Hidden Stories:

Self-injury, Hope, and Narratives

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Table of Contents

List of Figures

Acknowledgements

To the eight people who agreed to share their stories with me.

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To my parents.

To my family.

To my friends.

To my partner.

Thank you!

Declaration

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Preface

The portfolio presented here comprises of three sections: an empirical research project, a publishable paper and an extended case study. Each piece was completed as part of doctoral-level training and demonstrates my competencies as a counselling psychologist. The training was comprised of two components: academic and clinical. The first two parts of this portfolio demonstrate my academic competencies: an ability to design, conduct and write up an empirical research project with a view of submitting this for publication. The last part of this thesis demonstrates a clinical competency, which is the therapeutic one-to-one work with a client undertaken as part of the training. Even though these parts are all different, they have a common theme and illustrate my interest in people's personal stories. They all illuminate the importance of stories that people tell and those that they hide or struggle to tell.

Part One of this portfolio, the empirical research, came from my interest in self-harming behaviours. During my literature research, it struck me that a large number of studies in the field constructed self-injury in a negative way and in the same manner as suicide. My research uncovered another perspective, which indicated that suicide follows the loss of hope, although there might be other reasons that people commit suicide, whereas self-injury signifies something exactly the opposite. This can be illustrated with the following quotation: "It is easy to forget that dripping blood may accompany birth as well as death. The scars […] signify an on-going battle and that all is not lost…" (Favazza, 1996, p. 322).

Moreover, my literature research did not find any studies that would look at the phenomenon of hope within self-injury, which excludes suicidal idealisations. I then began to look closer at the concept of hope and noted that hope is considered to be an essential factor for therapeutic change to occur (Frank, 1968). Yet, it is the least researched factor that is common to all therapeutic approaches (O'Hara, 2010). Hope has gained some interest within the field of positive psychology that "has called for an examination of psychological strengths and competency, rather than pathology" (Valle, Huebner, & Suldo, 2006, p. 394).

I realised that this niche topic can have great significance for the field of counselling psychology as it moves the attention away from construction of self-injury as psychopathology. Finding another way of conceptualising the behaviour may help to inform treatment plans for individuals who self-injure. I believed that understanding how people who self-injure construct hope when they tell stories about their experiences would add to the existing body of knowledge and widen our understanding of the self-injurious behaviour. For most of the participants who took part in this research, self-injury is a secret and an embodied expression of hidden stories of suffering.

When I first started to look for a topic for the empirical research and this portfolio a few years ago, I found it interesting that most literature showed a great emphasis on topics and concepts that could be thought about as rather negative emotions and concepts. Only fairly recently, with positive psychology, there has been an increase in research looking into topics focused on positive emotions and concepts. Many researchers suggest that the negative emotions contribute to a greater extent to our experiences than the positive ones in the sense that we tend to give more weight to negative feelings (Larsen & Prizmic, 2008). It seems that what goes on for us in terms of the attention we give to negative affects is mirrored within the research fields. Furthermore, it is noteworthy that concepts such as depression, trauma, anxiety, anger and abuse become so deeply rooted into our societal discourse that they become a common sense. No one really asks what these concepts mean anymore. Of course, these are very complex, but if we ask anyone, they would be able to produce a definition of them. Interestingly, this is not the case with most of the positive emotions. Asking people what happiness or hope means makes us realise that people often struggle to define these ‘positive’ concepts. Additionally, people often find it uncomfortable to think about these and this is clearly reflected in the literature. In order to change this, more research is needed to help us think about the meaning of those concepts and how they can be used in a clinical practice. This allowed me to make a decision to look at hope as the hidden concept.

