Experiences of the self'* is *'Otherness'. 'Otherness'* was a word used by several participants to describe not only their sense of not belonging, but of being actively and fundamentally different and therefore separate from the rest of their social world. There seemed to be a connotation of therefore feeling alone and an outsider. As will be demonstrated below, sometimes this otherness was derived from perceptions and experiences of sexuality and in some instances was derived from perceptions and experiences of self-injury.

For Erin, this is expressed early in her interview in a simple and direct statement:

> *I felt that I was wrong in that capitalistic country that is Switzerland, that as everybody knows is the empire of capitalism and … I really felt like I was different. (Erin, 36)*

Erin describes her otherness here in relation to the society she was growing up in, which is not an uncommon feeling for many people, particularly during adolescence. Her choice of language is poignant with use of the word '*wrong'*, which implies that she was therefore not right, not okay or not herself in some way. Thus we can infer that feeling an outsider was something she experienced from an early age and which did not seem to sit well within her. It may also be interpreted that there seems to be a sense of sadness in how Erin speaks with a resignation in her tone, perhaps reflecting how she felt during that time, 'wrong'. In this case, Erin experiences her otherness in terms of the political and societal attitudes of the context she is living in. Erin's reference to her otherness continues later in her interview with a different tone and is described in relation to her sexuality:

> *Like, from most of the lesbians I know, I'm an atypical lesbian because I'm a vagina-tarian (laughs) and because yeah, I prefer trans men to women. (Erin, 480)*

Here Erin states that within the lesbian community she feels '*atypical*'. It is interesting to note how she perceives herself as having an otherness within an otherness. Already identifying as a lesbian woman positions her outside of a heteronormative society, within which she again recognises that she is not a 'typical' lesbian due to her preference for trans men, rather than cis-gender lesbian women and that that adds another layer of otherness to her identity. For Erin, this recognition is accompanied with humor in the above quote rather than with difficulty. It seems as though she is not daunted by her atypicality in this instance, instead finding it amusing. We could speculate that the change in tone when describing her otherness in these two quotes may reflect the passage of time, thanks to which she has grown more accepting and embracing of her otherness regarding sexuality which she has control over as an adult in terms of behaviour and expression, while as an adolescent she perhaps did not feel able to challenge or remove herself from the societal discontents she was experiencing. An alternative interpretation may be that her amusement and laughter in the second quote arises due to an unconscious discomfort, where the laughter acts as a defense against a perhaps painful reality of acknowledging the complex intersectionality between her layers of otherness.

Sue articulates her experience of otherness in the following quote:

> *I don't remember spending an awful lot of time having thoughts like 'I know I am a lesbian. I know I'm queer. I don't want other people to know. I'm going to hide it.' It wasn't explicit. I didn't*

> *express it. It was just there in thoughts and feelings that I almost didn't… the reason, I think I was self-harming was I couldn't suppress them. So I'd try and burn them away, or you know… in that sort of way. The same way when I was quite depressed and overwhelmed and having a let down… eight or nine years ago which was also, well, I'm going to cut that all away 'cause I'm not really quite sure what it is. So yeah, it's a difficult one because I hit so many different little, you know that whole intersectionality sort of thing, I'm sort of a… quite an in-between a lot of different spaces of otherness and it's quite confusing when you're trying to separate it uhm… because I'm not sure that's really possible first of all but, yeah I guess I'm tightly woven together I think. (Sue, 1134)*

The above quote offers a rich insight into Sue's experience of her own otherness beginning in relation to her identifying as a lesbian/queer woman, but progressing into her perception of being *'in-between a lot of different spaces'*. Once she taps into her otherness regarding sexual orientation, Sue considers all her otherness and the confusion which that has caused her. Within this quote, Sue also makes a direct link between her self-injury and her otherness. She describes not explicitly thinking about her sexual orientation while at the same time not being able to suppress or make sense of those feelings, thus resorting to cutting *'that all away 'cause I'm not really quite sure what it is.*' It may be interpreted that her otherness is something she cannot make sense of and cannot suppress either, therefore Sue experiences her self-injury as a means of attempting to rid herself of this otherness. There seems to be a poignant symbolism here, where the physical act of burning and cutting one's body, represents a contempt and violence towards that confusing otherness which Sue experiences in herself. Interestingly, Sue also eludes to the idea that her otherness is woven together

in a complex (and perhaps confusing) manner where she seems to acknowledge the difficulty in trying to separate it in search of clarity. Instead, Sue states recognises that she is not only woven together, but *'tightly'* so. This conjures images of a yarn of wool, tightly woven, interconnected and compact. Following on from this interpretation we might also consider the nature of such tightly woven objects are undone; in the case of a tightly woven yarn of wool, an unraveling is said to take place and it is interesting to reflect on how Sue and other participants speak of a kind of unraveling of the self often.

Like Erin, Sue recognises her otherness regarding more than one aspect of her identity. For Sue, the different spaces of otherness she occupies could refer to her mental health and self-injurious identity, her sexual orientation as well as her ethnic identity (being of South-East Asian origin and growing up in Europe). Sue's ethnicity seems to have had a significant impact on her self perception and otherness, as she reflects on how she has experienced her ethnicity as setting her apart from others in terms of family (being the only adopted and therefore non-biological member of the family), being an ethnic minority within the society she lives, and also within the LGBTQ+ community:

> *I was the only one in my family adopted so I had a family who were Irish and Caucasian. It was quite random ending up in Ireland. (Sue, 97)*
>
> *I was starting to… Coming to terms a bit more with being an Asian living in Ireland and sort of realising I was never really going to be accepted as Irish. (Sue, 289)*
>
> *… the race issue were still very much there and even in my new gay family, you know, there's a lot of, quite a lot of ignorance and racism*

and prejudice and again I was still being eroticised by… 'cause I was the only Asian lesbian in Ireland at one stage I think! (Sue, 973)

Sue is aware of the multiple layers of otherness she personifies which leaves her vulnerable to discrimination. In her identification of *'that whole intersectionality thing'* Sue seems to elude to a cumulative and complex way in which all of her otherness leaves her subject to multiple forms of discrimination, given that she identifies as belonging to several minority and/or marginalised groups. It may be interpreted that the *'random'* events leading to her life in Ireland was accompanied perhaps by a sense of not having any control or direction until then. This seems to be followed by a realisation that the environment she finds herself in, was not receptive or accepting of her, and never would be which was can infer was perhaps a painful realisation, particularly during adolescence. Following this painful realisation is another realisation that along she was being directly discriminated against for her otherness. The three parts of the above quote, thus can be interpreted as coming together to communicate a sense of not having agency or direction over where she was, realizing she would never be accepted by her environment, and then that she would also be subject to prejudice and discrimination from within a space which she had expected to feel accepted. Her ethnicity, perhaps seems to thwart her acceptance in the LGBTQ+ community.

Sue's response to this intersectionality she experiences is significant:

The… I stopped trying to fit in… And had more of a 'Fuck you' mentality of 'I don't really give a shit.' Which of course I did, but it was the teenage… Sort of lashing out or whatever. (Sue, 293)

Her response is one of indifference and *'lashing out'.* She reflects on her 'Fuck you' mentality as being a guise to cover her true feelings of actually caring about the discrimination she was experiencing. There is a tone of resentment in the above quote and the *'lashing out'* Sue mentions does not directly speak to self-injury, but we can infer that self-injury was perhaps a means of her being able to retaliate against discrimination, even if that retaliation was self-directed at the parts of herself which she was subject to discrimination for.

For Helen, her first reference to feeling different or atypical comes within the context of her childhood experiences and the mental health difficulties she was experiencing as a result, which she recognises made her an easy target for hostility from others:

> *So I was an easy target for people to pick on and I guess because I hadn't had the typical growing up experience you know, because I never had a stable family life. I didn't have the same experiences I didn't have the kind of, I wasn't coming from the same place that everyone else was coming from. (Helen, 138)*

It may be interpreted that for Helen, her childhood experiences are perceived as something which have a big influence on her ability to be accepted and integrated with those around her. She seems to that her early life positions her as coming from an altogether different place, almost connoting the sense of a foreigner navigating a new country and struggling to adopt the attitudes of their new environment.

Later in her interview Helen describes how her self-injury was a means to cope with bullying and feeling an outsider due to her childhood experiences. In addition, she goes on to describe experiencing her bisexuality as another layer of otherness with which she struggled:

> *Like, I don't, I don't hide it at all. I don't hide being bisexual, but I don't want to talk to people about it all the time… and yeah, that is something that was quite similar with self-harm, is that it's these things that you feel are weird and different and not accepted by other people and that you feel embarrassed of it and ashamed and like, you're wrong in some way and even though you know, my sexuality and mental health are two things about me that just are the way they are and I've now come to accept… it was very difficult to come to terms with both of these things and not to…. Be constantly questioning myself and you know, 'Why am I feeling this way? Why is this happening? Why cant I just be normal? (Helen, 816)*

Within the above quote Helen makes a direct comparison between her difficulty in being more open about her bisexuality and her difficulty in managing her mental health. Both appear to be layers of otherness which are not easy for her to negotiate, both in terms of accepting herself and being accepted by others. It could be inferred therefore that with each layer of perceived and indeed experienced otherness, Helen feels further and further away from the '*normal'* she mentions in the above quote. The emotions Helen identifies as being related to these experiences are embarrassment and shame, which are common in minority groups and which perhaps make her difficulty in coming to terms with herself understandable. In feeling shame and embarrassment, Helen's questioning about herself and her struggle to come to terms with '*both of these things'* demonstrates a similarity between her experience of her self-injury and of her bisexuality.

For Toby, a similar perception of his own otherness with regard to childhood experiences and sexual identity seems to exist. He reports experiencing his traumatic childhood as something which sets him apart from everyone else:

> *I'm trying to let go of the pains of the past by coming to terms with it and facing it but you know… no one will understand… I don't like to talk about these things with other people. No one understands and everyone seems to have it easier and I know that's a misconception but… I can't cope sometimes with it. (Toby, 268)*

In the same way that Helen is hesitant to talk about her bisexuality with others, Toby expresses a desire to not talk about his childhood trauma with others. It seems as though Toby's childhood is something which he sees as setting him firmly apart from others; there appears to be what he sees as an unbridgeable gap in others' ability to understand him and we can infer that this exacerbates feelings of otherness. It may also be interpreted that while Toby expresses a desire (or at least an attempt) to let go of his past, by processing it and facing it, he also recognises that this may need to involve speaking about his past, which is something he appears to feel quite daunted by. Importantly, Toby seems to identify that his difficulty in being able to talk about his difficulties is namely due to the fact that others will not understand, rather than his not being able to do so. There appears to be an anticipated fear of others inability to receive and understand what he desires to communicate, resulting in an expectation of having to strive forward without the understanding (and therefore support) of others.

Later in his interview, Toby refers to otherness regarding sexual identity and race:

> *I think that certain groups of gay men are targeted for annihilation for being who they are, different… And are just not wanted on the earth so there were some of my friends who, particularly black gay men who have killed themselves. (Toby, 845)*

While he does not reference himself in the above quote, we may assume that as he also identifies as a gay man, he is perhaps subject to similar targeting for *'annihilation'.* Toby's use of the word annihilation is striking as it emphasises a desire from the other to completely destroy the subject with a war-like force. Earlier during his interview Toby does relate his otherness as a gay man to being personally subject to hostility from others with *'I don't want to be an easy target so I don't walk around in a skirt but I walk fast and there have been times when I've, well I've felt I've had to walk around with a weapon'* (Toby, 890), again conjuring images of a war-like defensive stance. In adding the otherness of race/ethnicity to an already existing otherness regarding sexuality, Toby refers to a similar intersectionality which Sue does. Both acknowledge their perception of ethnicity and sexual orientation as being a combination of otherness which is somehow threatening to the self. In addition, Toby's focus in the above quote may be said to position himself as being in a better (or less difficult) stance than peers who identify as both gay and as an ethnic minority. Within the quote, Toby's sense of angst about what is saying is evident. One possible interpretation may be that by conceptualising himself as not having to negotiate ethnicity as another layer of otherness along side his sexuality, that actually he does not struggle as much as others perhaps do. As such, he positions himself as struggling, but not as much as others and this may (unconsciously) have been an attempt to minimise his own struggles as a gay man.

Like Sue, Gene also makes a direct link between their experience of otherness and their self-injury:

> *But, I feel like, since having that… not isolation, but that 'otherness' from other people it does make it harder to cope and I feel like, if that's something you've got to contend with, I don't know… self-harm becomes a lot more appealing in a way. So, it does make it harder. (Gene, 730)*

Gene seems to recognises their otherness brings them closer to self-injuring, as a means of coping and in doing so we can perhaps assume that as a consequence of self-injuring to cope, they also feel an increase in 'otherness' due to further establishing in them, a self-injurious identity. Gene's otherness seems to be perceived as being something to content with, which connotes a sense of battle and negotiation with one's otherness. For Gene, the resulting need to content with their own otherness is followed by what an increase in the appeal of self-injury. Like Sue, Gene directly links their self-injury to experiences of otherness.

3.3.3. Sub-Theme III: *'Defective Self'*

'Defective self' is the third sub-theme emerging from the data under the super-ordinate theme of '*Experiences of the self'. 'Defective self'* refers to how participants experienced themselves as somehow damaged, deficient or flawed and this defective self was often referred to through a critical lens. This theme appears linked to other themes within experiences of the self in that, for some participants the defective part of them was very much linked to their otherness, whether that be regarding their mental state and self-injury, their experiences of trauma or their experiences of sexuality. However, the distinction between sub-themes of 'otherness' and 'defective self' lies in participants perceptions. Otherness speaks to reflections about feeling

different, not normal and apart from society, while the defective self refers to participant reflections about an inherent damage, fault or inadequacy regarding the self. Perceptions of the self as defective also appear related to the other super-ordinate themes of '*Experiences of the other'* and *'The Act Itself',* due to that fact that the self was often experienced as defective in relation to other people, i.e. the self is defective because it is not able to function like the self of other people is, which may then be interpreted as relating to a willingness to engage in self-injury.

Helen describes how perceptions of her defective self were highlighted and strengthened by bullying during adolescence:

> *So, other people making me feel bad about myself, especially comments about my appearance which I had been sensitive about at that time and feeling like I was ugly and like I wasn't pretty like other girls and I wasn't you know, attractive and… people weren't interested in me and made me feel really bad about myself and that manifested in hurting myself because, because I thought I deserved it or that, you know it was a sort of distraction from other things I was feeling. (Helen, 150)*

Helen's insecurities, particularly around her appearance, seems to be confirmed and confounded by comments from peers to the extent that she perhaps seems to internalise them and thus resorts to self-injury in order to punish her defective self, or to distract herself from feeling consumed by her defects. Helen directly identifies her feelings of being defective in comparison to others as a trigger for engaging in self-injury. It may be interpreted that comments from Helen's peers about her appearance seem to leave her feeling more vulnerable by feeding into the idea that she is indeed

defective. Later in her interview, Helen links her struggles around *'not being okay'* about her sexual identity as one part of the '*snowball*' of reasons for self-injuring:

> *Yeah, it all just kind of collects and snowballs and there's all these different aspects and all these different reasons why I would self harm but I think being, being queer and not being okay with it, was a big factor. (Helen, 784)*

In her *'being queer and not being okay with it',* Helen suggests that her being queer is therefore not acceptable to her in that moment and that the queer part of her is perhaps somehow defective. Helen's earlier reflections about herself as defective due to her childhood, bullying and subsequent mental health difficulties are perhaps a somewhat common experience for adolescents regardless of sexual identity. They also fall within a category of factors which lie outside of her control and which have happened *to* her. In contrast, Helen's experience of her sexual identity feels more like it is something which she simply *is.* While she indeed has a choice about who she outs herself to and when, we might assume that she does not have the same choice as to whether she is or is not bisexual. It is noteworthy in the above quote that Helen shifts into using the label of 'queer' rather than 'bisexual' as she had done previously in her interview. It may be that while reflecting on the collecting snowball Helen describes, a more umbrella-like term such as 'queer' was more comfortable to communicate her LGBTQ+ identity in a broader sense, rather then the more specific label of 'bisexual' which might emphasise her minority status further. It may be interpreted that by adopting a broader label for her sexuality, Helen recognises that not only bisexuals experiences a process of *'not being okay with'* their sexuality, but that it is something which all queer (or LGBTQ+) people struggle with. This interpretation may be further developed by considering use of a broader term such as

'queer' in this instance, may have offered some albeit unconscious sense of belonging and safety due to its shared experience status.

For Sue, the perception of a defective self emerges more as a consequence of her actions:

> *I think my life history has always involved some way of trying to control or hurt myself and then it became quite destructive. I had a bit of an emotional breakdown, I think it was 2009 and then I started self injuring in quite a serious way. Cutting myself quite deeply. Some of it was linked to uhm… sort of being drunk and making suicide attempts, cutting my wrists and just coping with things really badly, in the worst way 'cause I thought well I'm already fucked up… (Sue, 40)*

Sue's reference to herself as *'already fucked up'* seems to have spurred her on into a destructive lashing out. It may be interpreted that in recognising her difficulties, Sue retaliates against herself, drinking, self-injuring and attempting suicide in an attempt to destroy her defective self. Sue appears to recognise how her defective self is coping *'badly, in the worst way'* and there seems to be a tone of resignation and passive acceptance of her '*fucked up'* or defective self. We might further interpret that Sue's acknowledgement and resignation with her defective self as well as her bad coping mechanisms combine to result in a desire to attack and direct hostility towards it in the form of self-injury.

Later in her interview, Sue goes on to describe her partner's reaction to her self-injury, which also seems to confirm the defective parts of her:

You know "What's that about? You're broken, you need to get fixed, you need to get sorted out all of your stuff" and yeah, she really saw it as the main problem in our relationship. (Sue, 555)

As with Helen, Sue receives confirmation from other people that she is defective and needs to *'get fixed'*. The simplicity of the above statements perhaps represents Sue's perception that her partner did not really understand the complexity and multifaceted nature of her self-injury, instead reducing it to a solvable and logical problem. The solvable and logical nature of Sue's partners response, may be interpreted as suggesting that a practical approach to getting *'fixed'* exists. This is interesting to reflect upon in relation to how participants all experienced their self-injury as a (and often the only) means of coping or fixing themselves, even if temporarily. Participants seem, to experience themselves as complex, confusing and difficult to soothe through means other than self-injury, while others seem to imply the problem must have a solution, even if they are not able to identify it. Furthermore, it may be that the perception from others of self-injury being a solvable problem, implies to the person engaging in it that they simple are choosing not to engage with the solution, exacerbating feelings of self-blame and defectiveness.

Toby's experiences of himself as defective largely related to his childhood experiences which he repeatedly states during the interview had caused a deep sense of feeling damaged:

I can't really describe it very well but… I just feel that made me feel very unworthy. I wasn't enough. For my whole life I wanted to be enough to make them change. (Toby, 71)

The way in which he recalls his experiences of childhood suggests that Toby felt defective from early in life and this is evident in his framing of himself as lacking something, which he seems to have internalised:

> *I can't remember when it started but I know she had me at home and I can imagine she popped me out and just reached for a bottle of wine. (Toby, 58)*
>
> *I think I just internalised this sense of, I'm not enough. I'm not enough. I'm not worthy. I don't have enough goodness within me. (Toby, 108)*

The final statement within the above quote changes direction slightly and connotes more of a self-blaming position. Rather than simply being unworthy in the eyes of others, he goes on to say that he doesn't *'have enough goodness'* within him which implies he lacks a certain goodness that he should have; thus, he is defective. For Toby, his defective self appears to be confirmed and emphasised by the actions of others, much like the experiences of Helen and Sue with regard to their defective self.

For Gene, the defective self appears to be derived more from their own internal dialogue about themselves, rather than from the words and actions of others.

> *I would feel, like, pathetic. I don't know how to describe… like, everyone else can get on with their lives and you can't without doing this, that kind of thing. You're not matching up to other people because... you can't cope like other people can. (Gene, 227)*

In comparing their inability to function in the way other people are able to without self-injuring, Gene recognises this as a defect which triggers self-criticism and feeling '*pathetic*'. The way in which Gene begins the above quote in the first person and then

switches to the second person is curious. It may be interpreted that Gene begins the quote firmly speaking from a subjective and therefore personal perspective, but that after articulating their feeling *'pathetic'* switches to speaking in the second person to (albeit unconsciously) distance themselves from their own words as a means of defending themselves against the discomfort of reflecting on feeling pathetic. Gene appears to derive their sense of defective self not directly from the words or actions of others, but from comparing themselves against what they perceive to be as others coping better than they are. For Gene, Helen, Toby and Sue the defective self seems closely dependent on experiences of other people.

The above analysis of the first super-ordinate theme '*Experiences of the self*' demonstrates how all participants expressed some kind of conflict, struggle and confusion in terms of their own identity and behaviours. Within this context, the multifaceted and paradoxical nature of self-injury can perhaps be understood better and this will be explored further in the next chapter. Feeling defective, whether in relation to one's self-injury or sexual orientation was a pronounced experiences for all participants.

3.4. Super-Ordinate Theme II: *Experiences of the Other*

The world and his wife's got an opinion and they'll make sure you hear it.

(Gene, 591)

The super-ordinate theme of '*Experiences of the other'* emerged from analysis of participants' experiences with regard to their social worlds which encompassed family, friends, peers, partners, professionals as well as the wider society with whom they are not acquainted, but who held a particular space in their meaning making around experiences of self-injury in terms of societal norms, attitudes and acceptance. Three sub-themes emerged with this super-ordinate theme: *'Family', 'It's hard to talk*

about' and *'Stigma'*. The following section will offer the reader an analysis of the divergences and convergences within participants' experiences of the other.

3.4.1. Sub-Theme I: *Family*

All six participants discussed familial relationships as significant. For some they were a source of distress and trauma, while for others they were a source of support and understanding. Those participants who had supportive familial relationships, also acknowledged periods of anxiety within which they feared reactions of family in relation to both self-injury and sexual identity. While those participants who experienced family as sources of distress, also acknowledged the presence of affection and closeness within those relationships.

At the very start of her interview Anne makes a direct association between her self-injury and family dynamics:

> *I started self harming when I was nine and that was I think, primarily due to family breakdown… separation of parents and a bit of a chaotic environment at home with that going on… but that was kind of, only a couple of times when I was nine. I didn't really know what I was… why I did it. I just knew that I was in a lot of pain and I wasn't, I wasn't allowed to talk about my parents separation 'cause it was still quite a taboo thing. (Anne, 4)*

Anne articulates quite clearly the trigger for her first episode of self-injury as the separation of her parents and subsequent family breakdown. Anne's statement of not really knowing what she was doing is understandable given her young age at the time. She is sure however, that she was *'in a lot of pain'* and also not allowed to talk about the source of her pain: her parents separation and family breakdown. The idea of not

being able to talk about her pain *'cause it was still quite a taboo thing'* creates a sense of emotional suppression, which when combined with her limited understanding given her young age as well as the *'chaotic environment'* she was living in seems to leave nowhere for her pain to be expressed, let alone processed. This interpretation could be developed further by hypothesising that with nowhere to express herself, her pain was therefore directed inwards at herself. An internalisation of emotions such as pain and anger is not uncommon experience for lots of people, whether conscious or not. The notion of not really knowing what or why she was engaging in self-injury is curiously followed by assertively stating that she was in a lot of pain. As such, Anne seems to reflect on her experiences in a somewhat fragmented manner where she identifies the trigger as being family breakdown and not being able to talk about it, her reaction as feeling pain and her response as being self-injury. While she does articulate the process she went through as a child quite directly, the above quote retains a sense of unawareness and an inability to consolidate her experience at that time, instead verbalising it with a tone of separateness. It may be interpreted that given Anne's young age at the time, the fragmented tone with which she offers the above quote may be said to represent her sense making at that time.