Part Two of the portfolio consists of a publishable paper. This paper was prepared for submission to the *Social Science and Medicine* journal, and is fully based upon

the empirical research presented in Part One of this portfolio. Due to the scope of the research and the length of its findings, it was not possible to include all of them in this paper. Therefore, a decision was made to focus on the main theme that emerged from the data analysis in this paper. This allows better understanding of the self-injury phenomenon and illustrates the meaning-making process for those who self-injure. Further, the focus of this paper seemed to fit with the main theme of the thesis that was built on stories that are hidden. In the case of self-injury, the behaviour becomes a means of expression and communication of suffering.

The final Part Three comprises of an extended client study. This piece of writing demonstrates my competencies in a professional practice and was based on the work undertaken during my training. This client study was chosen to be included in this portfolio due to the impact of telling a story that was kept hidden from the world on the client. This piece of writing is also a constant reminder for me of the core values of counselling psychology, which places an importance on a non-judgemental attitude and moves away from pathologising clients. This work illustrates what can be gained from allowing a person to tell the story that he/she hides and struggles to share, and how developing a meaning can be therapeutic for him/her.

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PART 1

EMPIRICAL RESEARCH

"Like a record of my past":

Hope Within the Self-injury Story

Abstract

The widespread perception of self-injury places an emphasis on the negative aspects of this behaviour. It is seen by many as a dangerous, self-destructive act, and psychopathology. However, there is a lesser-known view that constructs self-injury as a hopeful behaviour, through which a person attempts to communicate his/her own emotional states. This research aims to explore how people who self-injure construct hope in their narratives about self-injury in order to deepen the understanding of the self-injurious behaviour. As the researcher was interested in the individuals' subjective experience, the qualitative method of inquiry was deemed to be most appropriate. Eight individuals took part in narrative interviews. The Narrative Analysis method was employed to analyse the data. This process revealed a new type of narrative, called a cyclical narrative. The results showed that the self-injury story is the cyclical narrative. Four main themes were identified within this narrative, namely 'Experienced Chaos', 'Self-injury – The Way to Tell the Story, 'Resolution of the Story – the Paradox of *"I'm good*"', and 'The Story Continues…'. These themes correspond to the stages in self-injury stories, which are experienced by the participants in cycles. The participants described experiencing chaos, despair and hopelessness, and then self-injuring in order to end the chaos and get to a point where they felt good/better. In this context, self-injury is understood as a pathway of hope and the thoughts of the act of self-injury are identified as an agency thinking of hope. The goal of self-injury here is to get to the uncertain, yet highly desired, point of feeling better, and this also gives rise to the feeling of hope that life can carry on. However, these feelings did not last long and the whole cycle of chaos, despair, hopelessness, self-injury, and hope got repeated. The self-injury story does not have any real resolution or end. In this context, self-injury is seen as a way of telling a story about the chaos and underlying suffering. The experiences of chaos gave rise to feelings of hopelessness, and self-injury was presented as a way to end this state and as an attempt to restore hope in the narrators' lives. These findings are discussed drawing on narrative theory. Furthermore, some limitations of this research and recommendations for future studies directions are offered. The implications of findings for clinical practice and research are also discussed.

Introduction

In this chapter an effort has been made to give appropriate background information on the literature needed for a thorough understanding of the research rationale and its aims. First, the reader is being introduced to the concept of self-injury, its cultural and historical background, the definition and terminology, prevalence, risk, attitudes towards self-injury, and, lastly, understanding and treatment of the behaviour. Next, the concept of hope is examined, its definition and complexity, theories of hope, relationship with other concepts and importance for clinical practice and research. Further, a summary is provided with careful consideration being given to the link between the concepts of hope and self-injury, and the rationale for this research is provided. The chapter finishes with the statement of research question.

1. Self-injury

Self-injury is known to be a complex, yet common, behaviour. Even though there has been an increase in research in this area, it is still not very well understood (Skegg, 2005). Self-injury is considered to be a major public health problem (Kapur, 2009) and it is a common reason for hospital admissions (Kapur, 2006; Kapur, 2009). Self-injuring behaviour has been highly associated with suicide, and research showed that those who self-injure are at the greatest risk of subsequent suicide (Zahl & Hawton, 2004).

1.1. Historical and Cultural Origins

Self-injury has a long history and tradition in the modern world. Since ancient times, in many cultures it has been associated with healing, and the drawing of blood (or even skull-drilling) were considered as attempts at releasing the cause of the illness. Those practices were also supposed to prevent an individual from getting unwell. Some believe that these behaviours are consigned to history; however, there are still many societies where they are practised, and even in

Europe, blood-letting was performed until the first half of the twentieth century (Babiker & Arnold, 1997). Some methods of body modification and injury to the body have survived until the present day and continue to be practised, such as circumcision. Interestingly, this highlights that certain body modifications and injury to the self are socially acceptable, whereas others are not. Furthermore, some of the ways of harming the body are acceptable in various cultures but can be seen as a part of deviant behaviours in others.

In tribal cultures, Shamans (people in a tribe who can heal others, often associated with spirituality and witchcraft) attain their wisdom through suffering, and self-injury is seen as a means to gaining enlightenment (Long, Manktelow, & Tracey, 2012). Some of the ways of injuring and marking the body are seen as a way of showing belonging to and being a part of a community (e.g. the common practice of tattooing in prisons), and they also symbolise one's identity and status. Further, within certain societies they are associated with power, strength, beauty and desirability (Babiker & Arnold, 1997). Moreover, injury and torture have always been practised as forms of punishment in many societies throughout ancient and recent history (Favazza, 1996).

All of the above show that injuring one's body is present in all types of societies and cultures throughout the history. However, it is only recently that some of the forms of self-injury in today's modern world have been seen as illnesses and disorders (Favazza, 2009).

Karl Menninger (1938) was the first to point out the importance and relevance of self-injury for psychiatry and clinical practice. However, the term self-mutilation appeared for the first time in a paper published in 1846, which contained a case description (Chaney, 2011). The phenomenon gained much interest and research started to grow in the area only over the past two decades, especially after publication of a book entitled *Bodies Under Siege* by Faravazza in 1986.

Until fairly recently, those who self-harmed were highly isolated due to the social stigma and lack of contact with others who self-harm. From around 2000, Internet sites focusing on self-injury began to spread and be popularised (Adler & Adler,

2007). Initially, those were public forums that were mainly unregulated. However, with time, an increasing number of communities required memberships and accepted members that would subscribe to a similar ideology, controlling content via moderation of responses/posts (Lewis & Baker, 2011). Research shows that many of the groups and websites have different focuses; some of them promote recovery, whereas others offer support, and there are also those that promote and glorify self-harm (Swannell et al., 2010). The latter have been identified as a serious trigger for self-injury, and in recognition of this, in 2012, one of the biggest blogging websites Tumbler banned the pro-self-injury content on their site (Ostroff & Taylor, 2012).

Adler and Adler's (2011) research found that there were two main ways in which people got engaged in self-injury websites. The first method involved "passive participation" (p. 110), which included people who looked at websites and messages but did not respond to them. They found that, for many, this provided a sense of acceptance and community in itself without the need for further engagement. The second way to engage was in the "interactive support groups" (p. 110) through the process of active participation and engagement by posting one's own experiences, responses, advice to others, etc.

Online groups and communities allowed people to speak to each other about their self-harming behaviour and gain the benefits of belonging to a group without the risk of exposure (Adler & Adler, 2007). For many, this provided a sense that they were not alone in their struggle, and research showed that websites were highly regarded by their users (Baker & Fortune, 2008; Whitlock, Lader, & Conterio, 2007; Rodham, Gavin, & Miles, 2007). However, some research shows that even in 2007 there were still a lot of people who self-injured and did not look at cyberspace and therefore continued to feel isolated (Adler & Adler, 2011). The Internet enabled a deeper understanding of self-injury from service users' perspectives (please see section 1.7.5 for details of this).