Anne talks about familial relationships later in her interview with regard to identifying as bisexual and describing difficulty regarding being able to be open about it:

> *It's just another thing along the way to cause me worry and anxiety and also… it would have been another reason to be scared of judgment from my mum 'cause it's already bad enough, you know, I'm self harming but, if it also turned out that I wasn't the sexual identity that she thinks I should be… then that wouldn't be good and that just sort of added on the pressure. So I think it's just, it was just*

another level of needing to hide, or at least in my experience it was. (Anne, 716)

The above quote reveals how Anne anticipates a negative reaction from her mother about her bisexuality and therefore chooses to not out herself to her family due to these anticipated fears. Anne also positions her fears about outing herself alongside her self-injury and seems to perceive that both revelations would be too much for her mother to tolerate. *'Another level of needing to hide'* implies that both her bisexuality and her self-injury are factors which separate her from others both because they are not things experienced by most people and also because in hiding them, she distances herself from other people. Anne's framing of her self in relation to family as being both self-injurer, bisexual and needing to hide connotes a sense of building pressure where the anticipated unacceptability of these layers of self, seem to form into something which her family would judge her for. Interestingly, Anne does not elaborate on what she anticipates might follow after judgment. It may be assumed that she anticipates conflict, rejection, isolation, chastising amongst other things. However, it may also be assumed that for her the so-called secondary consequences are less important or tangible, but that the anticipated judgment is painful enough for her to want to avoid. In engaging in self-injury from a young age, Anne seems to learn to suppress her emotions and to hide her behaviours.

A similar sense of struggle with experiences of family during childhood is expressed by Sue:

I think looking back at it maybe it was attending to myself where I possibly felt I wasn't getting it from my Mother (Sue, 239)

'Looking back' from her current adult perspective, Sue is able to reflect on her mothers' emotional unavailability during her childhood and reflects on how she tends to herself in a 'self-mothering' (or 'self-soothing') way after having self-injured. It may be interpreted that post self-injury, Sue mimics the ideal mothering which she felt she was lacking during that time. As outlined under the sub-theme 'conflicting self', Sue at times may be said to mimic her mother's inability to deal with emotions by chastising her vulnerable self, and as is evident within the above quote may be said to also mimic her a fantasy version of her mother who does attend to the self. This interpretation may tentatively be developed into the notion that in Sue's experience, she had perhaps internalised both the dismissive mother as well as the fantasy of an ideal mother figure.

Around a similar age as Anne, Sue recalls also feeling that her emotions were not responded to by her parents in a way that felt helpful for her:

> *My parents sort of dealing with it was to minimise and dismiss it, "Oh, don't be silly, he didn't mean it, they're just being silly." You know, this kind of thing… So I think I was already managing, coping, suppressing things not really sharing them… So I was very… uhm… not listened to. (Sue, 110)*

Given that children tend to learn how to process and respond to emotions from caregivers, we might infer that when early experiences are characterised by feeling unable to express emotional states and receive understanding in return, that this leads to a process of suppression, much like Sue describes above.

Sue describes her first experience of self-injury as *'quite practical'* where she attempted to break her hand in order to avoid going to piano lessons and feeling that her parents

would not understand her desire of not wanting to go. Instead, Sue describes feeling frustrated with this and therefore attempting to in effect, solve the problem herself:

> *…when I realised I wasn't going to break my hand I remember continuing to hit this reinforced very frosted glass, quite strong seventies sort of window… and then I just kept whacking it. I think I remember a few times in that same bathroom hitting my head against the glass and stuff like that. (Sue, 145)*
>
> *It's quite a violent act in a way. (Sue, 152)*

For both Anne and Sue, self-injury seems to emerge as a solution to problems which as children they felt they had no alternative ways of managing, given that their family did not seem able to hear and respond to their emotional needs at the time. Sue also recalls her wider social context as a child as being very violent, having grown up in Belfast during the seventies, *'it was really really really violent'.* Her repetition here emphasises the level of violence she experienced around her as a child and also echoes a similarity in her assertion in the above quote about her own self-injury being *'quite a violent act'.* Later in her interview Sue describes instances of self-injury which are also quite extreme in their severity, requiring hospitalisation and physical treatment. One interpretation of the aggression inherent in Sue's chosen method of self-injury is that growing up in the societal violence she describes, perhaps acclimatised and desensitised her to violence. Thus, when she engaged in it herself within the context of emotional suppression and an anticipated lack of understanding or containment, Sue perhaps was able to more readily mimic the violence she was growing up within.

Erin reports a different experience of family, but one which is characterised by violence and is also relevant to her experience of self-injury:

> *I have to say that I have the violence in my blood. My mum was very violent, my grandmother was very violent and actually I understand now why I'm so violent because it's something that I have in my genetics. (Erin, 23)*

For Erin it seems that familial violence was present from an early age and that rather than her self-injury emerging within the context of unmet emotional needs as a child (although this may have been the case), she associates her own tendency for violence as a result of an innateness, or genetics. Similarly to Sue, it may be interpreted that Erin's tendency for violence was also, at least in part, learned. In growing up with a *'very violent'* mother and grandmother it could be that Erin learned violence could be a means of expressing oneself, to which she grew desensitised and therefore more willing to engage in later in life, whether through self-injury or other practices. For Sue, self-injury seems to have begun as a means of managing suppressed emotions, while for Erin self-injury was perhaps experienced as a means of emotional expression.

For Toby, a similar witnessing of violence within the family during childhood exists:

> *My Father was extremely violent for my whole life. Like most of my memories…. Of, of…. My Father are mainly him, like physically abusing my Mother and my Mother was pretty much horizontal most of my life with a bucket. My Father would bring her alcohol. I was growing up in a household where there was a lot of shouting, there was a lot of fighting. I remember as a young child like, looking at these very disturbed parents and being very scared of my Father. (Toby, 28)*

Sue, Erin and Toby are the only participants who report witnessing extreme violence as children. The other three participants report familial difficulties as children but not witnessing violence themselves. Sue, Erin and Toby also report the most extreme forms of self-directed violence, in comparison to other participants. Sue attempts to break her hand and describes instances of cutting herself so deep that she needed stitches and bandages often. Toby's most vivid recollection of self-injury is smashing a glass bottle and stabbing himself in the chest with it. Erin's experience of self-injury involved scratching and burning, at least once requiring a hospital visit and later developed into similarly 'violent' and extremely physical practices (albeit in her experience both controlled and non-pathological) such as body modification, body suspension and BDSM.

For Helen, her experience of family during childhood was not violent, but was also extreme and certainly poignant:

> *I had quite a difficult sort of, childhood. There was a lot of unrest (laughs). It was very unsettled… and I'm sort of, well, I, I have sort of been processing this for a few years… since my parents got divorced when I was twenty so five years ago… me and my sisters have been kind of coming to terms with the fact that we were abused by my father… and yeah, so it was pretty difficult and I was already a very anxious child… (Helen, 7)*

Helen does not elaborate as to what kind of abuse she and her sisters experienced from their father, but she links these experiences and a general 'unrest' directly to her starting to self-injure. Helen's laughter within the above quote may be said to reflect a discomfort with what she is about to say, which is perhaps also reflected in her vagueness about the kind of unrest which she experienced. Without offering many

details, Helen seems to convey a sense of chaos during childhood with which she (and her sisters) are still coming to terms with. As such, it might be assumed that if Helen is still coming to terms with her childhood experiences as an adult, that during that time as a child the acute impact of those familial difficulties may have been overwhelming for her.

Finally, Gene also recalls family dynamics as significant when reflecting on their self-injury:

> *I think in the grand scheme of things, my family… like, my Mum's kind of, expectations are not really that great, they're not- It doesn't weigh heavily on me, like, it's not a big thing. But I feel like there is a standard in my household of, like, a stiff upper lip and, like, just get on with things and not complain about stuff too much… (Gene, 221)*

Gene tentatively identifies their family's tendency to *'get on with things and not complain too much'* which appears to imply a certain sense of their perhaps not feeling able to complain when they needed to, or of feeling as if their complaints would not be responded to with understanding from family members, much like the experiences reported by Anne, Sue and Helen. While Gene's description of family dynamics above is more tentative than that of other participants, it does seem to convey a similar social context within which an anticipation of emotional states not being heard or valid exists.

3.4.2. Sub-Theme II: *It's Hard to Talk About*

The second sub-theme emerging from data under the super-ordinate theme of *'Experiences of the other*' is '*It's hard to talk about*'. Analysis revealed a strong sense in most participants that it was difficult for them to communicate about their self-injury.

This theme is linked to the super-ordinate theme of *'Stigma'* (which will be presented within this section), as difficulty in communicating about self-injury is tied in with a fear of and desire to avoid the stigma associated with self-injury. However, participants' experiences of difficulty in talking about self-injury and the stigma associated with self-injury also emerged as two distinct aspects of their experiences of the other and have therefore been presented as two distinct but connected themes. *'It's hard to talk about'* appeared to reflect an anticipated fear with participant experiences seeming to capture their negotiation of how and with whom to talk to, while '*Stigma'* seemed to capture more experiences of finding a way to talk but of feeling perceiving stigma as a result of having done so.

Anne articulates her perception of why she struggled to talk about her self-injury as follows:

> *People just generally can't deal with the like, a human being harmed and then the idea of them doing it intentionally, is just like an unacceptable idea. (Anne, 575)*

Anne focuses on the difficulty for the other in receiving communication about self-injury, as the reason why she found it difficult to talk about. She alludes to a kind of taboo about talking about self-injury which echoes her earlier experience of not being able to talk about her parents separation because it was also taboo. It may be that Anne's early experiences of not being able to talk about familial problems, led to a tendency to perceive other taboos (such as self-injury) as also being an unacceptable thing to talk about openly. Anne also suggests that what others find hard to hear is the *intentional* nature of self-injury and in doing so she highlights an important aspect of why it may be so hard to talk about. In addition to self-injury being taboo and something which is anticipated to evoke judgment and a lack of empathy, Anne

positions its taboo nature as also relating to the physicality of it. Indeed, it is acceptable and often expected to express empathy and concern for harm having come to another. However, when that harm is intentionally self-inflicted the tendency for others to empathise and understand appears to thwarted in Anne's perception. There therefore appears to be a disconnect between how emotional and physical pain are received and responded to by other people.

Sue focuses on the need to hide her self-injury and how she navigates being confronted with talking about it by her brother:

> *You were also hiding something because it was a secret I had. My brother became aware of it and… I uhm… He… I just said 'Oh, myself and my friend were messing around' and… But I know he was like 'That's just… Teenage girls being weird.' (Sue, 208)*

She appears to minimise her self-injury and attempts to make it casual within the context of her simply *'messing around'* as an adolescent. Despite experiencing her brother as quite a containing, she still does not feel able to directly tell him that she has been self-injuring. It is interesting here to note how despite having a warm relationship with her brother who was able to soothe her often, Sue still avoids talking about her self-injury with him. It may be interpreted that given Sue's lack of emotional attending from her mother and the resulting suppression of emotions she describes previously, this tendency lingers within the and pervades her interaction with her brother in this instance. Within the context of Sue's relational dynamics with her emotionally avoidant mother, and despite an expressed idea of what better mothering might look like, Sue still struggles to articulate herself even when talking to her brother who is indeed experienced as containing and somewhat motherly figure for her. It may have been that his confronting caught her off guard, it may be that Sue struggled to

understand and articulate her self-injury given her young age at the time and that her experiences of trying to talk about her emotions in general, as well as an anticipation of dismissal, combined to result in her minimisation of self-injury.

Helen recalls a similar experience as Sue, when confronted by her mother about her self-injury in the quote below:

> *I think I just clamed up. I think I just kind of refused to say anything about it and I just, I just waited for her to go away (laughs). Just because I didn't, I don't know, I didn't want to… I didn't want to admit to it I suppose. Yeah, so…yeah I didn't really go there. (Helen, 116)*

For Helen, and indeed all participants, talking about their self-injury is perceived as a kind of threat with some inherent danger being risked. For Sue, this resulted in minimising and avoiding, while Helen's experience in the above quote could be interpreted as evoking a kind of fight, flight or freeze reaction in which she resorts to freezing. If interpreting Helen's reaction within the context of this innate and primal survival mechanism, it could also be inferred that Helen experienced her mothers confrontation as a grave threat of some kind. Helen goes on to describe how this confrontation about her self-injury was not quite what she would have expected it to be, which seems to have increased her refusal to discuss it:

> *… she said you know, 'I've noticed these cuts on your arm. It's really dangerous and you shouldn't be doing that', (laughs). 'You know because you can get an infection.' You know, the emphasis wasn't really on, you know, 'Are you okay?', sort of thing, or like,*

'You should, you shouldn't do that because it's bad for you'. (Helen, 89).

Helen describes her mother's more practical perspective of her self-injury; it is something which is dangerous due to the risk of infection. The practical nature of the response received, as well as the Helen's sense of awareness that she would have preferred a more emotionally focused response, is evocative of Sue's earlier experience of her partners more practical reaction to her self-injury. At the same time, Helen articulates perhaps the response she would have preferred from her mother as being '*Are you okay?*' or as being *'You shouldn't do that because it's bad for you'* emphasising that the resulting badness from self-injuring is about the *you,* or the self, the individual, rather than about risking an infection. In not receiving the kind of approach she expected from her mother, Helen opts for silence over trying to communicate as if her mother's failure to approach in the way she would have wanted causes in her an increased expectation that she will be misunderstood or made to feel worse somehow. Her difficulty in being able to talk to her mother, despite the opportunity to do so is exemplary of a similar experience for all participants. Talking about their self-injury (and often their sexuality) seems to risk opening themselves up to something threatening. The intersectionality explored earlier under the sub-theme of *'Otherness'* seems pertinent here. In choosing to talk about (and thus admit, confirm or reveal) their self-injury, or indeed their sexual orientation to others, participants appear to be aware they therefore risk being subject to the discrimination which accompanies that otherness.

Gene's recollections about finding it difficult to talk about their self-injury touches on another aspect, which relates to their not having enough awareness or understanding of their problem to be able to communicate about it:

I didn't really like talking about it and I felt like… I don't think I was fully aware of the problems I was having anyway, like… I didn't have that kind of self-awareness. (Gene, 98)

With hindsight, Gene seems to acknowledge that they did not have the necessary tools to understand their self-injury, let alone be able to talk about it with others. This is echoed throughout their interview as they repeatedly describe a kind of confusion and lack of understanding around their self-injurious behaviours both from themself as well as from others:

… the possibility that people knew what I was going through, but still didn't feel like, I don't know… it's kind of a complex thing. (Gene, 145)

… it was like this big joke. As if I was taking time off for the fun of it and I was just like… "That's not what this is". Yeah. (Gene, 163)

Although Gene does not finish the sentence in the first part of the quote above, it can be interpreted as relating to the perception that others recognised what they were going through (a very difficult time) and did not attempt to communicating or support them, or of people misinterpreting their taking time off from school. *'That's not what this is'* is a simple and direct statement emphasising the misunderstanding they suspect others hold about them. When considered in combination with Gene's earlier expressed lack of awareness about their own self-injury, perceiving others' lack of willingness to empathically communicate directly with them and instead choosing to mocking them, it is evident why Gene would struggle to communicate about their self-injury, let lone address the misconceptions about themselves and their self-injury received from others. If Gene does not understand it themselves and furthermore

suspects that others mock them about self-injury, we might infer that feelings of shame and embarrassment might accompany such interpersonal contexts.

For those who are confronted about their self-injury, the response seems to be one of dismissal and avoidance, perhaps echoing how they also feel dismissed by others, or of minimising in order to avoid anticipated negative reactions. There appear to be multiple and complicated reasons for why participants struggled to talk about their self-injury but what they all had in common was that self-injury was perceived as something difficult to articulate and which others react negatively towards.

It is also important to note here that participants' experiences of finding it hard to talk about their self-injury, was quite similar to their experiences of finding it hard to talk about their sexual orientation. Both self-injury and sexuality were experienced as something to hide and feel ashamed of, albeit with some subtle differences between the two. This overlap between experiences of difficulty in communicating about self-injury and sexual orientation was apparent during analysis under several themes. A visual representation of the overlap between experiences of the two can be seen in appendix 9 under the theme of experiences of the other.

Self-injury is something which participants knew was somehow having a negative impact on them, despite how effective and protective it was for them. While sexuality was something which was not fundamentally perceived as being bad for them, but which they still held shame and hesitation in talking about:

> *Its… it's a bit of a weird one because I haven't had much of a chance to really address or talk about the issues.. well, not issues… I haven't really been able to talk about it, really… because, as I mentioned before I have a Christian background,*

> *family…it's not… it can be difficult. It obviously depends on… your family. I… one of the reasons I don't talk about it is because I feel like it would complicate things more than necessary and actually just keeping it to myself is just easier and won't really do much harm (Anne, 609)*

Anne articulates that she has not *'had much of a chance'* to talk about her sexual orientation, identifying her religious familial background as a reason for her hesitation in talking about it more openly. Her family context is perceived as not being a space within which her sexual orientation can be discussed. Anne's experience here is further highlighted when compared to her finding a safe space within which she can talk about her self-injury and how transformative that was for her, (see quote on page 61 under sub-theme *'A new perspective'*). By contrast here, Anne acknowledges that for her currently, talking openly about her sexual orientation (i.e. outing herself) would complicate things in a way which she is not willing to endure and instead prefers the *'easier'* option of keeping to herself. The final part of the above quote is important to highlight as Anne states that keeping things to herself is not only easier, but that for her it *'wont really do much harm.'* While she assumes that her bisexuality would be difficult for her family, the idea of keeping it to herself is not seen as not harmful. Anne seems to overlook any harm which might arise for herself in keeping her sexuality hidden from her family. There is a sense that Anne has not considered, or is not able to consider the sadness and resulting pain inherent in the idea that her in hiding her sexuality from her family she perhaps hides a significant and fundamental part of her self. This notion will be explored further in the next chapter, with reference to relevant literature.

Gene expresses a similar difficulty *'to put into words'* their gender and sexual identity to other people:

> *Yeah… it's such a kind of… your own feeling of your own gender identify is such a, not personal but such a unique and individual thing to you, it's hard to put into words, and that's why it's such a hard thing for people who are not familiar with non-binary identities to understand because it's not an experience they can relate to at all. (Gene, 705)*

Gene identifies that the reason one struggles to communicate about their experience of gender identity is because it is unique and individual, thus emphasising the lack of similarity and norms perhaps as reference points. Gene develops this observation further by asserting that some people are unfamiliar with non-binary identities and cannot therefore understand or relate to it; much the same as their experience of self-injury. Gene also emphasises the highly idiosyncratic nature of self-injury as being one of the reasons why they perhaps struggle to articulate it to others. Gene seems to imply that given others have not had the similar experiences, that they cannot explain it to others in an understandable way. This interpretation could tentatively be developed further by assuming that given Gene suspects gender identity is hard to understand if one has not questioned (or had to question) it, that those who have been through a similar process would be able to receive and understand it somehow more sympathetically. Thus, the sense of isolation their minority status affords them seems perhaps to imply that a peer group who had had similar experiences would be beneficial in terms of social support.

The process of talking about and negotiating visibility around ones' sexuality is reported by all participants as a something which began as quite difficult but which seemed all go through a process of gradually becoming more able and comfortable

with embracing as part of the self (as will be evident in subsequent themes presented), unlike their experiences of self-injury.

3.4.3. Sub-Theme III: *Stigma*

The final sub-theme emerging from data analysis under the super-ordinate theme of *'Experiences of the self'* is *'Stigma'*. The stigma associated with self-injury is well known, thus participants seemed to hold an expectation of being subject to that stigma. It seems that participants experienced the stigma around self-injury as only serving to increase their feelings of otherness and self-criticism, thus further increasing the desire and likelihood of them self-injuring again.

> *So, you're like made to feel quite, like you're doing… well you're doing something bad and you should feel ashamed. People don't really understand why you're hurting yourself and they just react badly to it and… because it's about self harming which is reacted to negatively and I guess there's a bit of a cycle. I felt like the only way I could deal with those emotions was to carry on self-harming 'cause I didn't really know what to do in getting rid of that cycle of emotional pain. (Anne, 165)*

Within the above quote, Anne articulates eloquently the cycle within which self-injury, stigma and emotional pain occurred for her. Her experience of stigma is spoken with a sense of time where those others causing her to feel bad and ashamed are now aware of her self-injury, unlike experiences of anticipating judgment under the previous sub-theme '*It's hard to talk about'.* While Anne does not specify who exactly she is being judged by, there is no doubt her experience of the other in this instance is negative and fraught. A cycle of self-injuring due to emotional distress, feeling ashamed and judged by others for having self-injured and feeling worse as a

consequence of that experienced stigma, seems to have fed back into a cycle of distress, thus increasing urges to self-injure.

For Anne, experiences of stigma regarding self-injury seem to be particularly poignant:

> *I get really annoyed about like, the stigma of self harm in particular because it's like, sometimes it feels like people who self harm can be so demonised. (Anne, 542)*

Anne's use of language is striking with the word '*demonised'* which conjures a kind of evil and inherently bad connotation; something which she finds herself *'really annoyed about'* and which echoes Toby's repeated reference to the demons inside of him in the previous section. The discontent Anne expresses around the stigma of self-injury is something she addresses in her work within a mental health charity by facilitating self-injury support groups and giving talks about in order to raise awareness and reduce stigma. Further analysis of that aspect of her experience will be returned to under the theme of *'Recovery'*, later in this chapter.

Sue reflects on her experiences of stigma around self-injury with the following:

> *I think as a woman it's always something that has been there and available that I've been aware of… but complex in terms of all the implications and the guilt trip and the hiding it and trying to explain it to other people who don't quite understand. And then the intellectualising it and the "Oh it's a cry… attention seeking, it's this that and the other" and really sort of battling through a whole sea of judgment about it. And just concentrating on the behavior as opposed to well, this is a symptom of something else. So in that*

way I think it's you know… I sort of experience it as quite complex.

(Sue, 478)

Sue describes a kind of reliability and stability around self-harm, unlike her experience of other people, particularly regarding feeling judged and discriminated against as a child due to her ethnicity. She seems to perceive others' opinions about self-injury as coming from a reductionist or intellectual point of view reflecting a lack of understanding, an oversimplification and a lack of empathy. Sue also highlights an outdated but still held by some notion that self-injury occurs as an attention seeking behaviour. While this may be the case for some, it is noteworthy that no participants in this research reported self-injuring for a consciously attention-seeking reason. Quite the contrary, participants reported going to great lengths to hide their self-injury, finding great difficulty in talking about it to anybody and feeling stigmatised for having engaged in it. Sue's use of the phrase *'a whole sea of judgment'* highlights how the stigma around self-injury for her is multiple and varied; there exists for her an entire ocean of it and it is thus perhaps understandable why she and indeed others, are protective about keeping it a secret. Towards the end of the quote, Sue also insightfully recognises that peoples stigma about self-injury is also related to their tendency to focus on the physicality and the behaviour (which we could assume they find disturbing) as opposed to the behaviour being a symptom of distress and pain (which we could assume might evoke empathy). For Sue, the stigma associated with the self-injurious behaviour therefore overlooks the underlying factors, which might help reduce stigma and increase empathy.

For Helen, the anticipation of stigma seems to experienced as a heavy burden:

Well, the reason I hid it was because I didn't want to be known as somebody who self harmed because in my mind there were all

> *these negative stereotypes and all this sort of stigma around it that I didn't want associated with me because I already had issues with my identify. I didn't want this to be another thing that was weird about me. That was you know, that people would be scared of or laugh at or you know, whatever reaction people might have. I just didn't want that to be associated with me as a person… Yeah, I suppose because I had this internalised stigma of what people who self-harm are like which obviously I now realise is a complete fabrication. (Helen, 409)*

While Helen expresses her desire to avoid others being scared of her or of laughing at her, it may also be interpreted that she also appears to have internalised that anticipated stigma, even if it has not yet been experienced. Helen seems to make sense of her anticipation and desire to avoid stigma regarding self-injury as being motivated by an already held negative stereotype about people who self-injure, which she appears to distance herself from later in the quote. What Helen appears to be implying is that over time, she perhaps experienced a process of confronting her own held assumptions and stereotypes about those who self-injure, and in identifying as a self-injurer she arrived a the conclusion that those stereotypes and associated stigmas were a *'fabrication'*, which she no longer holds true.

For Gene, they describe their experience of stigma regarding self-injury as *'stressful'* due to people's opinions about it being imposed on them in some way:

> *It's always kind of stressful, because the world and his wife's got an opinion and they'll make sure you hear it, that kind of stuff… (Gene, 591)*

The above quote implies that this imposition is not welcomed and while they do not elaborate further about what people's opinions might be, it can be inferred that there is an expectation of them being negative and therefore finding this rather stressful. In contrast, what they prefer to do instead is keep it private and not think about it, let alone hear others negative opinions about it:

> *I felt like if I like, covered it up or wore long sleeves then I could forget about it. (Gene, 345)*

The above quotes convey from Gene an imposition of opinions from what feels like a large and abstract group of people; everyone. This word of people may be interpreted as being experienced by Gene as somewhat determined to make their opinions heard, again seeming to overwhelm Gene who resorts to a desire to forget about her self-injury, thus perhaps avoiding the stigma around it.