In Great Britain in 1986, in response to the medical and psychiatric system and the growing number of service users' organisations, 'Survivors Speak Out' was founded. Their members consisted of patients of mental health institutions who

referred to themselves as survivors (Campbell, 2005). The movement was supposed to give a voice to those who were on the receiving end of psychiatric treatments and was seen as an opposition to the oppressive psychiatric system. Two of the survivors, activists Maggie Ross and Diane Harrison, together with a few other women, started a charity organisation called Bristol Crisis Service for Women. They were all self-harming. As a result, a movement called 'Self-Harm Survivors' was formed (Cresswell, 2005).

As a result of the actions of these organisations towards encouraging people to speak about their experiences and their understanding of their difficulties, Louise Pembroke, together with other activists, organised a conference in 1989 on self-harm (Cresswell, 2005). Both of the above-mentioned women spoke at this conference. Pembroke (1994) later published accounts of conference speakers in a book called *Self-Harm: Perspectives From Personal Experience.* This book became one of the most important and influential texts that represents the user's perspective on self-injury. Other texts produced by the movement include those by Harrison (1995) and LeFevre (1996).

Pembroke later started the National Self-Harm Network, which meant to be a campaigning organisation promoting an idea of risk reduction and minimisation. These were in contrast with the idea of stopping self-harming behaviour promoted by mental health services (Pembroke, 2007).

The core ideology of the movements was the attempt to defend the rights of those who get in touch with mental health services. One of its most important functions was a collection of knowledge. Therefore, the main aim of service user organisations has been to produce and promote user-led knowledge and challenge psychiatric and medical views of problems.

1.2. Terminology and Definition

There are two main and most basic classifications of self-injury: direct (understood as acts that directly damage the body tissue, e.g. cutting) and indirect (e.g. substance misuse, eating disorders, reckless behaviour). Within those categories,

we can identify behaviours on a scale from low to high lethality (Walsh, 2006). Some also categorised behaviour in terms of whether it is culturally sanctioned (rituals and practices), or pathological (Favazza, 2011).

Self-injury and self-harm are often used interchangeably in research and literature to illustrate the same types of behaviour. However, some consider self-injury as one of the behaviours covered under the term of self-harm, and self-harm is more often treated as an umbrella term that refers to a range of one's behaviours that are harmful to oneself. There are many definitions of self-harm and many terms are used in the literature and research to describe this behaviour. Some other terms used are: self-injury, self-mutilation, deliberate self-harm/self-injury, intentional self-harm/self-injury, self-harm/self-injury with/without suicidal ideations, non-suicidal self-harm/self-injury, self-inflicted violence, self-wounding, self-abuse, and parasuicide (Sutton, 2007).

The broad definition of self-harm would include behaviours such as substance abuse, eating disorders, overdosing, suicide attempts, tattooing, etc. More narrow definitions would refer sometimes to a single behaviour, such as self-cutting, which refers to cutting the skin.

NICE (2011) proposed a classification of self-harm as comprised of self-injury and self-poisoning regardless of the motivation behind the act; in other words, whether its intent is to end one's life or not. They justified this by the complex understanding of motivation that may not always be easily established.

Studying self-harm is made difficult due to the lack of clarity and consistency amongst clinicians and researchers in the field, who often adopt terms without giving explicit definitions, making it difficult to establish what forms of self-harm are being under investigation (Nock, 2010). Moreover, there are often differences in the definition of different terms across different countries. As an example, the most commonly used term to describe a type of behaviour involving impulsive acts of self-harm in the United Kingdom is 'deliberate self-harm', whereas in the United States it is 'non-suicidal self-injury', which stresses the initial motivation and excludes suicide attempts. However, those two terms differ in terms of behaviours

that they exhibit due to emphasis on later lethality, and not only initial motivation (Skegg, 2005).

There is an extensive argument in the literature both for and against each of the above-mentioned terms. The use of prefixes, such as ‘deliberate’ and ‘intentional’, has raised a lot of concerns amongst clinicians and those who self-harm. The term ‘deliberate self-harm’ is being criticised for suggesting that a person always has control over their behaviour. Therefore, it is argued that this term contributes to pathologising those who engage in self-harm and increases stigma associated with it (Allen, 2007). Similarly, the prefix ‘intentional’ suggests that self-harm could also be non-intentional and accidental. Both prefixes ‘deliberate’ and ‘intentional’ raise questions with regard to the act of self-harm done when a person dissociates, as this could be also seen as non-intentional and non-deliberate (NICE, 2004).

Some researchers and writers conceptualise self-harm and suicide as having the same meaning and use one term to describe them both. However, research showed that self-harm and suicide are very different concepts, with the former not an attempt at ending one’s life (Gollust, Eisenberg, & Golberstein, 2008). However, there are also other reasons that people commit suicide, such as to “make others better off” (Brown, Comtois, & Linehan, 2002, p. 111), perfectionism, to express anger, and for manipulative reasons, for example, punishing others (Boergers, Spirito, & Donaldon, 1998). However, as Allen (2001) pointed out, making the distinction between self-harm and suicide can be very difficult due to the relationship between the intent and whether the result is in lethality of these behaviours. It has been known that some forms of self-harm have a high degree of correlation with death regardless of the initial intent, and other forms of even more serious behaviours had not intended an outcome of death. Research with a population who self-injure showed that 50% of those living in a community and 70% of those in inpatient settings report attempted suicide (Muehlenkamp & Gutierrez, 2007; Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006). However, Allen (2007) argued strongly against the classification of self-harm as indicative of suicide, suggesting that this assumption can possibly impact patients’ treatment by clinicians in a way that is overprotective and therefore does not facilitate empowerment. Furthermore, Walsh (2006) wrote: “The intent of self-

injuring person is not to terminate consciousness [like in the case of intention of someone who is suicidal], but to modify it" (p. 7).

Nock et al. (2006) distinguished self-injury from non-suicidal self-injury with the only difference in definitions of the two being whether they contain suicidal ideation or not. The current study's literature review also recognised the need to differentiate between forms of self-injury with suicidal intent from those without it, as these behaviours have different functions.

The present research adopts a definition that has been found to be widely accepted, and states that self-injury is a "deliberate and often repetitive destruction or alteration of one's body tissue without conscious suicidal intent but resulting in injury severe enough for tissue damage to occur" (Favazza, 1996; Gratz, 2001; Pattison & Kahan, 1983). This definition seems to be in line with one more recently presented by Glenn and Klonsky (2011) for non-suicidal self-injury. They defined it as "a class of behaviours defined by deliberate, direct, and self inflicted tissue damage without suicidal intent and for purposes not socially sanctioned" (p. 751). These definitions include behaviours such as cutting, hitting, biting, scratching, banging, burning, scraping, and wound-picking, and exclude behaviours such as piercing or tattooing, overdosing and self-poisoning, substance abuse, eating disorders, and any harm to the self with a suicidal intention in mind.

Moreover, for the purpose of this research, the terms self-injury, self-harm, self-injurious behaviour, and self-harming behaviour are used interchangeably throughout, referring to the same definition as shown above. If any departure with regard to the use of these terms is taken, an effort is made to show this explicitly.

1.3. Attitudes and Stigma

A lot of research in the area of self-injury has been devoted to understanding attitudes of professionals towards self-injury and those who self-injure, and also stigma associated with the behaviour. Stigma has been recognised as the main factor contributing to secrecy of the behaviour, preventing seeking help by those who engage in self-harm (Howerton et al., 2007). Unlike most of the areas within

the field of self-injury, attitudes and stigma has been mainly investigated using qualitative research methods.