Participants' accounts of stigma in relation to their self-injury capture a common experience for many people, but more so within those who identify as minority groups such as those with mental health difficulties and those belonging to sexual minorities. This will be explored further and in relation to existing literature in the next chapter.

3.5. Super-Ordinate Theme III: *The Act Itself*

> *It was quite complex, but it was very simple.*
>
> *(Sue, 468)*

The third super-ordinate theme emerging from analysis of the data was *'The act itself',* which refers to the self-injurious act. This theme captured the experiences related to

self-injury, including reasons for self-injuring which was largely reported as being related to emotion regulation and in particular to experiences of anger, as well as experiences of how effective self-injury was for participants. Other sub-themes also overlap with this super-ordinate theme, for instance '*Conflicting self*' which is included under the first super-ordinate theme of *'Experiences of the self*' as well as *'Stigma'* under the second super-ordinate theme of '*Experiences of the other'*. These associations with other themes will be explored within this section, however *'The act 'The Act Itself'* is distinct in that it focuses on participant experiences immediately prior to, during and following self-injury.

3.5.1. Sub-Theme I: *Intense Emotions*

All six participants appear to report intense and distressing emotional states leading up to self-injury which were somehow relieved or reduced through engaging in it. Anne describes a distraction from emotional pain which self-injuring seemed to offer her:

> *I think it was just nice to not feel the emotional pain or not be so focused on that, at least for a while. Because obviously if you're bleeding or if you're sore or whatever then you can treat that and that very much will… your body is like, deal with this instead of all the stuff that's going on in your head about whatever's troubling you at the time. It was just nice to not have that kind of muddled mess that was going on in my head. (Anne, 135)*

The physicality of Anne's *'bleeding'* and feeling *'sore'* seems to allow her to focus on something visible and tangible, rather than feeling consumed by her emotional pain or as she calls it *'that kind of muddled mess that was going on in my head*'. While her emotional pain and her confusing thoughts are something she cannot see or touch, and as described earlier in this chapter, something she struggles to talk to people

about; her physical pain perhaps symbolises in a more acceptable way the emotional pain she feels. Within the above quote there seems to be a significant shift in mental state, which is achieved through self-injury and which Anne seems to appreciate. Anne goes on to offer one particularly clear account of engaging in self-injury in order to directly manage her emotions in the following quote:

> *… you can't really control your emotional pain, well not really. It's not easy to, but the physical pain stopped my brain from doing whatever it was doing. It was going into panic mode… and I managed to stop that with physical pain and that was also something I could treat and sometimes It was a bit therapeutic to be able to physically treat myself, even though I couldn't put a plaster on my brain or whatever, that was at least something I could sort of, help heal. (Anne, 355)*

It could be interpreted that in feeling powerless to address her mental health, Anne feels somewhat empowered, or at least in control, by being able to address her physical wounds. It is interesting to note how Anne's narrative here implies that her emotional distress and overwhelming thoughts seems to cease with a distinct abruptness with the infliction of physical pain. We might assume that without engaging in self-injury that a more gradual and progressive decline in Anne's distress may have occurred. However, by engaging in self-injury a kind of immediate relief and replacement may be interpreted as occurring. This interpretation highlights the seeming effectiveness of self-injury for Anne; while other methods may well be effective in eventually reducing her distress, self-injury seems to do so immediately and effectively. The effectiveness of self-injury feels confident in Anne's narrative above, however upon further exploration we it could be speculated as to where those intense emotions have gone. It seems difficult to conceptualise them as having been

resolved with such immediacy and lack of attendance. Hence, it may be interpreted that in engaging in the physical act of inflicting pain upon herself, Anne does not resolve her distress with lasting relief, but instead seems to put them on hold temporarily, perhaps implying that they remain lurking and brewing somewhere inside of her.

Sue's experience of intensely felt emotions is characterised by a similar but not identical process:

> *I think beforehand it would have been, I think a mixture of a lot of racing thoughts, anxiety, feeling overwhelmed and usually the first thing.. response would be I need to kill myself, I can't bear this and then after I'd worked through that there would be uhm.. you know, well what's left for me to do now? And then I'd start preparing stuff and decide I'm just going to chop and cut myself. (Sue, 400)*

For Sue, her intense emotional state leads first to consideration of suicide, which once '*worked through'* leaves her with a kind of residual need to act. Thus, she prepares her tools and decides to '*chop and cut' herself.* Sue's choice of language here may be interpreted as evoking quite a crude mental image of butchery and a sense of brutality towards herself. The intensity and complexity of her emotional state prior, is reduced to a simple decision to act. The process is one which Sue repeatedly describes during her interview: experiencing intense and overwhelming emotions, followed by a drastic reduction in them through self-injury. At the same time, Sue also acknowledges the short term reduction of intense emotions, which was followed by a longer term increase in emotional difficulties:

But also in terms of my own work trying to understand it while still self-harming… So there was, you know…. thinking about it, it was quite complex but it was very simple. It was a very, weirdly it's a very simple act but it... led to a lot of emotional issues and also uhg… yeah, quite… I would change it now. I'd prefer if I… if there was a less sort of, obviously destructive path but I think it did help me resolve quite a few things. (Sue, 464)

It seems here that the immediate reduction in emotional intensity is highlighted as short term only, given that in the longer term for Sue, her self-injury *'led to a lot of emotional issues,'* thus the paradoxical nature of self-injury is again evident in the above quote. Like Anne, Sue seems to recognise the simplicity with which self-injury can reduce her distress, but unlike Anne, Sue goes on to describe the temporary nature of this relief. Participants appear to be experiencing a process by which the emotional turmoil avoided through self-injury, seems to lingering after the effectiveness of physical pain as has subsided.

For Erin, emotional intensity was described as something she seemed to seek out through her early use of self-injury, rather than something she tried to reduce and she sets this desire to feel within the context of wanting to somehow be and feel her true self:

I had to do all the steps in order to be myself and to feel myself so, self injury, yes, so… I was very young and wanted to have strong feelings from it. I felt that I was wrong in that capitalistic country that is Switzerland, that as everybody knows is the empire of capitalism and… I just always really felt like I was different, unlike everyone

around me and I didn't understand that, I wanted to explore something that could give me a new vision of things. (Erin, 32)

Erin's description may be interpreted in many ways. It may be that due to living in an environment which she felt was not acceptable to her and within which she felt unlike everyone around her, she engaged in self-injury as a means of feeling something other than different, if perhaps she was feeling numb or disconnected from her environment at the time. It may be that Erin engaged in self injury in order to have strong feelings which would distract her from her discomfort regarding living in a capitalist country. Or, it may be that a discontent with the world around Erin at a young age when she perhaps did not yet have to tools to remove herself from that environment, manifests itself in the form of frustration, and she expresses this frustration by engaging in a self-punishing act. Feeling consumed by the capitalistic society around her, self-injury perhaps provided a way to feel grounded, real and somehow more authentic for Erin. Erin's experience within the above quote seems to imply a sense of seeking emotional intensity related to a discontent with her environment which contrasts to other participant experiences of seeming to seek distraction from emotional intensity often derived from within.

The notion of engaging in self-injury in order to feel more grounded, is echoed by the experiences of Helen, albeit within a different context:

I had all these terrible thoughts about myself and the only way that I could sort of get them out was to, was to cut myself and to… and to take control of it that way and you know, when I was really really upset and crying and you know… couldn't control my emotions, that was what I would turn to, to sort of bring myself down. (Helen, 222)

Helen appears to experience her critical self and her emotions in this instance as out of control and extremely upsetting, emphasised by repetition of the word '*really'*. She seems very sure of the fact that self-injury was for her, a means of bringing herself *'down'* which seems to be referring to a reduction of emotional state similar to Anne and Sue. Her use of language with regard to ridding herself of the *'terrible thoughts'* is followed by the phrase *'the only way I could get them out was to, cut myself'.* Although she does not explicitly say it, there is a sense of getting them out by cutting, i.e. cutting the terrible thoughts out. This is something which several participants alluded to, as if an opening of the skin which is the final physical barrier between the self and the world, allowed the thoughts or emotions to flow out of the self and be released into the world. The release of blood from the body may also symbolise the emotional release and echoes the ancient practice of blood letting which was seen as a means of also ridding people of their afflictions, whatever they may be. In contrast to Anne and Sue, Helen's reduction in emotional state may be interpreted as being more gradual somehow, she is *brought down* rather than *stopped*. It may be that Anne, Sue and Helen shared a general experience of reducing emotions through self-injury, but their choice of language as explored above highlights subtle yet significant nuances in how they reflect on conceptualisations of it. While self-injury seems to be experienced by participants in quite similar ways with regard to emotions and the act itself, the idiosyncrasies inherent are also evident.

Toby's most vivid and extreme memory of self injury is described as being preceded by a build up of traumatic life events:

> *PhD, stop sleeping 2 nights a week, Mum died, so stop sleeping about 3 nights a week, getting HIV, was about the 4th night a week I stopped sleeping and by the time my partner died, I remember for weeks on end I was not sleeping for 5 days in a row… (Toby, 383)*

Toby lists the events which took place in a somewhat detached manner without any reference specifically to how he felt emotionally as a result of the rising tensions and traumas he experienced. The litany of sleepless nights listed by Toby in a somewhat dispassionate tone does not distract from the growing sense of pressure rising within his quote. It may be interpreted that while Toby lists events without emotion, we can assume he must have been experiencing an extremely intense emotional period during this time. The nature of the trauma Toby lists as occurring for him is complex and severe; it may be that listing events in the way he does serves to protect him from accessing the associated emotions. It may also be that accessing and attempting to communicate those emotions is perhaps too daunting or difficult a task in that, language may be inadequate to convey what he may have been feeling at that time. Later in his interview, Toby does offer a more emotionally focused description of his expreinces, and his earlier avoidance of doing so can perhaps be understood given the intense fragility he communicates during this part of his interview:

> *I'm in pain inside. There's a little child, there's a little boy in here that's been hurt and is trying so hard in his life and I'm sharing with you… it's emotional (voice breaks)… I've got a lot of stuff to deal with. I try to play it down in my head and tell you about it and it just sounds so crazy. (Toby, 626)*

In this moment Toby's tone changes drastically as he is overwhelmed by the weight of his experiences and recalling them during the interview. He identifies the '*child*' inside of him who still experiences intense hurts and pains at the recollection of what he has been through and it might therefore be inferred that while Toby was in the midst of those experiences his emotions may have felt devastating and intolerable. An interesting observation within the above quote is how Toby seems to refer to a past

tense child version of himself, yet his choice of language and change of focus to the present tense, acknowledging me in the room with him is palpable. In doing so Toby seems to bring all of the emotional intensity of his child self into the present moment and it may be tentatively interpreted that this is indeed how he experiences his traumas as recurring within him.

Emotional intensity is also described by Gene, again within a different but equally intriguing context:

> *It's kind of quite odd to describe apathy as being intense because it's the lack of feeling but sometimes it would be, like (exhales loudly), I don't know how to describe… Like, it sounds… like, super (lowers voice and gestures) 'poetic and edgy' but, like… The void would become so intense that it wouldn't fit inside yourself… I don't know, it like, I feel like if I didn't deal with it... I don't know what would happen. It just felt, like, unbearable so I decided I had to. (Gene, 197)*

The emotional intensity Gene experiences is identified as apathy and while they rightly acknowledge the paradox inherent in what they are saying, it feels plausible and real for them which is reflected in how animated and expressive they are in speaking these words, as if in attempt to emphasise how they felt at the time. The apathy within seems to occupy space inside of Gene which they articulate as *'the void'* and which grows so big and intense that it could be interpreted as no longer containable, and Gene seems to fear what could happen if that void is not contained. The experience of Gene described here, somewhat echoes that of Erin, where it can be interpreted that a *lack* of feeling is experienced as unbearable and where self-injury could be interpreted as providing a means of making the numbness more bearable:

Well… I feel like a big part of my depression is apathy, not feeling anything a lot of the time and so self-injury for me was kind of a way of, I don't know… controlling that. (Gene, 172)

Gene ends the above quote by directly stating self-injury was a way of controlling their emotions. The notion of control in self-injury is significant and warrants further interpretation, which will be offered later in this chapter under the super-ordinate theme of *'Recovery.'*

3.5.2. Sub-Theme II: *Anger*

The second sub-theme emerging from the analysis under the super-ordinate theme of *'The act itself'* was *'Anger'.* While anger may be categorised under the previous sub-theme of '*Intense emotions',* it felt prevalent enough to warrant being categorised as a distinct sub-theme due to the fact that participant accounts of intense emotion (as outlined above) tended to be generalised and while some did identify specific emotions (confusion, depression, panic, fear, apathy, dissociation, anxiety, shame, guilt) they tended to refer to a sense of emotional intensity which was characterised by multiple and often conflicting emotions, which was conveyed through use of language under the previous sub-theme. In contrast, anger was an emotion which all participants referred to specifically and with regard to experiences of self-injury and which seemed to hold a particular poignancy in narratives told.

I would say on a lot of occasions it was anger… and then some of the time because I was actually depressed at the time, I was just usually already numb anyway. (Anne, 370)

Anne identifies anger as the first emotion when asked about the emotional experience around her self-injury. She follows this up with depression and feeling numb, which it may be interpreted are all somewhat associated emotional experiences. Depression and anger are emotions which commonly occur in existence with each other and there are many theories hypothesising about their relationship which will be explored in the next chapter with reference to existing literature. Depression may be said to be anger directed at the self in psychodynamic terms and within the context of self-injury the idea of directing anger towards oneself is obviously of particular significance

For Sue, anger is a theme present throughout her interview, with several references to how she perceives herself as having internalised anger derived from her environment:

> *So I think the anger possibly even though I wouldn't have been able to verbalise it at the time would have been, well… you know… yeah, I think the only word I can put is.. was frustration expressed as anger. It's quite a violent act in a way. (Sue, 148)*

Sue makes an important observation with hindsight, that she would not have been able to verbalise her anger at the time, which again seems a common occurrence for participants. Sue's assertion that her frustration was expressed as anger could be interpreted as a consequence of feeling like she had no place to voice or vent her frustration, meaning that it was eventually expressed as having developed into anger and violence. Within the above quote Sue also makes a link between her feeling angry and her carrying out the '*violent act'* of hurting herself. There is a tone of aggression in Sue's choice of words, a sense of lashing out with an explosiveness seems to be implied. While emotional intensity accompanied all participant narratives of self-injury,

the rising nature of anger and associated frustration was articulated quite differently by participants, with more specificity and clarity.

> *I used to get really angry, frustrated… I'd sometimes hit things and then would start hitting myself. (Sue, 15)*

Sue describes here a kind of progression with regard to the object of her anger as being firstly *'things'* and then herself. Anger directed at the self may also be interpreted as a kind of self-punishing act or a way of combining frustration at one's environment and release from unbearable emotions. In addition to directing her anger towards herself, Sue also describes experiences of directing her anger outwards, at those around her:

> *So I would get into fights, I would fight back, I would get into verbal fights and I was quite, uhm… You know, fairly on the edge of ending up completely beating someone up, or in the end ending up in some prison (laughs)… You know, in the youth offending and so… Uhm… So… And I think that was a way to contain that… To contain the rage. (Sue, 188)*

Sue's accounts of anger above appear to communicate her experience of directing anger towards herself, objects around her as well as other people. She describes verbal and physical fights with others, even risking an altercation which would result in her incarceration, which emphasises the severity of the fights she was getting into as well as the level of anger she may have been experiencing. Sue goes on to identify her anger as *'rage'* which has more of an implication of uncontrollability and lashing out which seems apt, given the context she describes. This lashing out is presented as enabling her to *'contain the rage',* which is a curious choice of language. The

description may also be interpreted as implying that Sue getting into fights was a way of *releasing* the rage, rather than containing it. These interpretations lead to consideration of what Sue's uncontained rage might have looked like. If getting into fights allowed her to contain her rage, we could assume that her uncontained rage perhaps could have been a kind of unstoppable and deadly force, which she sems to allude to. Indeed, Sue states several times in her interview that self-injury and the behaviours she associates with it, were in fact what kept her alive and protected her from a specific deadly force; suicide. The experiences Sue refers to with regard to anger throughout her interview are particularly poignant and it is clear that frustration, anger and rage for her, are a big part of how she makes sense of her self-injurious behaviours during that time.

For Erin also, anger is closely associated with her early experiences of self-injury:

> *I can remember that sometimes when I was very angry I used to take forks and hurt myself in the legs, because I have very sensitive skin in my legs. (Erin, 185)*

There is a deliberate intention within her quote of hurting herself, more specifically on her body where she is particularly sensitive, thus perhaps conveying a desire to really feel the pain Erin was inflicting on herself. There is a simplicity with which Erin delivers the above quote by identifying her anger, the means of self-injury, the body part and the reason behind this choice. There appears to be no doubt or confusion and it may of course be that hindsight allows for such clarity while at the time, Erin may not have been so sure of what and why she was doing. Nevertheless, the clarity with which Erin communicates her self-injury in the context of anger, contrasts to her earlier experiences of other emotions as being more confusing and layered.

Helen recalls her experience of self-criticism which is accompanied by anger and frustration. Given that Helen was having self-critical thoughts and feeling angry, again there is potential logic which is perhaps understandable in directing this anger towards oneself:

> *I was having all these, you know bad thoughts about myself and feeling angry and sad and frustrated it was… yeah, it was something like, that I knew would help me feel better. (Helen, 258)*

Interestingly, Helen refers to the same anger-associated emotions as Sue; anger, frustration and sadness. Helen adds that in engaging in self-injury, she *knew* she would feel better in some way. While she does not explicitly state how and why she would feel better, we can infer that Helen experienced a kind of release or satisfaction from being able to act on her anger even if it meant hurting herself, it seems worth while for her in this instance. There is also a directness in her tone within the above quote. She seems sure that self-injury would be a reliable method and means of helping her to feel better. Similarly to Erin and other participants, Helen appears to reflect on her anger with more clarity in comparison to experiences of other intense emotions.

Toby uses language which echoes Sue's experience of anger in the following quote:

> *I can't remember feeling any pain while I was doing it. It's like it didn't hurt because the adrenaline must have been running. I was just so angry. I was so possessed with rage. (Toby, 421)*

Toby uses the word '*anger'* first, and then *'rage'* with which he describes being *'possessed with*' again echoing his earlier reference to the demons inside of him. Within the quote above, it could therefore be interpreted that in this instance, that demonic part of himself took over and attacked his self. There appears a progression inherent in the quote above, which Sue also referred to where anger may be interpreted as developing into an uncontrollable rage. The severity of his anger is also reflected in his not feeling any pain, given the extremity of how Toby self-injured in this instance, by stabbing himself in the chest with a broken bottle. While he acknowledges that *'the adrenaline must have been running'* which would have reduced his ability to feel the pain, we might still consider that such an extreme act of self-injury reflects the extent to which he felt consumed by his anger.

Gene recalls their experience of anger and self-injury as having a subtle yet important distinction in comparison to other participants in that, they make a direct link between being angry with their mother and experiencing self-injury as being their mothers' fault:

> *I think we'd had a row or something but it was nothing major and that was the first time I did it. And I can remember- (exhales sharply)… It's quite harsh actually, thinking this kind of, like… not joy but like… this kind of vindictive pleasure that like... I was so angry at my Mum and that led me to self-harm and that kind of felt like something she was at fault for. (Gene, 260)*

Gene's first experience of self-injury is recalled as taking place within an interpersonal conflict with their mother. The '*vindictive pleasure'* they mention may be interpreted as a kind of pleasure one might derive from hurting another in a devious act of revenge. Instead, Gene hurts themself and experiences pleasure, while directly seeing their mother as being at fault. An alternative interpretation of Gene's *'vindictive pleasure'*

may be that they feel pleasure due to the fact that they perhaps know their mother would be affected negatively if she knew Gene had self-injured as a result of their conflict. If the other in this instance had been a peer or an acquaintance, or even a partner or other family member, Gene may not have felt the same vindictive pleasure. Within the context of a mother-child dynamic, Gene seems to assume an inherent difficulty and upset which their mother would experience as a result of knowing about Gene having self-injured. It is therefore possible that Gene felt this vindictive pleasure in harming the object of their mothers affection: themselves.

3.5.3. Sub-Theme III: *Effective Self-Injury*

The final sub-theme emerging from analysis under the super-ordinate theme of *'The Act Itself'* is '*Effective self-injury'*. The effectiveness of has been touched upon in presentation of previous sub-themes in this section, but its prominence for all six participants warranted inclusion as distinct theme. Previous sub-theme of *'Intense Emotions'* is closely related to '*Effective Self-injury'* in that, self-injury was experienced as reducing or generating intense emotions. While the emotional experience of self-injury was captured by previous two sub-themes, participant narratives also seemed to capture other ways in which self-injury was effective for them and which will be explored in this section. Inherent within the effectiveness of self-injury also emerged an insight into how self-injury became an often paradoxical and certainly a cyclical experience which participants struggled to refrain from feeling caught up in.

> *I remember just like, I was, I was starting to have a panic attack and I very clearly remember cutting my arm but it was over… this tea-towel and it probably didn't matter but it was with my left arm to my right. I'm right handed. I would usually do it the other way around and it was just... I was completely, I didn't feel*

anything when it happened. Sometimes, like… it's like still painful when it happens but I was completely numb. I literally… I did not feel anything and then I cut myself a few times and then I wasn't panicking anymore… (Anne, 332)

The experience of a panic attack is perhaps the epitome of feeling a loss of control. A rising feeling of dread and fear take over, accompanied by a sense of losing control and severe physical symptoms, which it seems as though Anne is able to combat quickly and effectively by self-injuring. The clarity with which the quote is delivered by Anne and her attention to details seems to emphasise her certainty about the incident she reflects upon. It may be further interpreted that this clarity also related to the effectiveness of self-injury for Anne where she simply isn't panicking anymore and we might assume that this was a desired and intended consequence. Anne also acknowledges something odd in her self-injury described within this quote in cutting her right arm with her left, which seems not to be how she normally self-injures. It may be that given the her state of panic at the time and the desire to quickly alleviate this, that Anne did not follow her usual ritual in preparing to cut herself out of absent mindedness or haste. Alternatively, it may be that Anne sought a new or alternative, and therefore more risky experience of self-injury to alleviate what she envisaged was an unusually severe state of distress. Either way, despite her panic, Anne seems to engage in self-injury knowing it will effectively reduce her state of panic. The description of not feeling the physical pain may also be interreted as adding to the perceived effectiveness of self-injury, in that we might consider physical pain as a deterrent. Anne however, simply does not experience pain in this instance, whilst she experiences the benefits seemingly immediately. Anne's intense and complicated emotional state prior to self-injury is described as being numbed with a quick, simple and direct physical act; '*I cut myself a few times and then I wasn't panicking anymore.'* The effectiveness of self-injury in managing Anne's panic in this instance is striking.

Anne again identifies the effectiveness of self-injury in her experience and how it allowed her to feel more in control of herself, namely of her emotions:

> *Being... it was, it was partially about control. I felt out of control in my situation. As I say it's not very easy to control your emotions especially if you are depressed… I didn't want to feel like that but it happened anyway. So I often felt like, quite helpless… so I guess the self-harm was a way of having some control and it's like… in a way like how other people might use other vices. Eating disorders and alcohol, drug abuse… I'd say they, well… in some way they're all like a form of escapism and or control and it just so happens that the method I ended up using was self-harm. I feel like it's, it's really closely related to other kinds of harmful behaviors anyway. (Anne, 410)*

Anne recalls her experience of depression as something which happened *to* her and which was unwanted and this seems to reflect her sense of not having control, which engaging in self-injury allows her to counteract with a sense of immediecy. She makes a comparison between self-injury and *'other harmful behaviours'* such as alcohol and drug abuse. Indeed it is possible to see the many similarities within cycles of alcohol and drug abuse when compared to self-injury. While substance abuse may cause longer term physical health problems, it offers users a fairly rapid and effective (albeit short term) solution. Thus, the individual feels compelled to continue engaging in that behaviour due to the strength of its effectiveness in helping them to alter emotional states in the short term, giving them a sense of control over what they are feeling in that moment, much like the cycle of self-injury described by participants.

For Sue, she articulates a different but similar effectiveness of self-injury in her experience:

> *I think it's definitively a coping mechanism. I think it stopped me from, I think it actually kept me alive. It helped me… whereas I didn't actually… when I felt overwhelmed it didn't mean I'd go and throw myself off the building or drink or take overdoses or try and kill myself. (Sue, 666)*

The above quote implies that for Sue, self-injury was could be interpreted as a means of effective protection from herself. Sue's multiple halting sentences before being able to go all the way and finish her sentence could be interpreted as her difficulty in voicing how self-injury prevented her from suicide. It seems she needed several attempts before what she wanted to say could come out. This may be due to the somewhat contradictory nature of what she is saying if taken at face value; hurting herself stopped her killing herself. Of course, when looking beyond the face value of what Sue is saying, the contradiction may be better understood. It may be interpreted that for Sue, self-injury is the lesser of two evils; she avoids attempting suicide, because she can self-injure and this sentiment is reiterated at other points during her interview:

> *Well I was heavily depressed and I thought about suicide a lot and… sometimes instead of, once I'd worked through the suicidal feelings I still, I was often left with this sensation of.. of… irritableness and feeling like I'm looking for something, or I need to do something or I need to take some action and then I'd start thinking of cutting myself, I'd think about blood and the drama of it… (Sue, 374)*

Again Sue directly states that self-injury was something she turned to when she was feeling suicidal and that the residual feelings which were left over one she had '*worked through the suicidal feelings'* were manageable through self-injury. Feeling suicidal is an intense, severe and existentially profound experience to go through. It is often one which individuals often go through alone, without support or feeling able to talk about it with others. Sue somehow manages to work through her suicidality, but it is perhaps understandable that after having been through such an intense process internally, she finds herself compelled to *act* in some way, to have some sort of outward visible expression of what she has just been through and therefore turns to self-injury. The tone with which Sue delivers the quote, infers a sense that if she cannot commit suicide, self-injury is effective in some way with regard to helping her manage resisting suicide. *'The blood and drama'* which Sue describes also seems significant in that, the drama may also be helpful to her in that moment in releasing her '*irritableness and feeling like I'm looking for something, or I need to do something or I need to take some action.'* The drama of her bleeding (and assumed need to clean herself up) may have allowed her the very *'do something'* she was looking for. The presence of self-injury as a physical option in being able to act, as well as the drama which comes with it, mat be interpreted as reducing Sue's suicidality.

Toby refers to the effectiveness of self-injury as being in its' ability to *'numb the pain'*, i.e. to replace emotional pain with numbness and for him, this is related to avoidance of sinking into a depressive state. His use of language evokes a sense of submerging slowly into a painful depression, within which self-injury can offer a kind of buoyancy:

> *Why do people do these things? They do them to numb the pain, to sort of… to be able to avoid sinking into the awful depression, which is the alternative. (Toby, 226)*

The above connotation is further emphasised by the below quote in which Toby positions self-injury within the context of other harmful behaviours in the same way that Anne does:

> *Yeah. Uhm… well…. I think it becomes a kind of constellation of defense mechanisms that I employed. Starting with depriving myself of food, fasting, starving myself, that uhm… developed into drug taking behaviors as a young man that helped me keep the weight off, that could also be considered as self-harm. (Toby, 201)*

Again, the use of language is poignant here. The *'constellation of defense mechanisms'* Toby refers to conveys a sense that self-injurious behaviours in his experience, defend him and protect him from something effectively, even if temporary. It could be interpreted that what self-injury defends him from, is himself, or at least a part of himself; '*but of course that ugly beast is still there.' (Toby, 496).* It appears as though, for Toby and indeed other participants, the effectiveness of self-injury is in some way acknowledged as being short-lived and not without negative consequences. For Toby, the ugly beat he refers to still resides within him thus, the effectiveness of self-injury seems not to be in resolving problems, but rather in temporary dissipating them. Despite it's temporary nature and acknowledged negative consequences, the strength and reliability of self-injury as a coping mechanism is something which all participants speak of with confidence.

For Helen, feeling better and feeling in control again is where the effectiveness of self-injury exists:

> *… it was something like, that I knew would help me feel better. You know, like, the counseling, the CBT and everything was meant to give me ways to control things but nothing really was effective apart from hurting myself. That was, that was the thing that I could always… knew was going to help. (Helen, 261)*

Helen compares the effectiveness of self-injury to what most people would consider the valid, healthy and appropriate alternative, mental health treatment. But in the comparison made here, there is no doubt that for Helen, neither cognitive behavioural therapy nor counselling seemed effective whereas self-injury is the one thing she '*knows'* will help. Helen also refers to self-injury as enabling her to feel calmer and more in control, similarly to Anne's experience explored earlier in this section. Helen goes on:

> *But, it really made me feel calmer and really you know, 'cause… and when I was sort of recovering from it and… from all of these little episodes and cleaning myself up and everything it was… I don't know, I suppose I just felt more in control and more uhm… more grounded. (Helen, 236)*

The use of language evokes a similar image to that evoked by Toby's use of language regarding the effectiveness of self-injury. For Toby, self-injury lifts him *up* out of sinking into a depression, while for Helen her use of language in the above quote evokes a sense that self-injury brings her *down* and grounds her somehow. While one uses self-injury to rise out of depression and the other uses self-injury to return back to the ground, it could be interpreted that engaging in self-injury to effectively and efficiently return to a baseline of feeling and functioning.

Gene explores the effectiveness of self-injury for them, in a very direct and clear manner,

> *It wasn't as if "Okay, this situation is out of control and if I self-harm I will be able to control it." That's not what I was thinking but if the particular feeling got like, too much or too intense, if I self-harmed it, you know… would make you feel better so I just did it. (Gene, 176)*

They relate it to feeling in control and feeling better, echoing Helen's experience. Gene goes on to describe their experience of the effectiveness of self-injury which also echoes more of what Toby and Helen state, with the below quote:

> *Yeah. It kind of would bring me down, more down to like a baseline level of like… I can like do things. You know, I can get out of bed in the morning, I can like… I don't know it just kind of like… Balanced things out. To make sure I could at least be semi-functional. (Gene, 188)*

Gene expresses how self-injury was for them, effective in bringing them back to *'baseline'* in the same way as Helen and Toby (although for Toby, self-injury *lifts* him up to baseline) and they translate this baseline as a level from which they are able to *'at least be semi-functional'.* This seems to be an important development of the effectiveness of self-injury in that it not only brings Gene back down to baseline, but also allows them to function better somehow. Thus, it may be interpreted that self-injury is not simply about trying to feel less or more of anything, but also about needing to function effectively.

The super-ordinate theme of *'The act itself'* ends here. The above analysis and interpretations show how self-injury for all participants was strongly related to experience of intense emotional states, particularly anger and that self-injury played a very effective role in participants' experiences of regulating emotional states and being able to function. Whether for generation of emotion or reduction of emotion; this aspect of the behaviour was key for all participants. In addition, it is clear that there was a shared experience of self-injury being a highly effective means of feeling protected from suicide, defended against the self and more in control, even if only temporarily, which some participants related to therefore being able to function in the world, something which they otherwise might not have been able to.

3.6. Super-Ordinate Theme IV: *Recovery*

The only way to save ourselves is by being ourselves.

(Erin, 608)

The fourth and final super-ordinate theme to emerge from analysis of the data was *'Recovery'.* This super-ordinate theme represents the experience of overcoming their struggles, which all participants reported in relation to self-injury and associated difficulties. Participants' accounts of overcoming reliance on self-injury incorporated a shift in their perspectives, which involved different factors but which shared the common experience of feeling as if they had either returned to something, or found something new that enabled an alternative means of coping with life. This emerging theme captures the profound strength and empowerment participants eventually felt in their journey with self-injury. Analysis within this section focused on how participants found ways to not only overcome their self-injury, but also transformed that achievement into something they were proud of.

3.6.1. Sub-Theme I: *A New Perspective*

'A new perspective' emerged through analysis of participants' expressed changes in how they experienced and made sense of themselves, their self-injury and the world around them.

> *I don't know, I think it's because to me now, my experiences are more of a useful tool in the way that… I got involved with peer support. For me the thing that really actually changed things for me… was the peer support program. (Anne, 486)*

Anne explicitly states that her experiences of self-injury and the associated difficulties with emotions and identity are now a *'useful tool'* for her. She associates this change in perspective about her self-injury and herself as being a consequence of having gotten involved with a peer support program. This stands in stark contrast to her earlier meaning making around her experiences of self-injury as painful, overwhelming and confusing. We might infer that she has been able to make sense of those same experiences and turn them into something she now finds useful or at least positive in some way. Anne elaborates on how her experience of peer support services enabled her to change her perspective:

> *I was able to talk about the things that were troubling me and the self harm with people who I knew understood, although we all have our own circumstances, we all basically had had the same experiences and they wouldn't judge me either. It wasn't like, a free for all place with no rules. It's still very much a structured safe place to be, but it wasn't somewhere where they… I wouldn't walk in there and they'd be like 'Stop self harming now!' it was like, 'How are you getting on?' There just*

wasn't any pressure and there was no judgment so for those couple of hours every week I would have a safe space where I didn't have to worry about the things I was saying… (Anne, 496)

It could be interpreted that the effective ingredients of peer support which seemed to allow Anne to consider a new perspective were feeling like she was understood, sharing experiences with those who did not judge her and feeling like she had a safe space to express herself within. Therefore we might further infer that in feeling safe within peer support, Anne did not anticipate stigma or judgment about her self-injury or her mental health, which seems to have been an invaluable experience for her at the time. Often this is not people's experience of mental health services and professionals, particularly for those who self-injure, as services and professionals can sometimes increase feelings of shame and stigma, or this is anticipated as being the case, even if it does not transpire. For those who identify as a sexual minority, it could be said that feeling heard and understood without fear of judgment is particularly important. At risk of taking the interpretation a little far, it could also be inferred that while the peer support group Anne refers to does not seem to be specifically aimed at sexual minorities, in feeling safe there it may have been that she found this experience validating in terms of all aspects of herself including her sexual identity and not simply with regard to her self-injury, i.e. in being able to explore her self-injury otherness, she also felt more able to accept her sexual orientation otherness.

In addition to benefitting from peer support services, Anne states that she has remained involved with the service and now facilitates self-injury peer support groups as well, and works on raising awareness to reduce stigma:

The work just continues to be really effective and like I said, I just now use my experiences to help… I just try to explain things from

> *my perspective having gone through it, that they might better understand. Because people are becoming a lot more willing to listen now… and I've done quite a lot of talks about the stigma around self harm. (Anne, 518)*

It appears Anne has come full circle, in a sense. She now talks publicly about her experiences of self-injury, instead of hiding them as she did before. This sheds light Anne's previous assertion about self-injury having now become a *'useful tool'* for her. In the way she describes, we might interpret that in contributing towards to reduction of stigma around self-injury, Anne perhaps derives a sense of empowerment at being able to confidently address the things she once struggled with in public forums.

For Sue, a similar sense of gain for having been through her journey with self -injury is expressed:

> *That's just another… process or a journey that I've been on and I'm still here, getting on with stuff. So, I think it's made me more resilient, stronger, it helped me to understand myself. (Sue, 713)*

In addition to making her feel more resilient and stronger, Sue identifies that her journey has also helped her understand herself better. Given the conflict and confusion that Sue reported experiencing earlier in her interview, this improved understanding seems of paramount importance with regard to not only cessation of self-injury, but also with regard to her sense of self and understanding of that self within the world around her. The quote above connotes much more of a sense of calm and acceptance. Sue goes on to describe how her journey through self-injury not only helped her understand herself, but also helped her and is reflected in her artistic endeavors:

That whole process brought me back to my art as well and I used a lot of my art to… uhg... I remember somebody saying that the paintings I was doing about nine, eight-nine years ago were really angry. When I look back now they sort of are, they're like an aggressive landscape and… and… it's completely different where I am now. (Sue, 718)

I felt maybe a bit self indulgent, but looking back now I think it really was me uhm… Sort of coming back to art and instead of cutting shapes all over myself I started drawing again and I think that really helped. (Sue, 362)

In her *'coming back to art'* and also in being able to see the difference in her art work seems to be a visible and tangible indicator of her recovery. Her return to art, perhaps offered her alternative means of expressing herself, instead of having to turn to self-injury. Sue's use of the phrase *'instead of cutting shapes all over myself I started drawing again'* is poignant. In shifting from *'cutting shapes'* on her body as the canvas to express herself, she seems to return to using drawing as a means of expressing herself, without harming herself.

While Anne turns her experiences into something positive through her involvement with peer support services and Sue turns her experiences into art work, Erin expresses a new perspective with the following:

I don't want to destroy myself. Actually I could destroy myself, if I would well, this is not my intention. My intention with time has changed and it's about healing me with cuts and pain instead of destroying me. (Erin, 387)

> *Now when I'm angry I take a tiny bit of diazepam (laughs) and so I'm a bit relieved and then I do my artistic things with my friends that I… you know body modification and stuff… because I don't take drugs, I don't drink alcohol. Normally I, normally I go swim in the sea or go and dance or go and run with dogs from the dog shelter or whatever, I do some sport like pole dancing or I go and I ski, (laughs). (Erin, 212)*

Erin articulates a desire not to destroy herself and instead to heal herself, albeit with cuts and pain. The method, for her remains the same, but her perspective and use of that method as well as what she seems to derive from it appears to now have changed into something more positive for her, and while she continues to engage in behaviours which technically speaking involve the destruction of body tissue, for Erin this is transformed into something quite healthy which she positions along side typically healthy physical activities such as running, swimming and dancing. There also appears to be an interesting shift in how Erin reflects on her changed e perspective with an added social element to her healthier alternatives, which was not present regarding her self-injury in younger years. The *'artistic things'* she replaces self-injury with are engaged in with friends and there also appears to be a performative element to what she describes in relation to her body modification and body suspension (this is confirmed later in her interview). While self-injury was a private and destructive experience, Erin now relies upon activities which are shared with the world through what appears to be friendship and performance and which also seem to offer her health and a deep seated sense of spiritual connection:

> *I understood that piercings or something connected with piercings was going to be my God, actually. My freedom, my safe place, my truth, my belief, my everything. (Erin, 94)*

Erin's experience is somewhat different from that of other participants within the sample in that, she continues to engage in practices which could be interpreted as self-injurious, violent or destructive. However, her *experience* of those practices and the process with by she describes engaging in them, as well as the benefits she derives, is indeed much like other participants' experiences of strength and recovery.

Helen's experience of a change in perspective can be interpreted within the following quote:

> *Like I've come to terms with it. I've got tattoos to cover them up, the scars, which has actually been really helpful. Like, it's been really sort of… cathartic in a way to not have this reminder of myself and how difficult things were for me when I was younger. (Helen, 452)*
>
> *I suppose I was tired of not wanting to show parts of my body because of the scars and I wanted to have something that was, that was pretty, that I wanted to look and that I wasn't ashamed of… so, I've been building them up over the last three and a half, no, four years. I've been building them up and I now have… I still have some to, that I want to get but, the majority, the worst scars are covered now. Which is nice… But I see that now and don't see the scars. That's, that's the past now. It's enabled me to sort of, move past it. (Helen, 479)*

For Helen, the covering up of her scars from self-injury with artistic tattoos which are *'pretty'* to her, may be interpreted as symbolising her having overcome something and shifted into a new perspective, which is better for her. Her scars seemed something

she was self-conscious of; they are an indicator to the world and may remind to her of the associated distress and potentially evoke shame regarding what she has been through. In reality, the scars of her self-injury are still present, as may be the internal scars of what she has experienced, but in tattooing over them, there now exists another layer of the self she has chosen willingly and intentionally and which she finds attractive, thus she is able to somehow '*move past it'.*

Toby's sense of a change in perspective is captured by the below quote within which he seems to embrace and integrate his *'demons'* into his wider sense of self, rather then attempt to ignore or exorcise them away. His words evoke a sense of integrating parts of the self as well as of accepting parts of the self:

> *And my demons will be more loving than harmful and because I'm forgiving in my nature I just think I'm going to get further in life from that. I'm looking forward to the future where I hope it's less tumultuous. (Toby, 690)*

Toby talks in the future tense, perhaps implying that his change in perspective is still ongoing, but the paradox he connotes with his *'loving demons'* seems to capture the paradox of self-injury very well. Toby states that he looks forward to his future which indicates a certain sense of hope and willingness to move forward through his life. He also expresses his hope for a less tumultuous future and this could be interpreted as an acknowledgement that things could still prove difficult in the future, but his forgiving nature evoked a new element of self-compassion and acceptance.

Gene also expressed a kind of change in their perspective where self-injury was no longer something they wanted to or felt able to continue engaging in:

I felt like during that time I was, kind of… growing a lot as a person, like, and making sure that I was... I don't know. I'm always kind of keen to like, improve myself and I was making myself become more confident and more.. I don't know, on top of my studies and stuff like that. Trying to put behind in the past what I've messed up already and with that, like, came…. I felt like you can't improve myself as a person if I'm gunna carry on with this harmful behavior so I stopped doing it, even though I really wanted to at times just for the sake of it… having a better self-image of like, I don't know, being able to look in the mirror and like, not feel so out of control all the time, feel proud of what you've done during the day kind of helped me deal with it, so… Yeah. (Gene, 487)

Within the above quote there seems to be a recognition that if they would like to *'improve'*, self-injury would have to be dropped as a coping mechanism. While this appears an obvious idea, it was clearly not something Gene felt able to access and reflect on while they were in the midst of self-injuring. Gene elaborates on what factors enabled them to *'look in the mirror'* and *'feel proud of what you've done'* which implies a kind of new relationship with themself; one which is more accepting:

I feel like having the courage to not be assumed as straight is always kind of a nice thing because sometimes it can be like- even now, like, I wouldn't say that I'm particularly bothered being, like, being not straight but some situations can be quite scary in the sense that… you can either say nothing and let people assume you're straight or.. you know, say something. And if you manage to say something in that situation and kind of like, don't-… that is quite a positive thing I find and uhg… it's, like, when you go home

and think 'Yeah, I'm glad I said something' and stuff like that, so I think that's quite nice. (Gene, 509)

Gene refers here to the micro-aggressions which individuals belonging to minority groups might experience on a daily basis and finds a positive correlation with addressing them and their mental health, which also implies that not addressing them was having a negative impact on their mental health. This positive correlation for Gene between coming out and improved mental health will be explored in more depth within the next section. With regard to the current theme of '*A new perspective'*, it is evident within the above quote that while Gene did not feel able to address the daily struggles with regard to their sexual and gender identity in the past, at some point a shift occurred which seemed to motivate them to address these daily struggles, seemingly with great benefit.

3.6.2. Sub-Theme II: *Taking Control*

The second and final sub-theme emerging from the analysis under the super-ordinate theme of *'A new perspective'* was '*Taking control.'* Given participants' shared experiences of losing control which has been evident through presentation of previous themes, it was unsurprising that in their account of recovery, taking control was a prominent theme. Self-injury was experienced as a means of taking control for many participants, but seems quite distinct from the kind of control which they describe below.

Anne communicates a realisation that she in fact has some choice in how her treatment is delivered and that seems to imply that she has some control over it. If self-injury is something which causes her to feel out of control, it makes sense that it should be important for her to understand that she does have some control (albeit not total control) over a treatment with which she engages:

> *I hadn't realised or been informed before that basically I… I had some say in my treatment… Obviously it was their decision in the end but I could say 'I would prefer it if my treatment went this way or that way.' (Anne, 296)*

Anne makes an important distinction between her not realising and her being informed that she does have some say in her treatment. An individual accessing treatment for self-injury might experience hesitation about engaging in the process at all, especially if feeling the stigma attached to self-injury and especially if presenting as an adolescent or young adult in the midst of mental health difficulties. It may be inferred that in feeling like she had some control over the treatment for self-injury, Anne was perhaps able to begin to feel in control of something as such, allowing her a starting point for recovery which in the midst of the cycle of self-injury may have been inaccessible at the time.

For Sue, her sense of feeling more in control is not related to treatment, although she did receive treatment, but is instead related to her own leisure activities:

> *You know… and a lot of things were just getting repressed which I knew were still there because I would still have incidents of becoming angry and sometimes having fights in the street and I'd started doing karate around 1990 and you know, I managed to tone that down, which it did, it really helped. So I did a lot of I suppose quite empowering things, which helped me feel more in control. (Sue, 979)*

Sue associates directly her engaging in empowering activities with her feeling more in control. Assuming that with power comes control, Sue seems to recognise this clearly

as being her own experience at the time. The activity Sue refers to in the above quote is karate, which perhaps enabled her to continue expressing a kind of violence or aggression, but within a controlled and safe context, much like Erin's experience of body modification, body suspension and BDSM. Both seem to have found a healthier outlet for their violence, rather than self-injuring or suppressing it completely:

> *I was a lost soul. A young lost soul. A young dark soul and I reached the light with these things, I took control of myself again… so, other people might think I'm psychotic or that crazy because I do these things, but I'm not. (Erin, 620)*
>
> *I wanted to heal myself from violent rape that I went through when I was nineteen because of the fact that I'm a lesbian a guy raped me so… problems that I had in my life when I was at that point, after solving those problems, always with BDSM, piercing all of the body modification, but without taking pills or without going to a psychologist or anything. Only with the healing power of body modification, then at that point being a straight-edge girl and having solved all my problems, then I was ready to get the big body suspension prize that is the best thing that I explored in my life and is…. The highest thing I can say. So I'm doing this regularly because of the power it brings. But, only after preparing myself for years. (Erin, 303)*

The above quote eloquently articulates Erin's sense of understanding that to others, her practices may appear pathological. In her journey from feeling a *'young dark lost soul'* to, through these practices, being able to reach *'the light'* she makes clear that she rejects the perception that her practices are pathological and are instead for her, a means of reaching her authentic and powerful inner self. Erin speaks of how

engaging in such practices allowed her to heal herself of trauma through BDSM and a lengthy process of preparing her body for suspension. It may also be interpreted that withi the above quote, the emphasis seems to be on healing herself in a way which maintains her independence and control, '*without taking pills or without going to a psychologist or anything'.*

Similarly to Gene, Helen associates her sense of taking control with addressing her sexual identity. With hindsight, she seems able to see the problems it caused for her, implying that she was not able to address this before:

> *… since coming to identify as bisexual I really have realised it was something that caused a lot of problems for me. In not being able to accept it. Addressing it for me, meant I was taking some control in a positive way instead of in a destructive way. (Helen, 874)*

Helen also highlights that in this context, her taking control was not a destructive method (which we can assume she is referring to self-injury), but instead is '*in a positive way.'* It could be inferred that in not feeling able to address her sexuality, Helen experienced a growing sense of lacking control. When conceptualised within the context of her sexual identity being assumed heterosexual, we might imagine that daily life provided many instances of confrontation within Helen and it seems as though in finding a way to address her sexuality, Helen regains a sense of agency.

> *I'm glad I've managed to control myself to the extent that I'm not, I'm not scared of loosing control like I used to be. I'm not worried about where things are going to go if they start getting a bit argumentative or aggressive or confrontational. I know that I can reign myself in now. There's a lot to be said for that. (Toby, 694)*

For Toby, he associates his ability to take control of himself as allowing him to no longer fear being out of control. As well as having confidence in his being able to control himself, it could also be interpreted that doing so and consequently ridding himself of the fear of loosing control was a powerful process to go through and he acknowledges the power of his experience with '*There's a lot to be said for that.'*

> *Once I started uhm, coming out to people and started taking a bit more control over my own life… I felt like it was easier to take control over how I was dealing with my depression. So that positive correlation between recovery and coming out for me. (Gene, 474)*

Much like Helen, Gene relates their newly gained sense of control with their coming out. Gene seems to go further however, in saying that once they were able to take more control of communicating their sexual and gender identity, this in turn had a positive impact on their mental health. In their case, the experience of coming out seems to have empowered them and perhaps grounded them within their own authentic identity, which consequently improved their mental health.

3.7. Conclusion

This chapter offer an interpretative analysis of participants experiences of self-injury while highlights the complex, multifaceted and idiosyncratic nature of the phenomenon for those who identify as LGBTQ+. This analysis aimed to answer the research question of 'how does an LGBTQ+ individual experience and make sense of their self-injury?' While emerging themes captured similarities in experiences, this detailed analysis also highlights the differences in those experiences and the idiosyncratic nature of how individuals experience of both self-injury and sexuality. The next chapter will offer readers a discussion of findings from this analysis within the context of

existing literature, an account of the implications and contributions of this research as well as an evaluation methodology.