Research showed that the attitudes towards self-injurious behaviours are highly ambiguous regardless of the staff group under investigation, such as those working in prison (Short et al., 2009), medical context (O'Donovan, 2007) and teachers (Best, 2005; Simm, Roen, & Daiches, 2008). All the above-mentioned studies also pointed out that participants admitted a lack of understanding of self-injury, which was usually combined with a lack of training in this area, and also very limited support. This may contribute to negative views of self-harm and reinforce the stigma. It has been reported in research that even within health services the behaviour is consider as attention-seeking and a waste of time for those who care for individuals who self-injure (Schoppmann, Schröck, Schnepp, & Büscher, 2007; Simpson, 2006). Those who self-harm are referred to as treatment-resistant (Craigen & Foster, 2009), which then reinforces the resistance amongst staff to work with this client group. However, it has been suggested that this 'resistance to treatment' can be due to the goals of a treatment being misalignment between clinicians and clients (Allen, 2007). Research showed that this leads to clinicians' and clients' disappointment and a sense of failure, preventing further communication between the two groups (Anderson, Standen, & Noon, 2003). It has been reported that the work with this client group often leads to clinicians feeling inadequate and powerless (Gardner, 2001). Research also showed that clients expressed dissatisfaction with regard to medical and psychiatric care (Hume & Platt, 2007; O'Donovan, 2007). This can be due to the medical model being favoured. This model constructs self-harm as pathology and the need to stop the behaviour is emphasised within it (Stevenson & Flecher, 2002). Interestingly, clients reported most satisfaction from contact with specialist services (Warm, Murray, & Fox, 2002) and treatment that targeted the exploration of underlying problems, rather then the self-injurious behaviour itself (Craigen & Foster, 2009). This seems to confirm Guralnik and Simeon's (2000) observation that in order to offer an effective treatment, clinicians need to be able to hear the stories of those who self-harm.

Based on an extensive literature review with regard to the attitudes of clinical staff towards those who self-injure, Saunders, Hawton, Fortune, and Farrell (2012) concluded that negative views of staff echo negative experiences of those who get in touch with services. This clearly highlights the need to develop further understanding of self-injury to help both those who injure and those who work with them in order to promote and facilitate the process of change and decrease stigmatisation of the behaviour, hopefully allowing more people to seek help. Further, Bosman and van Meijel (2008) called for more research with the focus on interventions that can help to prevent self-injury with "emphasis on effective communication between professionals and patients" (p. 180).

1.4. Prevalence

The earlier mentioned lack of consistency in terms of terminology makes attempts to assess the extent of the behaviour very difficult. This is coupled with the main focus of research to date being conducted with clinical and student populations, and varying behaviours included in different studies.

It is estimated that the epidemiology of self-harm is changing. However, due to the lack of a monitoring system, it is not possible to obtain reliable and accurate statistics (Bird & Faulkner, 2000; Halliwell, Main, & Richardson, 2007). It has been estimated that hospital admissions due to self-harm are on the increase, with the rates of self-harm in UK being the highest in Europe: 400 per 100,000 population (Horrocks, 2002). A study that examined self-harm hospital-reported incidents in three UK cities noted a small increase (around 8%) in numbers of reported self-cutting incidents over a period of eight years (Bergen, Hawton, Waters, Cooper, & Kapur, 2010). However, as mentioned earlier, these numbers might be higher due the number of self-injuries that are done in secrecy and people not presenting to A&E departments.

It has been estimated that prevalence for self-injury is around 4% in a non-clinical (meaning people not getting in touch with services and hospitals) adult population (Briere & Gil, 1998; Klonsky, Oltmanns, & Turkheimer, 2003). However, recently in the US, research showed prevalence within this group at 5.6% (Klonsky, 2011).

For the adolescent community population, prevalence has been estimated to be from 13% to 45% (Jacobson & Gould, 2007; Lloyd-Richardson, Nock, & Prinstein, 2008; Nock & Pristein, 2005; Plener, Libal, Keller, Fegert, & Muehlenkamp, 2009), with an especially alarming lifetime prevalence rate in girls aged 12-14 of 56% (Hilt, Cha, & Holen-Hoeksema, 2008). However, a recently conducted cohort study in Australia observed that only around 30% of adolescents carried on self-harming in their early adulthood, that is, at the age of twenty (Moran et al., 2012).
For a clinical sample, all the prevalence rates given above are even higher, and they were estimated to reach even up to 60% (Prinstein, 2008).