4. Discussion

4.1 Introduction

The following chapter will offer readers a theme-by-theme summary of findings as outlined in the previous chapter while positioning them within the context of existing literature and highlighting how they confirm or contradict the body of research. The overall contribution of this research to the field of self-injury and its' significance for the LGBTQ+ population will be explored, as well as a consideration of future directions for research. In addition, a methodological evaluation of this research will be offered. Within this context of an evaluative discussion of findings it is important to again clarify the research aims: to explore how adult individuals identifying as LGBTQ+ experience and make sense of self-injury. Particular attention was given to experiences pertinent for LGBTQ+ individuals. As will be further explored below, participants' narratives demonstrated complex and changeable experiences of self-injury, given further resonance by reflections around experiences of sexuality.

Adopting an IPA approach allowed for an emphasis on the most pertinent themes emerging from analysis in a way which was particularly helpful and appropriate, given and sensitive nature of both self-injury and sexuality. The commitment to an inductive

approach inherent in IPA allowed participants to discuss their experiences in their own way, setting their own agenda and expressing what they prioritised (Smith, Flowers & Larkin, 2009). While IPA research does not aim to offer generalisable findings, it does instead offer findings which can be theoretically incorporated into clinical practice, and its' insights are particular useful when working with minority and stigmatised groups. This chapter will close with a brief summary and conclusion.

4.2 Summary of Analysis

Broadly speaking, the key contributions of the present research are in offering a comprehensive account of how LGBTQ+ adult individuals make sense of their experiences of self-injury. Existing research suggests that individuals identifying as belonging to a sexual minority group demonstrate increased rates of suicidal behaviours, self-injurious behaviours and mental health difficulties (Hatzenbuehler, 2011; Herek & Garnets 2007; Mortier et al., 2018), and while some of the findings from this research are applicable to self-injury in general, the aim was to place particular emphasis on the particular meanings attached to participants' experiences given their sexual minority status.

Four super-ordinate themes emerged from the analysis of the data. 'Experiences of the self' was the first theme emerging, and captured participant reflections around multiple and often conflicting inner selves, as well as a resulting confusion in their experience of this. All participants acknowledged a part of the self that was aware of the destructive nature of their self-injury and the negative consequences it had for them, but also outlined another part of the self that felt compelled to self-injure, given the perceived effectiveness of self-injury when coping with difficult emotions. This polarisation of selves was reported as difficult for participants to manage and they often found that the critical and chastising part of themselves increased feelings of otherness

and shame. As a result, participants experienced themselves as flawed, abnormal and therefore defective in some way, due to their self-injurious identity and/or their LGBTQ+ identity.

The second super-ordinate theme emerging from data analysis was ‘Experiences of the other’. This theme related to participant experiences of their social worlds, including family, friends, peers, partners, professionals and wider societal attitudes. Experiences of family were particularly pertinent for all participants who reflected on early experiences which might have predisposed them to self-injury. Experiences of struggling to talk about self-injury was also emphasised and stigma emerged as a strong factor influencing this process. Of particular significance was that ‘Experiences of the other’ seemed to generate exploration not only self-injury, but also of sexuality in terms coming out, negotiating visibility, anticipating and experiencing discrimination. Regarding both self-injury and sexual identity, participants reported an anticipation of judgment or disapproval and this anticipation seemed to cause much stress and further increase feelings of isolation. An internalisation of stigma associated with both self-injury and sexual identity was reported within this sample. The parallels between participant experiences of self-injury and sexuality will be explored below, highlighting how those who self-injure and also belong to a (sexual or other) minority group, anticipate and indeed experience particularly pronounced feelings of isolation and otherness.

The third super-ordinate theme emerging from the analysis was ‘The act itself’. This theme captured participants’ understanding of their emotional states and reasons for self-injuring (predominantly emotion regulation), with a particular focus on the role of anger in self-injury. In addition, this theme captured the perceived effectiveness of self-injury for participants in increasing feeling of control, reducing distress and in acting as a protective behaviour for some participants.

The final super-ordinate theme emerging from analysis was ‘Recovery’, which aimed to capture how all participants described a journey in which they eventually found ways to overcome their difficulties related to self-injury. For some participants this was preceded by positive experiences of coming out, which enabled them to feel able to take control of their self-injury, and for other participants recovery was hindered by experiences relating to their sexuality. A new perspective seemed to accompany participants’ experiences of recovery, as they felt better able to take control of their self-injury.

While this chapter will seek to situate findings within the context of existing literature, it is also necessary to recognise the idiosyncratic nature of each participant experience of self-injury, as captured by the phenomenological approach of this research which does not aim to make generalisations, but instead value the individual experience and meaning making. Furthermore, emerging themes are presented as a result of researcher interpretations of participant interpretations, as is the nature of IPA research. Thus, the findings are a result of combined participant and researcher meaning-making.

4.2.1. Experiences of the Self

That those who self-injure experience the self as complex and conflicting is well established in existing literature which highlights how individuals’ desire to manage emotions through self-injury exists alongside an awareness that self-injury also generates another set of negative emotions (Klonsky, 2007; Morris et al., 2015). Individuals therefore experience the benefit of being able to manage emotional states through self-injury, however are thereafter subject to increased feelings of shame, isolation and fear (Morris et al., 2015). Nock and Prinsteins’ (2004) four-factor model proposes that there exists a paradox within experiences of self-injury in which

individuals feel conflicted between a desire for alleviation from unwanted emotional states that self-injury will offer, and an awareness that self-injury is destructive for them in that, another set of negative cognitions and emotions are experienced as a direct result of having self-injured. This research supports these existing findings by highlighting the conflicting and paradoxical nature of experiences of the self in those who self-injure with a similar process of feeling compelled to self-injure to manage distress and with feelings of regret, shame, isolation and fear all being reported post self-injury by participants.

Existing research suggests that those who identify as belonging to minority groups are disproportionately affected by self-injury (Hawton et al., 2014; Vinokur & Levine, 2019; Cooper et al., 2006; Luiselli, 2009), including those identifying as a sexual minority (Cawley et al., 2019; McDermott et al., 2018; Whitlock et al., 2006). LGBTQ+ individuals are subject to increased adverse experiences due to their LGBTQ+ status, including actual or feared rejection from others, social isolation, stigmatisation, discrimination and bullying (Bruffaerts et al., 2010; McLafferty et al., 2016). Those identifying as LGBTQ+ and who also self injure, are therefore at increased risk of experiencing the negative consequences of self-injury outlined above. If those self-injurers identifying as cis-gender/heterosexual also experience feelings of isolation, fear and shame post self-injury, those identifying as LGBTQ+ who self-injure seem to express a particularly poignant and profound sense of defectiveness; in identifying as both self-injurer and LGBTQ+, the individual may perceive themselves as further away from 'normative' society (i.e. those who are heterosexual and do not self-injure) and therefore ever more isolated.

In experiencing themselves as belonging to a minority group of self-injurers as well as a sexual minority, LGBTQ+ self-injurers face an additional layer of otherness with regard to experiences of the self. Participants reported experiences of otherness not

only due to their self-injury but also due to their sexual orientation and/or gender identity. Sexuality in general was experienced by all participants as something threatening and difficult to manage at some point in their lives, much the same as their reported difficulties with managing self-injury. Direct links were made by participants around how they experienced either self-injury as another thing to hide in addition to their sexuality, or that their sexuality was something to hide in addition to their self-injury. Experiences of both seemed to confound each other and contribute to participants' increased feelings of otherness. Existing research supports the notion of increased stress when identifying as a minority within a minority, as found in this research. Jackman et al., (2018) explored experiences of trans-masculine individuals who self-injure. Researchers drew on minority stress theory (Meyer, 2005) and reported that in identifying as both self-injurer and LGBTQ+ individuals occupied multiple layers of otherness, as well as feeling a minority within the LGBTQ+ community also. As a result of multiple layers of otherness and the complex intersectionality at play as a result, researchers highlighted how experiences of the self and identity within this context can increase isolation and hinder attempts to access support. For example, those identifying as transgender may experience prejudice from lesbian, gay and bisexual identifying individuals, hence accessing peer support may be a process (at least initially, during early exploration) fraught with rejection. In identifying as both self-injurer and LGBTQ+, participants in this research appear to reflect on experiences of a similar nature, where occupation of multiple minority statuses increases the difficulties of negotiating the self within this process.

Indeed, even within close friendships and familial relationships, participants reported fear of discrimination and stigma regarding both their sexuality and their self-injury. This is also in support of existing literature which finds experiences of the self in self-injury are characterised by notions of non-acceptance, abnormality and conflict (Adams, Rodham and Gavin, 2005). Not only did participants experience the self as

conflicting and isolated, but also of being wrong, abnormal and deficient in some way. Some participants labeled their defective self as ‘demonic’, ‘devious’ or ‘vindictive’; despite the acknowledged negative consequences of self-injury, participants reported that their defective self seemed to ‘take over’ in a kind of dissociative state characterised by detachment from surroundings and indeed emotions. Interestingly, participants reported more severe instances of self-injury when in touch with this defective part of themselves. It seemed as though there were moments when the more compassionate and nurturing parts of the self were completely overtaken by the defective self. During these instances participants also described not feeling pain while self-injuring. It may be that the switch in sense of self which seemed to take over during these episodes of self-injury reflected the dissociation which is commonly experienced in self-injury (Karpel & Jerram, 2015; Calati, Bensassi & Courtet, 2017).

Experiences of the self as defective also seemed to be exacerbated by experiences of relating to other people (as will be explored in the next section of this chapter). Childhood experiences of bullying, abuse, racism, homophobia and of feeling invalidated by caregivers were also prominent among participants, contributing to experiencing the self as defective. This is also in support of existing literature which purports that such adverse experiences are predisposing factors for self-injury (O’Neill et al., 2018; Cawley et al., 2019; Hinduja & Patchin, 2010; O’Connor et al., 2012), particularly for LGBTQ+ individuals (Karlsen and Nazroo, 2002). The threat of perceived or actual social rejection and associated shame has the potential to be internalised in LGBTQ+ individuals (Moody, Starks, Grov, & Parsons, 2017; Okutan, Buyuksahin, & Sakalli, 2016), and this said internalised homophobia is well established in existing literature as being significantly associated with self-injury (Igartua, Gill & Montoro, 2014; Scott, Pringle & Lumsdaine, 2004). This research firmly supports the body of existing literature around the associations between internalised homophobia and self-injury. While self-punishment is a well documented function of self-injury

(Gratz, 2003; Klonsky 2007), the current research findings seem to reflect this in terms of internalised homophobia where, for those individuals experiencing bullying, abuse and discrimination (due to self-injury) who also identify as LGBTQ+, those adverse experiences have a particularly poignant impact and potential to be internalised into a sense of shame and unacceptability regarding one's LGBTQ+ status. Participants in this research reported that both anticipated and actual experiences of homophobia, contributed directly to those feelings of shame and self-hatred.

4.2.2. Experiences of the Other

The theme of 'Experiences of the other' sought to capture participant experiences of social worlds, including family, friends, peers, partners, professionals and wider society. Narratives of experiences of the other were sometimes positive in that, other people were understanding and supportive; however, participants' narratives tended to focus on experiences of the other as unsupportive, lacking understanding and empathy, and often judgmental.

Experiences of difficult familial dynamics were described as important by all participants. The breakdown of familial relations was presented as a significant trigger for self-injury, as was feeling invalidated by family members. Participants experienced familial breakdown and separation as traumatic, but what they identified as having most impact was feeling unable to express pain and turmoil around these experiences, rather than the experiences themselves. Other participants reported witnessing or being subject to severe violence and abuse during childhood, either from within the family or from within peer groups. McMahon et al. (2018) found that childhood maltreatment significantly increased the risk of self-directed violence as an adult, and that more specifically those who experienced childhood maltreatment were more likely to engage in self-directed violence over interpersonal violence. Within the current research, those participants who self-injured in the most extreme ways were

also those who experienced (either witnessed or were subject to) extreme violence as children, and it may be that as a consequence of their experiences of childhood violence, they were more prone to later engaging in similarly extreme forms of violence towards themselves. This finding is in support of the existing literature associating childhood maltreatment and exposure to violence with self-injury (Sami & Hallaq, 2018; Vaughn et al., 2014; McMahon et al., 2018; Bautista et al., 2018).

Li et al. (2019) conducted research more specifically focusing on relationships between sexual identity, adverse childhood experiences and non-suicidal self-injury. They found that LGB respondents reported higher odds of exposure to childhood abuse (physical or sexual) than heterosexuals. In addition, even when exposure to childhood abuse was not reported, it was found that LGB teenagers suffered strong perceived or actual pressures from family as well as some adverse childhood experiences relating directly to their LGB status, which was associated with increased probability of non-suicidal self-injury. Findings from the current research support this notion and highlight how perceived or actual familial pressure and experiences of childhood adversity are common for LGBTQ+ individuals, increasing the likelihood of them engaging in self-injury.

Childhood adversity and invalidating environments are also purported by research supporting Marsha Linehan's biosocial model (1993a) of emotion regulation, as being particularly relevant and evidence based for self-injury. Research suggests that an interaction between biological predispositions and environmental experiences including a lack of validation from others when experiencing distress significantly contribute to the onset of self-injury (Adrian et al., 2018). Such findings are of particular relevance for this research considering participants' reports of not being able to express distress (or of expressions of distress being invalidated) as being the

source of further distress, rather than the precipitating events themselves (i.e. family separation, bullying from peers, homophobia).

In not feeling able to express their distress, participants reported an internalisation of experienced emotional pain and specifically of anger. Psychodynamic models of depression help understand such experiences in that, self-injury is hypothesised as representing an unconscious and unacceptable desire to attack the other, which is instead directed towards the self (Freud, 1917). Psychodynamic theory also conceptualises the quality of early attachments as pivotal in a child's development (Bateman & Fonagy, 2006). If caregivers are able to receive and contain both 'good' and 'bad' parts of the child with affection, understanding and containment then the child is said to internalise an ability to do the same later in life (Klein, 1933). However, if care givers are unable to validate and contain the child's 'badness' (or vulnerability), the child will also struggle to integrate and accept these perceived defects later in life. The current research findings seem to chime well with this theory, particularly given the additional layer of reported adverse experiences of participants due to their sexuality. As adults, it may be that attempts to protect the psyche by getting rid of unacceptable or disturbing feelings on a conscious level, individuals play out an internal self-critic by attacking the perceived defective and unacceptable parts of the self; both self-injurious self and the non-heterosexual self.

The stigma associated with self-injury is well known (Long, 2017; Long, 2019; Jackman et al., 2018; Burke et al., 2018) and findings from this research also demonstrated the weight with which participants experienced that stigma was closely related to experiences of shame. The shame participants reported experiencing around their self-injury relates to their value representation, reflecting the perception of a negative representation of themselves in the mind of others (Unoka and Vizin, 2017). Perception of the self as shameful due to self-injurious status was also

reflected in participants' desire to hide their self-injury in an attempt to avoid stigma and further feelings of shame. This research also supported findings from existing literature around the reciprocal relationship between suicidality and stigma (Carpiniello & PInna, 2017) where suicidal behaviours such as self-injury cause stigma, but conversely stigma also causes suicidal behaviours. Participants reported an expectation of stigma, which served to increase their feelings of shame and self-criticism. Stigma around self-injury was experienced as something participants felt unable to address while they were self-injuring perhaps due to the anticipation of this causing more difficulties for them. There was an overwhelming expectation that others would not understand their self-injury and would chastise or judge them for it, which was often extended to professionals and health care organisations in general, thus supporting existing research proposing that those who self-injure also anticipate an institutional stigma related to self-injury which prevents them from seeking help (McDermott, Roen & Scourfield, 2008). At least two participants directly stated that they had internalised the stigma they experienced around self-injury, with thoughts such as "I am weird" and "People will laugh at me", which seemed to feed into the desire to hide self-injury as well as to increase feelings of needing to self-injure again. Other participants alluded to similar processes occurring regarding an internalisation of self-injury stigma, if not directly stated. Participants spoke about their 'self-injurious identity' as something they were ashamed of and went to great lengths to hide from others, therefore, findings from this research did not support the (albeit dated) commonly held view that self-injury is a means of seeking attention (Bach-y-Rita, 1974; Bostock & Williams, 1975; Pattison & Kahan, 1983). More recent research has helped dispel this misconception, instead finding that self-injury is seldom motivated by attention seeking and manipulation (Lewis & Heath, 2013; Long, 2017).

The experience of stigma reported by participant was related not only to self-injury but also to sexual orientation and gender identity. As with self-injury, stigma

associated with belonging to a sexual minority is also well established in the existing literature (Bruffaerts et al., 2010; McLafferty et al., 2016; Gower et al., 2019; Kaniuka et al., 2019; National LGBT Survey, 2019). Participants in this research reported being subject to prejudice, discrimination and even sexual violence due to their LGBTQ+ identity. In the same way that stigma associated with self-injury was internalised, stigma associated with sexuality was also internalised. The internalisation of stigma related sexual minority status in this research is a complex one which professionals are at risk of perpetuating. Hughes et al., (2008) found that mental health staff understood well why LGBTQ+ individuals who self-injure found it hard for them to access services, but that only 33% of staff routinely discussed sexual and gender identity with service users. Hence, it seems that mental health staff avoid discussion of sexuality and gender, potentially exacerbating felt stigma in those who do find ways to access support.

Further findings from research exploring the relationship between stigma, self-injury and sexual minority status comes from Jackman et al. (2018), who report that in a large sample of transgender participants, non-suicidal self-injury was reported by more than half of the sample and that it was associated with *felt* stigma (perceived or anticipated rejection) more so than with *enacted* stigma (actual experiences of discrimination). The current research findings seem to not only support the findings of Jackman and colleagues, but emphasise an important distinction in that, regardless of actual experienced stigma, the anticipation of stigma is more pertinent in contributing to self-injury than the actual experience of it. Indeed this was an experience reported by participants in the current research. There was an ever-present awareness of the potential for being targeted due to one's LGBTQ+ status in daily life.

Attempts to avoid stigma have been suggested as leading to an exacerbation of feelings of otherness, isolation, and shame (McDermott, Roen & Scourfield, 2008). Cultural and queer theorists suggest that a pride/shame binary exists which remains strategically essential in the management of LGBTQ+ individual's negotiation of everyday life (Munt, 2000; Probyn, 2000; Sedgewick 2003). Participants in this research reported daily negotiations around the visibility of self-injury, but also around outness in relation to their sexual and gender identities. Munt (2000) argues that for LGBTQ+ individuals, same-sex desires generate feelings of marginality, which echoes the findings of this research. Queer theorists go on to propose that LGBTQ+ individuals may experience shame about their desires and refute this shame through discourses of pride; a conscious awareness of this process was reported by two participants in this research. However, LGBTQ+ identity is formed, queer theorists propose that it is rooted in the shame/pride binary where pride relies on the erasure of shame and shame remains unspoken (McDermott, Roen & Scourfield, 2008). Given this notion, phenomenological research allowing LGBTQ+ individuals to voice and reflect on their experiences of shame seems of paramount importance. Probyn (2000) states that 'pride operates as a necessity, an ontology of gay life that cannot admit its other' (p.19-20). Probyn's quote as well as other queer theorists' ideas about the shame/pride dichotomy also hold relevance in regard to the conflicting self reported above in this chapter.

Minority stress theory also helps understand these reported findings. Research indicates that those belonging to a minority group, such as a sexual minority, face greater exposure to social stressors relating to stigma and prejudice (Conron, Mimiaga & Landers, 2010; Thoits, 2010). Furthermore, minority stress theory suggests that sexual minorities in particular experience daily micro-aggressions and slights in the form of expected rejection regardless of actual discriminatory circumstances (Frost, Lehavot & Meyer, 2015). The cognitive

burden associated with negotiating one's outness on a daily basis and the self devaluation inherent in internalised homophobia, position LGBTQ+ individuals who self-injure as a particularly complex and vulnerable population (Meyer & Frost, 2012; Meyer, Schwartz & Frost, 2008), as evidenced by the findings of this research. Participants reflected on experiences of both proximal daily and distal anticipatory stressors, as purported by Meyer (1995) as being common in sexual minorities. In addition, participants also reported a tendency to minimise minority status and experienced stressors particularly with regard to familial relations and particularly during early stages of exploration and negotiating outness, further emphasising the significance of minority stress theory for this research, as is highlighted by the theory. The intersectionality between multiple minority statuses found in this research, as well as the resulting complications regarding sense of self and experience of others within the context of self-injury, also supports recent developments in the exploration of multiple minority research (Ramirez & Galupo, 2019; Miller, 2018; Alvi & Zaidi, 2019).

4.2.3. The Act Itself

The third super-ordinate theme emerging from analysis was 'The act itself' which captured participant experiences related to self-injury in terms of triggers for self-injuring, emotional states prior, during and post self-injury as well as the function of self-injury for them. The affect regulation function of self-injury is perhaps the most widely accepted and supported by existing research (Klonsky, 2007, Di Pierro et al., 2014; Hamza and Willoughby, 2015). Findings from this research firmly support this. Participants reported experiencing intense emotions in the lead up to the act and that those unwanted intense emotions were alleviated through self-injury. Furthermore, there seemed to be a process by which emotional states seemed to gather momentum, becoming increasingly intense and difficult to contain, leading up to engaging in self-

injury. This finding supports previous phenomenological findings from Bautista et al., (2017) who found a rising pressure or 'effervescing' of emotions leading up to self-destructive behaviours in those identifying as LGBTQ+. The study reports individuals experience a feeling of not being able to tolerate or contain the rising pressure and thus resort to acts of self-destruction, which was followed by a perpetuated sense of self-loathing and shame, as is the cyclical nature of self-injury and much like the experiences of participants in this research.

Muehlenkamp & Gutierrez (2004, 2007) report that individuals demonstrating higher levels of apathy are more likely to engage in self destructive behaviours. Some participants in this research reported that alleviation from unwanted intense emotional states was the desired result of engaging in self-injury, while for others the desired result was feeling generation. Interestingly, those participants reported the absence of feeling or apathy as unbearable in the same way as feeling overwhelmed by emotions. Thus, the function of self-injury for some was to generate affect rather than to alleviate it.

Anger was reported by all participants in this research as a significant emotion which they associated with experiences of self-injury. Psychodynamic interpretations of depression as anger turned inwards (Freud, 1917) seem particularly relevant here, especially within the context of a self-punishing internal critic outlined in the previous section of this chapter. Participants reported a range of emotions related to anger such as frustration and rage, all of which they associated directly with experiences of self-injury. The psychodynamic perspective sees acts of anger and aggression in later life as representing an unconscious fantasies to attack another. The anger which participants expressed towards themselves, especially within the context of a perceived hostile social environment which was anticipated as not accepting them can be hypothesised in a psychodynamic perspective as the physical attacks on

themselves were perhaps representative of desires to exercise vengeance (for example, towards those around them who were seen as perpetrators of discrimination and rejection). The unacceptability of these desires to the conscious mind combined with a tendency to internalise feelings of anger or hate towards others, means that self-injury is perceived as more acceptable for the individuals' psyche. Paradoxically, psychodynamic theory explains the experience of self-injury as a conscious attempt to rid oneself of disturbing desires to harm another, while unconsciously attacking the vulnerable parts of the self, (Cabaj, 2000; Mitchell, 2000).

Despite feeling angry at others and this being a potential trigger for self-injury, participants chose to self-injure rather than injure the other. In injuring the self, a kind of relief from anger or other emotional states was reported as being experienced. The experiential avoidance model of self-injury sees it as a negatively reinforced strategy for ridding the individual of unwanted emotional states such as anger (Chapman, Gratz & Brown, 2006), which fits with participants accounts of an emotional release during and following self-injury. While the experiential avoidance model does account for the maintenance of self-injury, it cannot adequately explain why self-injury is chosen over other means of experiential avoidance (e.g. distraction, thought suppression, substance abuse). Most participants in the current research did report other experiential avoidance behaviours as occurring alongside their self-injury (e.g. drug and alcohol abuse) suggesting that individuals do not simply rely on one means of experiential avoidance but instead employ a 'constellation of defense mechanisms' as was quoted by one participant in this research. Social learning theory offers two explanations as to why self-injury becomes the chosen method of experiential avoidance by suggesting that it may initially have been an attempt to emulate peers engaging in it, and that self-punishment becomes a substitute for family punishment which is associated with a temporary relief from anger, guilt and shame (Jarvi, Jackson, Swenson & Crawford, 2013; Nock & Cha, 2009). Within this research, all

participants reported the temporary relief from unwanted emotional states as pertinent, and only one participant reported that self-injury began after having learned about it from a peer.

The effectiveness of self-injury was something all participants in this research explored in their narratives. In engaging in self-injury participants seemed to be able to control their emotional states with great effectiveness and efficiency. Panic attacks were reported as ceasing, suicide was reported as being averted and a sense of feeling more in control and safe after self-injury was common for all participants. The protective function of self-injury in that it can for some be a means of avoiding suicide is well documented (Klonsky, 2007; Sagiv et al., 2019; Hirsch, Webb & Toussaint, 2017) and is supported by the findings of this research. Klonsky reports that the affect regulation function of self-injury is important, but that self-punishment, interpersonal influence, reduction of dissociative states and anti-suicide are also important functions. All of Klonskys' suggested functions of self-injury were found to be experienced by participants in this research, except for interpersonal influence (although this may indeed have been a function for some participants, it was not explicitly reported by them).

4.2.4. Recovery

The final theme emerging from analysis of data was 'Recovery.' This theme aimed to capture participants' accounts of how they found ways to overcome their self-injury and the associated difficulties. All participants reported that a shift in their perspective of self had occurred and that they felt a new sense of control within that shifted perspective.

While participants shared experiences of struggling with self-injury, they also shared experiences of overcoming self-injury, albeit in varying ways. For some participants,

peer support was the context within which their new perspective emerged. Peer support occurred in an informal sense (i.e. talking to friends) and also in more formal settings (structured peer support within clinical services). In being able to express themselves without fear of judgment, participants seemed better able to reflect on their destructive behaviours and motivations, and to find ways of refraining or replacing them with something else.

Peer support as an effective approach for supporting those who self-injury has received some empirical support from existing literature (Madjar et al., 2017; Griffiths & Bailey, 2015; Gayfer, Mahdy & Lewis, 2018) and the findings of this research appear to support that body of research. Participants who found informal or formal peer support helpful also reported a kind of 'survivor mission', often associated with those who have experienced trauma (Eskreis-Winkler, Shulman & Duckworth, 2014; Delker, Salton & McLean, 2019) in which they felt a profound motivation and responsibility to try and support others struggling with self-injury. Additionally, some participants expressed a similar 'survivor mission' with regard to LGBTQ+ status in that, having overcome their difficulties around sexuality, a strong desire and sense of responsibility to support those who may still be struggling was expressed. Receiving peer support appears to be a potentially very effective means of supporting those who self-injure, which is supported here and warrants future research.

This research found peer support to be particularly important for self-injury, but also in supporting participants as they negotiated their developing sexual/gender identities. All participants reported that within their sexual/gender development they initially felt isolated and disconnected, but that eventually they were able to find a space (in the form of friends, partners, support groups and other LGBTQ+ social spaces) within which they felt that their sexual/gender identity was not going to be received with invalidation or hostility, but instead with acceptance and understanding. In the same

way that participants placed great value in finding a validating, containing and supportive space regarding self-injury, they also experienced a similar process with regard to their sexuality.

Peer support for sexual minorities has been shown to be effective in reducing urges to self-harm (Ross-Reed et al., 2019). Given the increased likelihood of self-harm in sexual minorities, peer support groups aimed at those who self-injure and identify as LGBTQ+, seems to deserve further research. It should also be noted that existing research identifies that while accessing peer support is a difficult process, it is also one which has the potential to make minorities feel worse once they have accessed peer support. The initial exploration of similarities and differences with ones' peer group can cause further distress, while confronting earlier coping mechanisms of minimisation (Jackman et al., 2018).

In addition to peer support, participants in this research also reported finding alternative ways in which they were able to shift their perspective to healthier, less harmful coping mechanisms. In turn, this seemed to allow for the emergence of a more acceptable and adaptive sense of self. For some, art was a highly valued means through which they were able to express their emotions without fear of judgment or criticism, regardless of how disturbing the content. Scars from self-injury were initially experienced as triggering for some but for one participant, choosing to cover her scars with artistic tattoos, thus replacing them with something she consciously chose and found aesthetically pleasing, seemed to enable a new healthier and more accepting perspective to emerge. For another participant, the discovery of BDSM practices, (as well as of body modification and body suspension) became the means of a shifting perspective. This was an interesting finding within the context of self-injury in that, those practices may also be conceptualised as forms of self-injury. However, the discovery of these practices seemed to enable an enactment of violence and playing

out of power dynamics within a safe and consensual context, which was reported as transformative and empowering for this participant.

Contemporary understandings of sadomasochism are indebted to the works of Marquis de Sade (1965) and Leopold von Sacher-Masoch (1870), which were developed by psychologists such as Havelock Ellis (1927), Sigmund Freud (1938) and Richard von Krafft-Ebing (1886). While early depictions tended to firmly eroticise sadomasochistic practices, recently a more nuanced approach to understanding the psychological factors involved in these complex practices has emerged (Weinberg, 2006; Cross & Matheson, 2006). Research has explored BDSM as being more than simply 'kinky sex' as popularised by mainstream culture, instead attempting to conceptualise it as a lifestyle choice (Weiss, 2006b), a distinct sexual orientation (Sprott & Williams, 2019) and a 'serious leisure pursuit' (Newmahr, 2010). These contemporary conceptualisations of BDSM are important in the understanding of BDSM within the context of self-injury and sexuality as they remove the misconception of these practices as being motivated by sexual gratification. Research suggests that individuals who practice BDSM benefit from much more than the sexual liberty it offers them. Newmahr (2010) explores that sadomasochism is better conceptualised as a serious leisure pursuit using Stebbins definition (2007) of serious leisure, arguing that this perspective allows for an analytical framework beyond the 'bedroom' milieu, able to instead recognise the complexity and social richness of the sadomasochistic interaction. While self-injury is a solo practice, BDSM is partnered and incorporates a social element from which individuals are able to benefit. According to Stebbins criteria for serious leisure, 'durable benefits' should follow pursuit of the activity. These durable benefits include, skill and knowledge development (self-actualisation), self-expression, renewal of self, accomplishment, social interaction and belonging; all of which were reported in this research. While self-injury was experienced as

confusing, isolating and shameful, BDSM was experienced as empowering and offering a sense of belonging.

One common theme linking participants' experiences of a shift in perspective through a variety of means was that, while all acted out self-injury in private, the new means by which they found ways to replace self-injury with alternatives, involved a social element. Peer support involved a willingness to communicate and connect with others in a meaningful way. Artistic endeavors involved sharing art with others without fear of criticism. Tattooing involved connecting with and trusting the tattoo artist. BDSM, body modification and body suspension involved partnered and/or performative practices. Participants seemed to be able to share themselves with other people in a new way. This finding offers further support for the potential value of peer support for LGBTQ+ individual who self-injure, given that it also encourages sharing and meaningful connection with others.

What emerged from the analysis of participants' new found perspective, was a resulting sense of control. For some, finding ways to replace self-injury motivated them to also address their sexual/gender identity with more self-acceptance and confidence. For others, accepting their sexual/gender identity motivated them to address their self-injury. While it is not possible to make links regarding causation, it is significant and important to note that the management of self-injury was associated with the negotiating of sexuality. It was as if once participants felt able to take control of one aspect of their difficulties, they consequently felt more able to take control of other areas of their lives.

4.3. Clinical Implications and Relevance to Counselling Psychology

This research has clinically important implications both in terms of highlighting an area which needs further investigation and in terms of contributing to the understanding of

self-injury in those identifying as LGBTQ+. The findings offer valuable insights for practitioners working with self-injury in general. In addition, practitioners working with LGBTQ+ people will also benefit from taking on board the insights about how sexual minorities' experiences around their sexuality appear to resonate with their experiences of self-injury. Themes emerging from the analysis suggest that practitioners would do well to explore sexual and gender identity in those who self-injure, as well as to explore possible self-injurious behaviours in those who identify as LGBTQ+.

Findings emerging from the super-ordinate theme of 'Experiences of the self', highlight that self to self relating in LGBTQ+ individuals who self-injure is complex, changeable and multifaceted given that those individuals experience additional layers of otherness due to LGBTQ+ status which may lead to an exacerbated sense of disconnection from others, which professionals are faced with when assessing and treating. Findings from 'Experiences of the other' highlight how individuals who self-injure experience others as judgmental, critical and lacking in understanding. Given the highly idiosyncratic nature of self-injury as evidenced in this research, a phenomenological approach to assessing and treating self-injury which takes into account empirical findings about the phenomenon, but which focuses on the individuals' lived experience would help to minimise feelings of disconnection and increases meaningful engagement with service users. A focus on the individual while receiving their experiences as valid and important seems essential for both those who self-injure and those who identify as LGBTQ+.

Hughes et al., (2018) reported finding that reasons for mental health staff not routinely asking those who self-injure about sexual and gender identity were not having had adequate LGBTQ+ training to feel able to do so sensitively and not feeling as though their employing organisation or supervisor offered relevant support. Interestingly, the

study found a majority of mental health staff were in favor of mandatory LGBTQ+ training. Given the findings of this research together with findings from Hughes and colleagues, several implications for practice and training are highlighted. From a clinician's perspective seeking out training and professional development which enables them to feel more equipped to raise issues about sexual and gender identity during assessment and treatment seems of paramount importance. An individual responsibility lies with clinicians to address the gaps within their skill set and confront any avoidances not only to feel more equipped but clearly to aim towards reducing feelings of felt stigma from within health care providers. Given the evidenced difficulty of minority groups in seeking help, which is specifically pronounced when seeking support for self-injury, clinicians should strive to request, seek out and make use of existing literature, training and education around LGBTQ+ mental health which is quite widely accessible. Implications for clinicians in a more specific sense include ensuring to assess for sexual and gender development in those who self-injure by directly enquiring and offering an opportunity for the individual to take or decline. If sexual and/or gender identity are identified as significant, an exploration of that and how it may or may not relate to the presenting problem or the context of that presenting problem seems essential. In not avoiding asking relevant questions during assessment, clinicians are already supporting the individual to feel comfortable. In the way that daily micro-aggressions are experienced as stressful for minority groups, it may be that simple 'micro-acceptances' such as being asked about sexual and gender identity offer a small but important message of acceptance and equality. While it would be important not to assume that an LGBTQ+ identity was the sole or sufficient reason behind self-injury, it certainly warrants exploration of the individuals experiences.

In addition, an organisational responsibility lies with employers to ensure minority groups are not overlooked and offered services or treatments which are not tailored and informed to suit their needs. Delivering a treatment plan which is not suitable or

appropriate would serve to further exacerbate stigma and shame known to be already associated with accessing support. Given its' focus on addressing transdiagnositic shame, compassion focused therapy (Gilbert & Irons, 2005; Gilbert & Procter, 2006) seems a particularly appropriate approach for working with those who self-injure as well as those who identify as LGBTQ+. Clinicians, supervisors and services seeking suitable approaches for working with self-injury (with or without the lens of and LGBTQ+ identity) may find the principles and techniques of compassion focused therapy particularly useful.

Findings emerging from the theme of 'Recovery' also offer important implications for clinical practice. An important part of what allowed participants to find alternative ways of managing self-injury was the experience of being able to express oneself within a safe and containing space. Clinicians must emphasise the Rogerian core conditions in their therapeutic work with clients who self-injure and with clients who identify as LGBTQ+. Given that people who self-injure and identify as LGBTQ+ have marked difficulties with discrimination and stigma, the relational aspects of therapeutic practice are highlighted as being of paramount importance by this research. In addition, the Rogerian core conditions and relation style are particularly pronounced and appropriate within a compassion focused approach, as recommended above.

Peer support was a significant finding in terms of recovery in this research. Those who self-injure benefit from peer support from those who also self-injure and while in recent years this kind of peer support has become increasingly online, there seems much potential benefit from structured and facilitated support peer support groups. Much of the reasons why individuals do not seek help are overcome by replacing the professionals with peers who have similar experiences. Peer support may offer individuals a sense of context within which to negotiate tier place, it may offer an idea of process where examples of those further along or further behind are available and

it also offers a kind of real-life modeling which treatment from professionals is unable to. While peer support may be beneficial for self-injury and sexual identity, caution is needed by those recommending and facilitating those groups, as highlighted by Jackman and colleagues who identify that early explorations of identifying with a minority peer group may be initially experienced as counterproductive and that individuals may require additional support during those early stages of access.

The clinical implications of this research hold a clear relevance for the field of counselling psychology. Counselling psychologists are particularly well trained in being able to flexibly and interactively work with clients, which is of particular value for self-injury and LGBTQ+ psychology. Rafalin (2010) describes the 'subjective interpretative base' of counselling psychology which chimes well with the interpretative phenomenological insights offered by this research and positions counselling psychologists as well suited to working with self-injurers and minority groups; counselling psychology 'attempts to bridge the gap between research and practice and conceptualizes human activity and meaning relationality' (Manafi, 2010, page number). Counselling psychologists are able to offer those who self-injure and those who identify as LGBTQ+ a relational, empathic and meaningful experience of therapy, which this research purports as essential for this population.

4.4 Evaluation of Research

4.4.1. Strengths

The strengths of this research in terms of methodological approach are discussed in chapter 2. However, upon completion of the analysis and discussion, other strengths were identified which warrant reporting here.

The criteria for producing a good quality piece of qualitative research were held in mind throughout the research process. Yardley (2000) emphasizes a sensitivity to context

and commitment to rigor, transparency and coherence for all qualitative work, which the interpretative phenomenological methodology certainly allowed for in this research.

One of the main strengths of this research lies in its contribution to an under researched field. Self-injury has received an abundance of empirical attention, yet a phenomenological approach to exploring experiences of self-injury in sexual minorities is largely lacking. Even less attention has been given to those not in receipt of any mental health support, with most research recruiting from community mental health and inpatient services. The pronounced prevalence of and vulnerability to self-injury among sexual minorities, as well as the known risk factors associated with it in this population, warrant further research aiming to explore the experiences of this minority within a minority.

Identifying similarities between how individuals experienced their self-injury as well as their sexuality, this research highlights a novel area of research which has not yet been explored by existing literature, and offers insights for self-injury research, LGBTQ+ psychology and queer theory.

An additional strength of this study was that it offered a marginalised minority group the opportunity to express and reflect on experiences of sensitive topics, which hold much associated stigma. Given that the sample was non-clinical, it seemed to be a valued process by those who volunteered to take part. While recruitment for research around such stigmatized topics is difficult, those participants who do take part appear to benefit from and appreciate having had the opportunity to talk about their difficulties in a safe space (references). Participants also expressed an appreciation that this research was being conducted and expressed a sense of pride in being able to contribute to what they perceived to be a necessary but under researched area.

4.4.2. Limitations

It is also necessary to consider the limitations of this research. The first limitation is that while this research specifically aimed at recruiting a non-clinical sample (i.e. those who were not in receipt of any mental health support at the time of interview), and was successful in doing so, all the participants taking part reported not having self-injured for a significant period of time prior to their interview, meaning that while the sample was currently non-clinical, participants' experiences of self-injury were retrospective. While this research was indeed able to recruit a non-clinical sample, adjusting inclusion criteria so that at least one recent (e.g. within the last three months) episode of self-injury had taken place may have yielded different insights.

Another limitation of this research was the small sample size of six participants. While the purposive sampling in IPA research does not set a preferred number of participants and instead is concerned with recruiting a sample that provides enough richness of data to examine similarities and differences between cases (Smith et al., 2009; Willig, 2008), typically doctoral IPA research would recruit between 6-8 participants. This research was only able to recruit six participants largely due to recruitment difficulties. While many individuals contacted the researcher expressing interest in taking part, few of those individuals met the inclusion and exclusion criteria. The main criteria which excluded individuals from taking part was that they were currently in receipt of mental health input (individual therapy, community care teams, psychiatry etc.). Nevertheless, the data gathered from participant interviews was deemed to be rich and detailed enough to satisfy the IPA requirements and research aims.

Another limitation of this study is that is was perhaps not representative of the whole LGBTQ+ spectrum of identities. While it is acknowledged that IPA seeks a small and homogenous sample which was achieved by this research, four of the six participants identified as female, meaning findings offer predominantly female perspectives. In

addition to a female focused perspective, participants in this research were also predominantly university students with four out of the six being recruited from City University and ranging in age from twenty years old to. Given the predominantly female, student status and age range of participants, it may be that the sample was therefore less balanced and thus not representative of the general population. The potential impact of these mentioned limitations is that findings from this research have focused on one particular group of individuals who self-injure and identify as LGBTQ+; predominantly those who identify as female and as students. Those identifying as students typically (but not always) represent a certain life stage of exploration, negotiating sexuality, gender, social and peer worlds, psychological health etc are all normal developments during this life stage. Experiences of those who in mid and later life may be assumed to be quite different from those in their teens and twenties, particularly with regard to sexuality and mental health. While the age range sampled in this research did indeed offer important and valuable insights into those participant experiences during early and student life stages, what was sacrificed was perspectives of mid and later life LGBTQ+ individuals. Given that processes related to sexuality tend to be managed better over time for most LGBTQ+ individuals, it would also be an interesting insight to explore by focusing on those in later life stages.

Finally, while the recruited sample included individuals who identified as lesbian, gay, bisexual and gender non-confirming, no transgender perspective was included, which also warrants further attention within the field of LGBTQ+ mental health.

IPA research offers a detailed and rich account of individual's experiences. However, IPA does not allow for any inferences about why such experiences occur (Willig, 2008). IPA thus sacrifices generalizability and the 'why?' behind the phenomena it explores, and this was also the case for this research. Findings do not allow for the development

of explanatory models, which another qualitative approach such as Grounded Theory might have offered (McLeod, 2011).

A final limitation of this research lies in the interpretative process. Elliot et al., (1999) suggest that using multiple researchers offers qualitative research a way to check the credibility of analysis and findings. Due to the nature of this research as part of my doctoral portfolio, it was not possible to include other researchers. Instead I relied on attempting to rigorously adhere to IPA guidelines, often checking that I was addressing my original research question, and also liaising with my research supervisor on a regular basis.

4.5. Directions for Future Research

This research highlights several potential directions for future research. In general, more qualitative research focusing on the experience of self-injury in sexual minorities is needed. This research found that those who self-injure and also belong to a sexual minority experience complex and changeable processes with regard to both their self-injury and sexuality; these seem to impact on each other in a unique way, and future research should aim to focus on exploring the subjective experience of sexual minorities who self-injure.

This research highlights peer support as having the potential to be a particularly appropriate and effective means of offering support to those who self-injure, as well as those experiencing difficulties with their sexuality. The value of peer support is quite different from that offered by professionals and was found by this research to be very valued, while professional support was avoided. Furthermore, peer support seemed to support individuals finding their own ways of overcoming self-injury, rather than feeling as though they are being prescribed generic alternatives to self-injury.

Research suggests that LGBTQ+ individual's experiences of homophobia leads to attempts to manage without involving professionals due to shame-avoidance strategies (McDermott, Roen and Scourfield 2008). One study found that LGBTQ youth struggled to seek help for self-harm and suicidality due to difficulty articulating emotional distress as well as difficulty in 'telling about their failed self' (McDermott, 2014). As outlined earlier in this chapter, LGBTQ+ people fear discrimination and prejudice, often anticipating it before experiencing it. It follows that this anticipation hinders the likelihood of seeking support from professionals for self-injury; another potentially shameful part of the self. Thus, clinicians should focus on finding ways to make themselves aware of such LGBTQ+ experiences and better equipped to work with those who self-injure and identify as LGBTQ+. Finding ways to reducing stigma-laden and heteronormative assumptions when assessing and treating sexual minorities who self-injure seems an important direction for future research to focus on. From one perspective it would be presumptuous and detrimental to assume self-injury is always related to an LGBTQ+ individuals' experience of their sexuality, while at the same time it seems crucial to be create an environment where those issues can be raised and explored should they be important for that individual seeking help.

One study using a cross-sectional survey of mental health staff who had received LGBT awareness training found that those staff members were significantly more likely to report that they felt equipped to and indeed made efforts to routinely discuss issues related to sexuality and gender (Huges, Rawlings & McDermott, (2018). Such findings indicate that enhancing the mental health workforce in LGBTQ+ awareness through specific training, would have a positive impact on experiences for both professionals and service users. In order to ensure such LGBTQ+ awareness trainings are developed and delivered effectively, a small scale qualitative study exploring any difficulties professionals experience working with sexual minorities and the reasons why they may not feel equipped to explore issues related to sexuality would be useful. Findings would allow for training to be designed with experiences of both professionals

and service users in mind. Service user involvement in the designing and delivery of these training sessions, would also be valuable for those taking part and allow for a phenomenological focus to emerge along side a more clinical perspective.

As outlined above, one of the limitations of this study was that, although it aimed to recruit a non-clinical sample and was successful in doing so, the disparity between current non-clinical status and retrospective self-injury status, meant that it was not possible to capture the experiences of individuals who currently self-injure and who are not in receipt of mental health support. This research specifically targeted this population due to the hidden nature of many people's experience of self-injury and the difficulty in seeking help which sexual minorities experience (McDermott, Roen & Piela, 2013; McDermott, 2015). Future research might use more specific inclusion criteria than that which was used in the present research in order to target recruiting LGBTQ+ individuals who are currently (or have recently) self-injured and who are not receiving any mental health support. As well as focusing on the lived experience of self-injury among these individuals, future research might also focus on what makes it difficult to access professional support and what alternatives might be relied upon.

4.6. Final Reflections

Approaching the end of this research project, I found myself reflecting on having conducted the analysis and written up the findings as well as on the process as a whole so far. I was able to see the development of this research from its infancy in the planning stages some years ago to having almost completed it. The process felt an enormous and often daunting endeavor. However, at this stage I began to feel a sense of achievement and accomplishment also. The most difficult and demanding part of the process was undoubtedly the analysis stage. In part this was due to this being my first attempt at qualitative research but also due to my ever-present desire to do participants justice by engaging with their narratives in a way that would accurately

capture and relay their experiences. I was aware of the iterative process inherent in IPA research which acknowledges the participants' and researcher's joint interpretative efforts. However I was also aware that participants had voluntarily shared highly sensitive, emotive and profound experiences with me, a responsibility which I felt heavy on my shoulders.

In making sense of emerging data, I found myself overwhelmed and significantly impacted by the content of interviews. While searching for emerging themes and connections across cases, I used a large whiteboard to list emergent themes, allowing me to eyeball and reflect on them with added clarity. After a few days I abandoned this method due to the impact it was having on me. I found myself being quite affected emotionally by having the whiteboard of themes on my bedroom wall. I was struck by the evident struggle, distress and sense of shame reflected in participants' accounts. Interestingly, I found myself being more affected by accounts of their struggles with sexuality than by their accounts of self-injury. I used my reflective diary to note and explore these occurrences within myself. I reflected on how this was perhaps because it was something I was able to relate to, and which therefore reminded me of my own process of coming to terms with my sexuality. I was conscious to pay due attention to this process in order to maintain my own self-care, and also to ensure my resulting feelings and reflections did not impact my analysis too much, given my role as researcher. I found that discussing the process I was going through with peers both inside and outside of academia was useful in venting and being able to get advice and support fro people who have experience with similar endeavors. It was also important to maintain a balance in terms of time spent during analysis and write up. My tendency is to isolate myself and neglect taking breaks, but I found myself sometimes not able to focus and in need of a few hours or even days away from focusing on my research, which I tended to allow myself frequently. Considering participants' reflections around experiences of homophobia and how it may (or may not) have been internalised by

them, led me to consider similar processes occurring within myself. I suspect that while I had acknowledged that of course people identifying as LGBTQ+ may have experienced struggles, I had not consciously been aware of just how pertinent and extreme the impact of identifying as LGBTQ+ can be on an individual. The commonality and extremity of the negative experiences described by participants was striking, and left me with a sense of sadness sometimes. While this was difficult to manage and required me to take more regular breaks, it also provided me with the motivation to keep going and complete each section to the best of my ability.

In writing up my analysis and being able to make sense of the data as a coherent narrative in this chapter, I felt a relief of my earlier difficult emotions. I felt that I had done my best to capture and relay the experiences of participants and also found myself in awe of their bravery for having taken part and also of their reported recovery. I was reminded of the resilience of human nature and I was able to progress, overcoming my anxieties. Having completed the analytic process and write up, I was aware of now having gained a better understanding of the IPA research process as a whole. This having been my first attempt at qualitative research, it was understandably difficult and confusing at time, particularly during analysis. Having competed the process I was able to now reflect on how my anxiety to 'get it right' was perhaps perfectly normal but was also unnecessary and I imagined that if I were to go over the process again, I would aim to have more confidence in my abilities and more trust in the process of IPA analysis. While it is indeed demanding and the interpretative nature of analysis can be confusing and difficult to keep focused, there is also a structure to the process which I found myself in respect of, which contrasted to my often frustration with it prior. Within the structure of the IPA process, there also exists a flexibility and acknowledgment of the interpretative nature which I was now able to appreciate. Having come to understand the process of IPA and qualitative literature in general much better during the course of this process, I feel I have developed more

appreciation for the dedication which producing research requires and also more of a critical perspective when reading different texts, both in and outside of academia. It has allowed me to feel more confident as a clinician and has undoubtedly enabled me to develop the way I listen and attend to other individual's narratives being told.

Another aspect important to reflect on at this stage in the research was the evolving relationship I felt I had with participants. Having spent months delving into their narratives and analysing their words, I felt much more familiar with and closer to participants. I had read over their interviews so many times that I was incredibly familiar with them, almost as if they were each holding a certain space within my mind throughout the process. While this was sometimes overwhelming and even frustrating, most of the time I found it a kind of comfort, as if they were there with me in the process. One aspect of my researcher relationship with participants that I struggled with was trying to refrain from slipping into a more clinical mindset, where I found myself formulating and analysing in a way more akin to clinical work, rather than research. This was somewhat relieved in writing up this chapter, where I could finally allow for those reflections taking place to either enter into my write-up or not. I suspect that this is a common experience for doctoral students conducting their research and I found conversations with peers about this helpful in being able to bracket those conflicting roles within myself.

Overall my main sense at this stage in the research is one of relief. This was by far my most difficult academic endeavor to date; however, it was also the most enlightening, enjoyable and rewarding. I feel a sense of pride for having taken on this sensitive and complex topic, and for being able to contribute something to the body of existing research around self-injury and LGBTQ+ psychology.

4.7. Conclusions

Self-injury remains a major health concern worldwide. Turp (1999) identifies self-injury as a multi-professional issue, positioning its relevance for a broad range of health related fields. Self-injury also remains a significant predictor of the likelihood of engaging in suicide attempts (Muehlenkamp, 2014; Nock 2009). Self-injury within the LGBTQ+ population is particularly pronounced and individuals identifying as LGBTQ+ who also self-injure are subject to increased levels of perceived and actual discrimination.

This research highlights how experiences of the self for those who self-injure and identify as LGBTQ+ are conflicting, changeable and often characterized by self-criticism and shame and an amplified sense of otherness due to both self-injury and sexual minority status. Experiences of the other in LGBTQ+ individuals who self-injure are characterized by an anticipation of judgment, criticism, and discrimination. Regardless of whether those negative experiences of other people are actualized or not, LGBTQ+ individuals perceive themselves and their place within the wider society within a shame-avoidance context. Self injury was found to be an effective means of managing emotional states, despite the negative consequences associated with it. Overcoming self-injury was an idiosyncratic and profound process within which individuals seemed to find ways of moving from a private and shameful experience of the self, to a proud and reliant sense of self, which they were willing to share with others, often in the hope of supporting them.

These findings are novel and add to the growing body of literature focusing on self-injury in sexual minorities. Counselling psychologists should therefore consider the importance of these findings when working with those who self-injure and identify as LGBTQ+.

Part I - References

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Appendix 1 – Participant Information

Title of study: The experience of self-injury in non-clinical LGBT adults.

We would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the purpose of the study?
This study is being conducted as part of my postgraduate study for a Professional Doctorate of Counselling Psychology. I am exploring the experience of self-injury within LGBT individuals and hope that it will contribute to a better understanding of and treatments for the behaviour, therefore improving support for those who seek help.

Why have I been invited?
You have been invited to take part as you have indicated that you meet the inclusion criteria of being over 18 years old, identifying as LGBT and having engaged in self-injury three or more times over your lifetime. In addition, you have indicated that you are not currently receiving any professional mental health support and that you are not actively suicidal or psychotic. Eight people will be sought to take part in this study.

What will happen if I take part?
Your participation would involve taking part in an interview with me, which would last approximately 60-90 minutes. During the interview I will be asking you some questions about your experience of self-injury and the meaning you attribute to it. The interview will take place in a private location and the date and time will be arranged at your convenience. I will audio record the interview in order to transcribe and analyse it later and I will ask you to sign a form confirming this before the interview begins.

Expenses and Payments
Your travel expenses will be reimbursed and you will be given a high street voucher to the value of £10 once you have completed the interview.

Do I have to take part?
No. Participation is completely voluntary and you are under no obligation at all to take part.

You can withdraw your participation at any time during the study if you feel uncomfortable or distressed. Due to the sensitive nature of what you will be asked to think about, I would encourage you to be mindful and vigilant of any changes to the way you are feeling and any urges to self-harm, before and after taking part – if this occurs I strongly recommend you discontinue participation by stopping the interview and I will be happy to provide details of support services.

If you choose to withdraw at any time during the study this will not impact on your studies or grades in any way (if a student) and will not impact on any future treatment you may receive.

What do I have to do?
Once you have read through the entire study information sheet and are happy to participate, I will schedule a convenient time and date for us to conduct the interview, which will take place

at City University in London. The interview will last approximately 60-90 minutes and will be audio recorded.

What are the possible disadvantages and risks of taking part?
Due to the sensitive nature of the things you will be asked to reflect on, there is a risk that this may have a negative impact on how you are feeling. Interviews will be conducted in a non-judgmental manner and you will be free to refuse to answer any questions if you do not wish to. At the end of the interview I will ask you how you found it to participate, and I will provide information regarding sources of support should any difficulty arise for you as a result of discussing your experience. In the event that during the interview I develop serious concerns about your wellbeing and believe that you are at risk of serious harm (please note: self-injury does not necessarily constitute serious harm), I may have to seek help on your behalf. If this is the case, I would always discuss it with you first.

What are the possible benefits of taking part?
The possible benefits of taking part in this study are that you will be contributing to the improvement of our understanding of self-injury among the LGBT community, as well as the improvement of support services for those who seek help for self-injury.

What will happen when the research study stops?
Once the study has finished, or if it is stopped, all audio recordings of interviews will be deleted from all devices. The British Psychological Society requires that transcripts be kept for five-years after the study's completion and they will be confidentially destroyed following this period.

Will my taking part in the study be kept confidential?

- While the study is taking pace, only the researcher and research supervisor will have access to data collected. Data will be kept anonymously (using initials not names) and confidentially.
- Personal information and data collected will not be shared with any third parties.
- Your personal details will not be passed on to any third parties under any circumstances. If there are any serious concerns for yours or another persons' wellbeing, the researcher will encourage you to contact your GP or other medical professionals in order to ensure the safety of yourself and others.

What will happen to the results of the research study?
Once completed and submitted for grading, this study will be made available in the City University library. The final report on this study will not include any identifiable details to ensure that participant's details are kept anonymous. If you wish to receive a copy of the finished report, please feel free to contact me (using the details below) making the request and I will be happy to post a copy to you upon completion. If this study is submitted for publication within a scientific journal, all of your confidentiality agreements will be upheld.

What will happen if I don't want to carry on with the study?
It is important for you to note that you are able to discontinue or withdraw your participation at any time during the study, without having to give an explanation of why you have decided to do so. You will not be penalized in any way for doing so.

What if there is a problem?
If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: 'A phenomenological enquiry into the experience of self-injury in LGBT adults.'

You could also write to the Secretary at:
[redacted]
Secretary to Senate Research Ethics Committee
Research Office, E214

City University London
Northampton Square
London
EC1V 0HB
[redacted]

City University London holds insurance policies that apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Who has reviewed the study?
This study has been approved by City University London
Research Ethics Committee: PSYETH (P/F) 15/16 169

Further information or to take part in this study, please contact:
Saya Karavadra: [redacted]

Research Supervisor:
Dr Daphne Josselin
[redacted]

Thank you for taking the time to read this information sheet.

Appendix 2 – Interview Schedule

"I am going to ask you some questions about your self-harm. There are no right or wrong answers. I am simply interested in your personal experiences and how you make sense of them.

You can talk as freely as you are comfortable with and you are able to stop the interview at any time if you wish. If at some point things you feel upset or distressed, we can stop the interview and I will give you some time to consider if you would like to continue.

At times you may repeat yourself or jumping back and forth between questions, that's absolutely fine, please do feel free to talk as freely as you like.

I will always maintain confidentiality, unless I believe you that may be at risk of serious harm, in which case I might have to seek help on your behalf. However I would not do this without discussing it with you first, and I do not regard self-injury as necessarily constituting 'serious harm'.

Does that sound okay? Do you have any questions before we begin in interview?"

1. **Can you tell me about your experience of self-injury and how it began for you?**

   Can you tell me about the first time you self-injured?

   What was going on at that time for you?

   In what kind of ways would you self-injure?

   What did you think and feel about what you had done afterwards?

2. **Can you tell me about what led you to self-injure repeatedly?**

   Can you tell me about how it continued and why?

   How comfortable did you feel at the time talking to those around you about your SI?

3. **Can you recall a recent or a specific episode when you self-injured which stands out for you at tell me about it?**

   What else was going on for you during that the time?

   Can you tell me about some of the emotions around that experience?

   What was the physical impact?

   What kind of thoughts do you remember having around that incident?

   Was anybody else aware of that incident and if so, can you tell me about their reaction?

4. **What do you think the function or the purpose of SI was or is for you personally?**

Can you tell me about how you made sense of it all at that time?

Can you tell me about how you make sense of it when you think about it now?

What is it like for you to reflect on these experiences?

5. **Can you tell me about the process by which you came to identify as LGBT?**

Do you remember experiencing any difficulties during that process and if so how did you manage them?

Can you tell me about any positives for you regarding coming to identify as LGBT?

6. **What kind of emotions do you remember experiencing during this process?**

Can you tell me about any particular incidents which are prominent in your memory regarding your sexuality?

What was the social aspect of identifying as LGBT like for you?

7. **How do you understand your self-injury within the context of your sexuality?**

Do you feel that there is any association between your self-injury and your sexuality and if so, in what way?

8. **Is there anything that we have not yet discussed which you would like to add in relation to any of the things we have talked about today?**

Appendix 3 – Debrief Information

The experience of self-injury in non-clinical LGBTQ+ adults.

DEBRIEF INFORMATION

Thank you very much for taking part in this study. Now that it's finished we'd like to tell you a bit more about it.

This study is being conducted in order to explore the experience of self-injury in LGBTQ+ people and to consider the possible relationship between self-injury and sexual identity.

I am hoping it will contribute to a better understanding of and treatments for the behaviour for LGBTQ+ people and therefore improve support for those who seek help. You were asked to take part in the interview in order for me to hear about your experiences from your unique perspective.

If taking part has raised some concerns for you, I suggest you seek support in order to manage these concerns. If feeling at risk of self-injuring I advise you to seek an appointment with your GP, or, if your GP is not available/closed, for you to attend any local A and E department where a mental health professional will be able to talk through your concerns with you and offer appropriate support.

The below may also be useful resources to bear in mind:

- Samaritans: 24 hour emotional support helpline for anyone feeling isolated, distressed of struggling to cope on 08457 90 90 90. www.samaritans.org

- Harmless: User-led organisation for people who self-harm, friends and families. www.harmless.org.uk

- Elefriends: A general mental health forum offering a safe and supportive online community where you can listen, be heard and share your experiences with others. www.elefriends.org.uk

- Pink Therapy: UK's largest independent therapy organisation offering LGBT-specific support. www.pinktherapy.com

We hope you found the study interesting. If you have any other questions please do not hesitate to contact us at the following:
Researcher: Saya Karavadra [redacted]
Research supervisor: Dr Daphne Josselin [redacted]

Appendix 4 – Ethics Approval

CITY UNIVERSITY LONDON

Psychology Research Ethics Committee
School of Arts and Social Sciences
City University London
London EC1R 0JD

4th May 2016

Dear Saya Karavadra and Daphne Josselin

Reference: PSYETH (P/F) 15/16 169
Project title: The experience of self-injury in non-clinical LGBT adults.

I am writing to confirm that the research proposal detailed above has been granted approval by the City University London Psychology Department Research Ethics Committee.

Period of approval
Approval is valid for a period of three years from the date of this letter. If data collection runs beyond this period you will need to apply for an extension using the Amendments Form.

Project amendments
You will also need to submit an Amendments Form if you want to make any of the following changes to your research:

(a) Recruit a new category of participants
(b) Change, or add to, the research method employed
(c) Collect additional types of data
(d) Change the researchers involved in the project

Adverse events
You will need to submit an Adverse Events Form, copied to the Secretary of the Senate Research Ethics Committee [redacted] in the event of any of the following:

(a) Adverse events
(b) Breaches of confidentiality
(c) Safeguarding issues relating to children and vulnerable adults
(d) Incidents that affect the personal safety of a participant or researcher

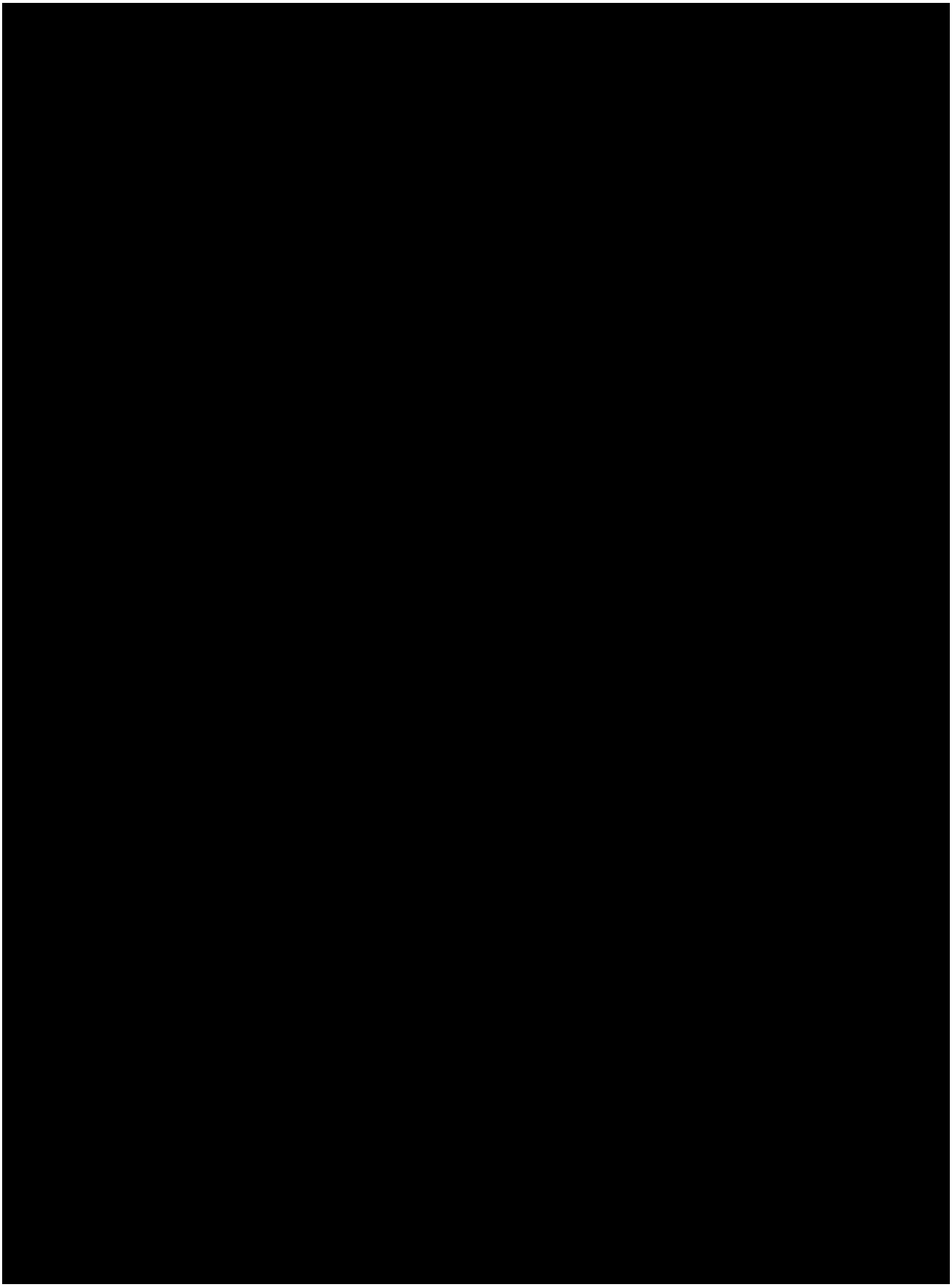
Issues (a) and (b) should be reported as soon as possible and no later than 5 days after the event. Issues (c) and (d) should be reported immediately. Where appropriate the researcher should also report adverse events to other relevant institutions such as the police or social services.

Should you have any further queries then please do not hesitate to get in touch.

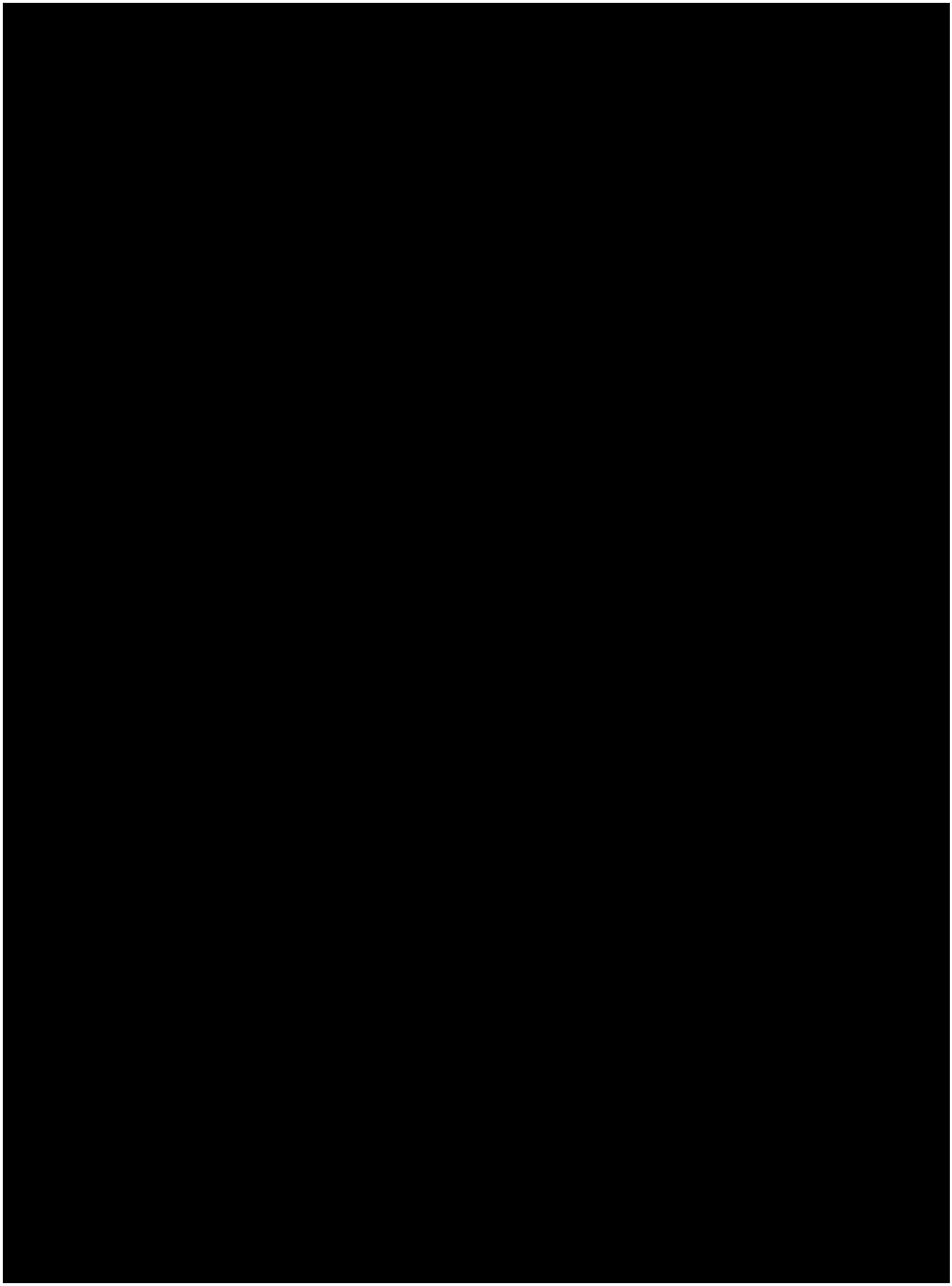
Kind regards

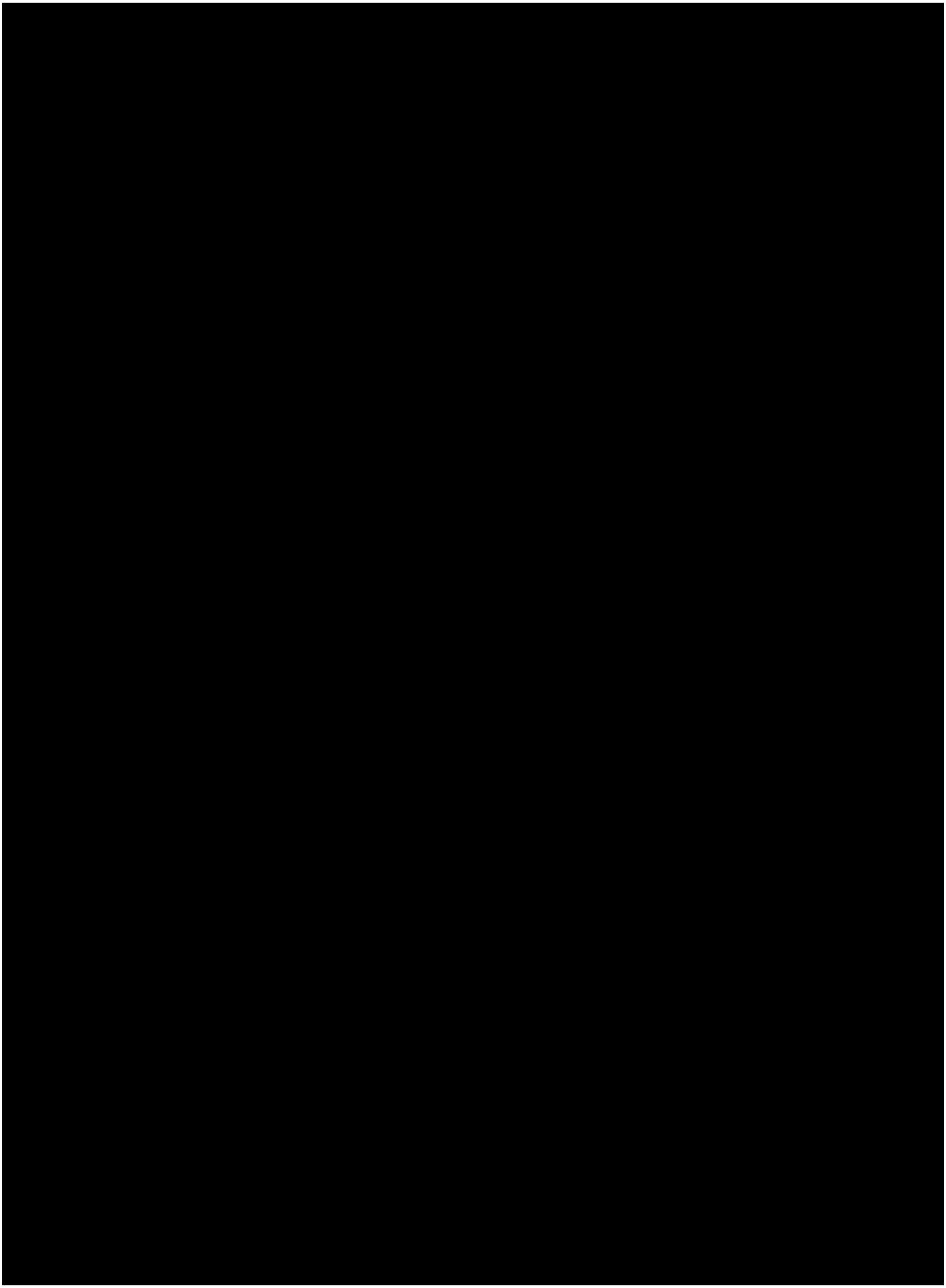
[redacted]

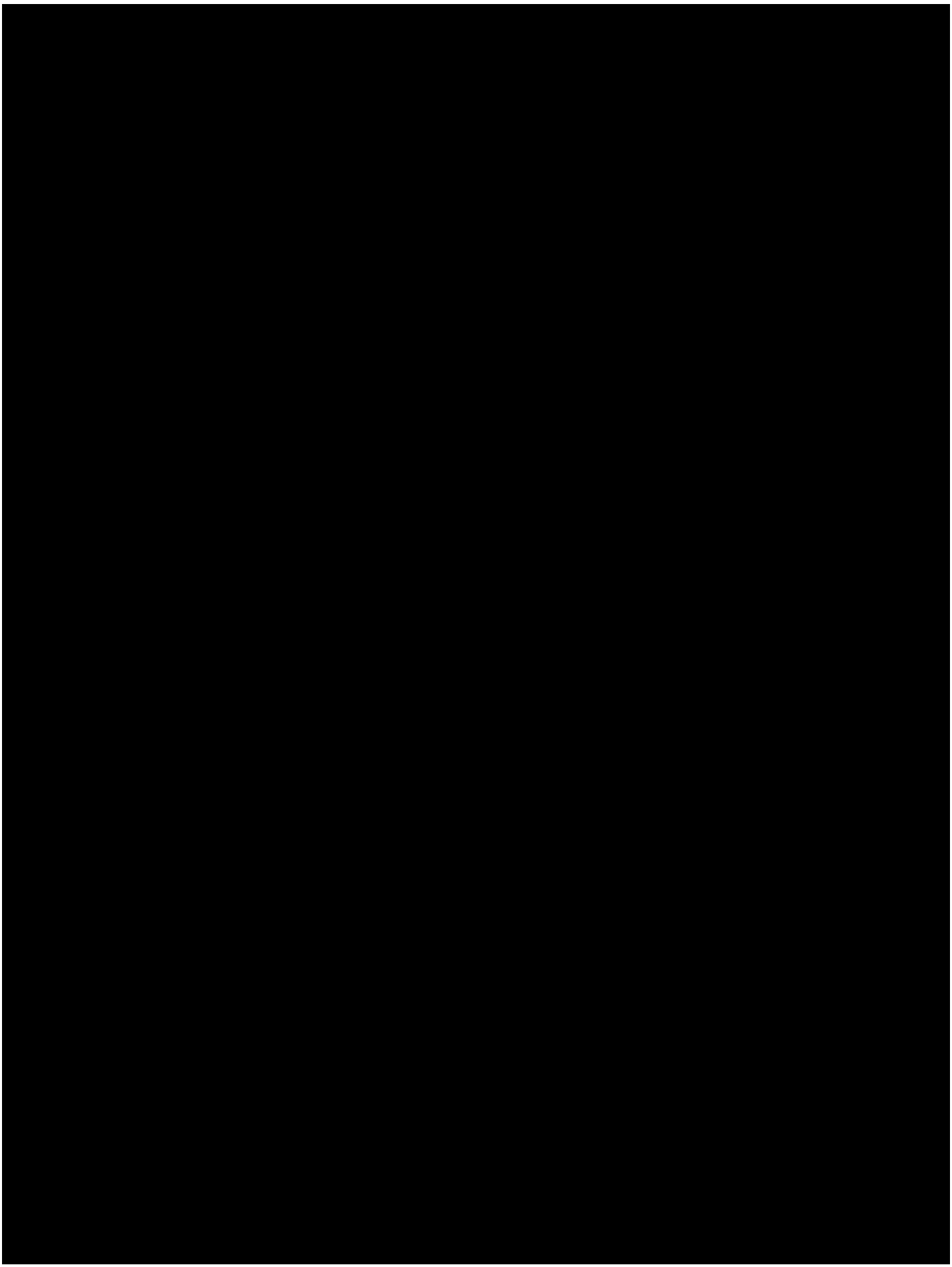
Appendix 5 – Examples of method used to visually represent associations between parts of data within certain paragraphs



Appendix 6 – Example of Descriptive, Linguistic and Conceptual commentary for *Sue*, with emergent themes







Appendix 7 – Example of emergent themes for *Helen* with quotes

Emergent Theme	Line	Quote
Intense emotions	8	I didn't really know what I was… why I did it. I just knew that I was in a lot of emotional pain
	65	it was still quite raw emotionally and sometimes I would cry in class
	82	I sort of ended up withdrawing
	85	I felt really bad about it and… that made me feel worse
	168	well you're doing something bad and you should feel ashamed
	173	it makes you scared to talk about it all
	253	I didn't want to hurt her either. It made me feel quite guilty.
	370	I would say a couple of occasions it was anger…and then most of the time because I was actually depressed at the time, I was just usually already numb anyway. Like, emotionally numb and I didn't really feel anything but at the same time there was… it was just a negative feeling
	734	just another thing to hide I guess and the pressure and anxiety that comes along with that.
	768	one of the feelings that was different was when I was thinking about my sexuality is the sadness
Managing emotions	9	I just knew that I was in a lot of pain and I wasn't, I wasn't allowed to talk about my parents separation 'cause it was still quite a taboo thing
	153	In my case personally, I think it was just the suppression of emotions
	171	that just increases the feelings of not being able to outwardly express myself
	355	you cant really control your emotional pain

Appendix 8 – Emergent and super-ordinate themes for the group						
	Anne	**Sue**	**Erin**	**Helen**	**Toby**	**Gene**
SUPER-ORDINATE THEME 1 -Emergent themes	**OTHER PEOPLE** - Family - Stigma - Impact on others	**EXTERNAL ENVIRONENT** - Hostile surroundings - Family	**EXPERIENCES OF THE OTHER** - Hostility - Prejudice & Discrimination - Community & belonging	**OTHER PEOPLE** - Discrimination hurts - They don't get it - Stigma - Early experiences of others	**EXPERIENCES OF THE OTHER** - Early experiences - Adult experiences	**EXPERIENCES OF THE OTHER** - Hostile others - Family - Otherness - They don't understand

SUPER-ORDINATE THEME 2 -Emergent themes	**EMOTIONS** - Intense emotions - Managing emotions	**INTERNAL EXPERIENCES** - Containing the rage - The split self - Fragile self - Intense emotions	**EXPERIENCES OF VIOLENCE** - Familial violence - Sexual violence - Innate violence	**EXPERIENCE OF SELF-INJURY** - Emotional turmoil - Managing emotions - Functional self-injury	**EXEPRIENCES OF THE SELF** - Self-image - Sexuality as a process - Negotiating visibility - Multiple selves	**SELF-INJURY** - It's a complex kind of thing - Self-injury as coping - Conflicting selves - The urge persist
SUPER-ORDINATE THEME 3 -Emergent themes	**SEXUALITY** - It's a process - Fear of judgment - Negotiating sexuality	**THE PHYSICAL ACT** - Pushing my limits - It's quite a violent act - Multifaceted self-injury - Bodily expression - Aesthetics of self-injury - Ritualistic self-injury	**THE SELF** - Overcoming myself - Empowered self - Otherness - Sexual self - Body as a canvas for expression	**THE SELF** - Multiple selves - Identity	**SELF-INJURY** - The act itself - Making sense of self-injury - Emotional experiences of self-injury	**EMOTIONS** - Overwhelming emotions - Conflicting emotions

SUPER-ORDINATE THEME 4 -Emergent themes	**SELF-INJURY** - Triggers - Process - Function	**IDENTITY** - Evolving identity - Otherness	**SELF-INJURY** - Extreme behaviors - Angry self-injury	**RECOVERY** - Turning things around - Belonging - Aesthetics	**TOWARDS A NEW PERSPECTIVE** - Learning to manage differently - Resilience	**NEGOTIATING SEXUALITY** - Figuring it all out - Visibility - Coming out
SUPER-ORDINATE THEME 5 -Emergent themes	**RECOVERY** - Finding a way to talk about it - A change of perspective	**A NEW PERSPECTIVE** - Developing an understanding - Belonging - Art	**SEARCHING FOR SOMETHING** - Connecting with myself - Searching for something - Rituals			**RECOVERY** - Taking control - A brave new me
SUPER-ORDINATE THEME 6 -Emergent themes			**TURNING IT INTO SOMETHING ELSE** - Healing pain			

			- Alternatives to SI			

Appendix 9 – Emergent and sub-themes with demonstrating overlap between self-injury and sexuality

Sub-Themes	**Emergent Themes**	**Line** **(Black – refers to self-injury)** **(Red – refers to sexuality)**
Experiences of the Other	Managing hostility	621,
	Fear of judgment	374, 386, 438, 848,
	Interpersonal conflicts	258, 612
	Family difficulties	224, 253, 524, 658,
	Anticipating rejection	658,
	Otherness / I'm different	445, 441, 578, 595, 605, 690, 695, 731, 768, 772,
	Don't care what they think	416, 442, 446,
	Can't tell people	79,
	Hard to talk about it	98, 373,
	Others don't understand	147, 165, 584, 643,
Self-Injury	Always dealing with it	331, 496, 589,
	Always a threat	314, 331,
	Its always there / the urge persists	125, 314, 496, 726, 793,
	I didn't understand it myself	101,
	It's a complex kind of thing	148, 238, 803,
	Lots of different things, lots of different times,	237, 799, 63,
	Little things building up	260, 412,
	It becomes a habit	268, 312, 315, 328,
	SI helps me cope	190, 228, 230, 298,
	Struggling to function	28, 73, 156,
	Effective SI	180, 188, 190, 215, 318, 337,
	Protective SI	228,
	It's a means to an end	210,
	SI as a release	215, 281,
	Feeling a failure / Critical self	70, 116, 120, 132, 293,
	Conflicting selves	299, 316, 330, 357, 443, 496,

	Defective self	120, 227, 293,
Emotions Overwhelming emotions	Spiraling out of control Unbearable emotions Intense emotions Anxiety Anger Control Depression Apathy / Void	43, 297, 339, 764, 18, 201, 204, 277, 38, 122, 134, 139, 172, 179, 370, 513, 253, 264, 639, 641, 174, 30, 81, 498, 172, 201, 276,
Conflicting emotions	A vindictive pleasure Conflicting emotions Guilt Regret It's kind of humiliating	211, 263, 297, 221, 296, 145, 162,
Negotiating sexuality **Coming out**	Coming out Fluid sexuality / gender identity / non-binary	385, 397, 438, 474, 534, 587, 578, 728,
Figuring it all out	Sexuality not such a problem	383, 390, 558, 546,
Visibility	Heteronormativity Societal attitudes matter Representation helps Allies help Invisible sexuality	509, 529, 593, 674, 767, 581, 704, 666, 747, 830, 564, 666, 437, 517,
Recovery	Recovery Growing and improving Taking control Focused on the future	478, 478, 488, 475, 475, 518, 492,
	Old self VS new self A new me Accepting myself Being brave Feeling proud	450, 451, 474, 490, 500, 680, 383, 416, 447, 502, 509, 533, 602, 502, 518,

Appendix 10 – Recurrence of themes across each interview

Themes	AT	SM	EC	HP	TM	GC
Experiences of the Self						
Conflicting self		x		x	x	x
Otherness		x	x	x	x	x
Defective self		x		x	x	x
Experiences of the Other						
Family	x	x	x	x	x	x
It's hard to talk about	x	x		x		x
Stigma	x	x		x		x
The Physical Act						
Intense emotions	x	x	x	x	x	x
Anger	x	x	x	x	x	x
Effective self-injury	x	x	x	x	x	x
Recovery						
A new perspective	x	x	x	x	x	x
Taking control	x	x	x	x	x	x

Appendix 11 – Super-ordinate and sub-themes for the group with quotes

Experiences of the self
Conflicting self Afterwards I'd feel quite sad. I'd usually start crying and then I would feel guilty and think "Crickey, what a stupid thing to do. What am I going to do with that?" (SM, 409) I always regretted it. Yep. I always, I always regretted that I'd done it because I knew, knew that I shouldn't be doing it and I knew that it wasn't good for me. (HP, 233) So, I'm a big mess of contradictions to myself. (TM, 655) And I don't know why I kept doing it for ages because afterwards I would always, regret doing it but, at the same time I felt better for doing it so I was trapped in this spiral of needing to do it so that I could continue with what I was doing, but I hated that I was doing it as well. So… I couldn't win. (GC, 295)
Otherness So yeah, it's a difficult one because I hit so many different little, you know that whole intersectionality sort of thing, I'm sort of a… quite an in-between a lot of different spaces of otherness and it's quite confusing when your trying to separate it uhm… because I'm not sure that's really possible first of all but, yeah I guess I'm tightly woven together I think. (SM, 1125) I felt that I was wrong in that capitalistic country that is Switzerland, that as everybody knows it the empire of capitalism and … I really felt like I was different. (EC, 36) So I was an easy target for people to pick on and I guess because I hadn't had the typical growing up experience you know, because I never had a stable family life. I didn't have the same experiences I didn't have the kind of, I wasn't coming from the same place that everyone else was coming from. (HP, 138) I think that certain groups of gay men are targeted for annihilation for being who they are, different… And are just not wanted on the earth so there were some of my friends who, particularly black gay men who have killed themselves. (TM, 845) But, I feel like, since having that… not isolation, but that 'other-ness' from other people it does make it harder to cope and I feel like, if that's something you've got to content with, I don't know… self-harm becomes a lot more appealing in a way. So, it does make it harder. (GC, 730)

Defective Self

Yeah, it all just kind of collects and snowballs and there's all these different aspects and all these different reasons why I would self harm but I think being, being queer and not being okay with it, was a big factor. (HP, 784)

I became the 'mental oriental', they just thought I was nuts so they thought no don't go there. (SM, 1018)

I just felt like I was worthless and like, obviously why wouldn't he be, want to go off with her instead? Why would he ever want me for more than just having sex with me? You know, I had all these terrible thoughts about myself and the only way that I could sort of get them out was to, was to cut myself. (HP, 218)

I want it to work otherwise it feels like a damning critique upon myself that's like, I'm not good enough again. (TM, 146)

I would feel, like, pathetic. I don't know how to describe… like, everyone else can get on with their lives and you can't without doing this, that kind of thing. You're not matching up to other people because... you can't cope like other people can. (GC, 227)

Experiences of the Other

Family

I started self harming when I was nine and that was I think primarily due to family breakdown… separation of parents and a bit of a chaotic environment at home. (AT, 4)

I think looking back at it maybe it was attending to myself where I possibly felt it wasn't getting it from my Mother who was, uhmm… In… In… In, a practical way a good Mother but emotionally very... and still is very, uhh… Detached from her own life and her own stuff and she cant deal with emotions. (SM, 253)

I have to say that I have the violence in my blood. My mum was a very violent, my grandmother was very violent and actually I understand now why I'm so violent because its something that I have in my genetics. (EC, 23)

I had quite a difficult sort of, childhood. There was a lot of unrest (laughs). It was very unsettled… and I'm sort of, well, I, I have sort of been processing this for a few years… since my parents got divorced when I was twenty so five years ago… me and my sisters have been kind of coming to terms with the fact that we were abused by my father… and yeah, so it was pretty difficult and I was already a very anxious child… (HP, 7)

I just think it stems from growing up in a household where my parents were negligent uhm… 'cause like I said I was put in foster care and my, both my parents were chronic alcoholics. My father was extremely violent for my whole life. Like most of my memories…. Of, of…. My father are mainly him, like physically abusing my mother and my mother was pretty much horizontal most of my life with a bucket. My

father would bring her alcohol. I was growing up in a household where there was a lot of shouting, there was a lot of fighting. I remember as a young child like, looking at these very disturbed parents and being very scared of my father. (TM, 28)

The way my household is very much, uhm… hmm, very, like loving one minute then like, very, like, angry the next. So its like not particularly harmful or anything, its more that like there's no kind of… like when I see families who are like, quite distant from each other it does make sense to me because we've always been kind of like loud, speak what's on your mind so when we're like on good terms its really great, but when we argue its really bad. (GC, 252)

Stigma

I get really annoyed about like, the stigma of self harm in particular because its like, sometimes it feels like people who self harm can be so demonized. (AT, 542)

I think as a woman it's always something that has been there and available that I've been aware of… but complex in terms of all the implications and the guilt trip and the hiding it and trying to explain it to other people who don't quite understand. And then the intellectualizing it and the "Oh it's a cry.. attention seeking, its this that and the other" and really sort of battling through a whole sea of judgment about it. (SM, 481)

Well, the reason I hid it was because I didn't want to be known as somebody who self harmed because in my mind there were all these negative stereotypes and all this sort of stigma around it that I didn't want associated with me because I already had issues with my identify. I didn't want this to be another thing that was weird about me. That was you know, that people would be scared of or laugh at or you know, whatever reaction people might have. I just didn't want that to be associated with me as a person… Yeah, I suppose because I had this internalized stigma of what people who self-harm are like which obviously I now realize is a complete fabrication. (HP, 409)

It's always kind of stressful, because the world and his wife's got an opinion and they'll make sure you hear it, that kind of stuff… (GC, 591)

It's hard to talk about

People just generally cant deal with the like, a human being harmed and then the idea of them doing it intentionally, is just like an unacceptable idea. (AT, 575)

You were also hiding something because it was a secret I had. My brother became aware of it and, I umm… He… I just said 'Oh, myself and my friend were messing around' and… But I know he was like 'That's just… Teenage girls being *weird*.' (SM, 208)

I think I just clamed up. I think I just kind of refused to say anything about it and I just, I just waited for her to go away (laughs). Just because I didn't, I don't know, I didn't want to… I didn't want to admit to it I suppose. Yeah, so…yeah I didn't really go there. (HP, 116)

I didn't really like talking about it and I felt like… I don't think I was fully aware of the problems I was having anyway, like… I didn't have that kind of self-awareness. (GC, 98)

The Physical Act

Intense Emotions

there's a bit of a cycle. I felt like the only way I could deal with those emotions was to carry on self-harming 'cause I didn't really know what to do in getting rid of that cycle of emotional pain. (AT, 175)

I think before hand it would have been I think a mixture of a lot of racing thoughts, anxiety, feeling overwhelmed and usually the first thing.. response would be I need to kill myself, I can't bare this and then after I'd worked through that there would be uhm.. you know, well what's left for me to do now? And then I'd start preparing stuff and decide I'm just going to chop and cut myself. (SM, 400)

I had to do all the steps in order to be myself and to feel myself so, self injury, yes, so… I was very young and wanted to have strong feelings. (EC, 32)

I had all these terrible thoughts about myself and the only way that I could sort of get them out was to, was to cut myself and to… and to take control of it that way and you know, when I was really really upset and crying and you know… couldn't control my emotions, *that* was what I would turn to, to sort of bring myself down. (HP, 222)

PhD stop sleeping 2 nights a week, Mum died so stop sleeping about 3 nights a week, getting HIV was about the 4th night a week I stopped sleeping and by the time my partner died I remember for weeks on end I was not sleeping for 5 days in a row so I experienced an acute psychotic break and I was kicking the door in. (TM, 383)

it's kind of quite odd to describe apathy as being intense because it's the lack of feeling but sometimes it would be, like (exhales loudly), I don't know how to describe… Like, it sounds… like, super (lowers voice and gestures) 'poetic and edgy' but, like… The *void* would become so intense that it wouldn't fit inside yourself… I don't know, it like, I feel like if I didn't deal with it... I don't know what would happen. It just felt, like, unbearable so I decided I had to. (GC, 197)

Anger

I would say a couple of occasions it was anger… and then most of the time because I was actually depressed at the time, I was just usually already numb anyway. (AT, 370)

So I think the anger possibly even though I wouldn't have been able to verbalize it at the time would have been, well… you know… yeah, I think the only word I can put is.. was frustration expressed as anger. It's quite a violent act in a way. (SM, 148)

I can remember that sometimes when I was very angry I used to take forks and hurt myself in the legs. (EC, 185)

I was having all these, you know bad thoughts about myself and feeling angry and sad and frustrated it was… yeah, it was something like, that I *knew* would help me feel better. (HP, 258)

I can't remember feeling any pain while I was doing it. It's like it didn't hurt because the adrenaline must have been running. I was just so angry. I was so possessed with rage. (TM, 421)

I was *so angry* at my Mum and that led me to self-harm and that kind of felt like something she was at fault for. (GC, 264)

Effective Self-Injury

you can't really control your emotional pain, well not really. It's not easy to, but the physical pain stopped my brain from doing whatever it was doing. It was going into panic mode… and I managed to stop that with physical pain. (AT, 355)

I think it's definitively a coping mechanism. I think it stopped me from, I think it actually kept me alive. It helped me… whereas I didn't actually… when I felt overwhelmed it didn't mean I'd go and throw myself off the building or drink or take overdoses or try and kill myself. (SM, 666)

when I felt angry I could, for example feel the sensation of a knife or a fork in my legs and that would give me that relief. (EC, 206)

it was something like, that I *knew* would help me feel better. You know, like, the counseling, the CBT and everything was meant to give me ways to control things but nothing really was effective apart from hurting myself. That was, *that* was the thing that I could always… knew was going to help. (HP, 261)

Why do people do these things? They do them to numb the pain, to sort of… to be able to avoid sinking into the awful depression, which is the alternative. (TM, 226)

if I self-harmed it, you know… would make you feel better so I just did it. (GC, 179)

Recovery

A new perspective

I don't know, I think it's because to me now, my experiences are more of a useful tool in the way that… I got involved with peer support. For me the thing that really actually changed things for me… was the peer support program. (AT, 486)

that's just another… process or a journey that I've been on and I'm still here, getting on with stuff. So, I think it's made me more resilient, stronger, it helped me to understand myself. (SM, 713)

I don't want to destroy myself. Actually I could destroy myself, if I would well, this is not my intention. My intention with time has changed and is about healing me with cuts and pain instead of destroying and punishing me. As a sadist and masochist I have to be very conscious of my… I mean, I'm very extreme. (EC, 387)

Like I've come to terms with it. I've got tattoos to cover them up, the scars, which has actually been really helpful. Like, its been really sort of… cathartic in a way to not have this reminder of myself and how difficult things were for me when I was younger. Even earlier, you know, not so long ago, you know its nice to have that covered up with something that I like looking at. (HP, 452)

And my demons will be more loving than harmful and because I'm forgiving in my nature I just think I'm going to get further in life from that. I'm looking forward to the future where I hope its less tumultuous. (TM, 690)

I felt like during that time I was, kind of… growing a lot as a person, like, and making sure that I was... I don't know. I'm always kind of keen to like, improve myself and I was making myself become more confident and more.. I don't know, on top of my studies and stuff like that. Trying to put behind in the past what I've messed up already and with that, like, came…. I felt like you can't improve myself as a person if I'm gunna carry on with this harmful behavior so I stopped doing it, even though I really wanted to at times just for the sake of it… having a better self-image of like, I don't know, being able to look in the mirror and like, not feel so out of control all the time, feel proud of what you've done during the day kind of helped me deal with it, so… Yeah. (GC, 487)

Taking control

I hadn't realized or been informed before that basically I… I had some say in my treatment… Obviously it was their decision in the end but I could say 'I would prefer it if my treatment went this way or that way.' (AT, 296)

You know… and a lot of things were just getting repressed which I knew were still there because I would still incidents of becoming angry and sometimes having fights in the street and I'd started doing karate around 1990 and you know, I managed to tone that done, which it did, it really helped. So I did a lot of I suppose quite empowering things, which helped me feel more in control. (SM, 979)

I was a lost soul. A young lost soul. A young *dark* soul and I reached the *light* with these things, I took control of myself again… so, other people might think I'm psychotic or that crazy because I do these things, but I'm not. I'm healthy now more than ever. (EC, 620)

since coming to identify as bisexual I really have realized it was something that caused a lot of problems for me. In not being able to accept it. Addressing it for me, meant I was taking some control in a positive way instead of in a destructive way. (HP, 874)

I'm glad I've managed to control myself to the extent that I'm not, I'm not scared of loosing control like I used to be. I'm not worried about where things are going to go if they start getting a bit argumentative or aggressive or confrontational. I know that I can reign myself in now. There's a lot to be said for that. (TM, 694)

once I started uhm, coming out to people and started taking a bit more control over my own life… I felt like it was easier to take control over how I was dealing with my depression. So that positive correlation between recovery and coming out for me. (GC 474)

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Part II – Publishable Paper