There is a marked inconsistency within literature and research with regard to gender differences in the use of self-harm. Some research claimed females to be more likely to rely on self-injury rather than men (Shea & Shea, 1991), with the ratio of girls versus boys being greater in adolescence (Moran et al., 2012) and then decreasing with age, and levelling at the age of 50, where there has been no age differences found (Hawton et al., 2007). A study looking at people presenting to the hospital over a period of twenty-three years found that most of those self-poisoning were indeed woman; however, in terms of self-injury, there were more men being seen in hospitals (Hawton, Harriss, Simkin, Bale, & Bond, 2004). On the other hand, Marchetto (2006) claimed that there is no difference between gender with regard to self-injurious behaviours regardless of age, but it is possible that research to date included mainly female and adolescent populations. This could have triggered attempts at explanation of the causes of self-injury as being associated with female sexual confusion, ambiguous relationship to their bodies, and menstruation (Zila & Kisielica, 2001). In light of the fact that as many men injure themselves as women, this explanation is highly problematic. Duffy (2009) pointed out that males may be less likely to admit their self-injurious behaviours due to the cultural and societal expectations that is placed on them, which constructs men as being strong and able to cope (e.g. the head of the family, the breadwinner).

The average age of onset for self-harm has been reported to be between 12 and 14 (Klonsky & Muehlenkamp, 2007). Nevertheless, it has been identified that

young adults, between the age of 18 and 25, are at the highest risk to engage in self-harm (Rodham & Hawton, 2009).

Self-injury is occasionally suggested to be more prevalent within the middle-class group (Zila & Kisielica, 2001). However, studies based on clinical populations seem to be identifying their participants as belonging to the low-income group (Hawton et al., 2004). This suggests that self-injury touches all social groups, but there may be a difference with regard to the social groups of people being recruited for research purposes.

To conclude this section, it is important to make a note of research by Klonsky (2011), which involved interviewing 439 adults in the US and found no association between self-injury and gender, ethnicity, educational history, or household income. This indicates that self-harm is much more universal phenomenon than it is believed. However, it is worth noting that the sample used for this study reflects only one group (the community population) and excludes others, such as clinical or A&E samples.

1.5. Risk Factors

As with any difficulty, there are some social, cultural, biological, emotional, and environmental features that may increase the probability of engaging in self-injurious behaviour. These are called risk factors. Klonsky and Glenn (2008) suggested that risk factors should be identified before discussing the cause of difficulties, and they proposed four of these for self-injurious behaviour, namely, childhood environment and adversaries, emotion dysregulation, self-derogation, psychiatric status, and biological predispositions. These are discussed below.

1.5.1. Childhood Environment and Adversaries

There is a belief that those who engage in self-injury grew up in environments that were ‘invalidating’; that is, their experiences had not been acknowledged and they had no form of expression, making it impossible for an individual to learn how to express their experiences (Linehan, 1993). This claim arose from an association

between self-harm with childhood abuse. Indeed, research showed that childhood maltreatment is associated with engagement in a behaviour such as self-harm amongst college students (Gratz, 2006). Furthermore, childhood traumas have been identified as a factor that may affect a person's ability to form trusting relationships with others. Research reported a correlation between childhood sexual abuse and self-harm (Boudewyn & Liem, 1995), and many of those who admitted their engagement with self-injurious behaviours also disclosed abuse (Denov, 2004). Based on this, some concluded that all people who self-harm have experienced abuse in childhood (McLane, 1996), and treated these behaviours as a "manifestation of sexual abuse" (Cavanaugh, 2002, p. 97). However, a meta-analysis of studies concluded that there is no support for this claim (Klonsky & Moyer, 2008). Furthermore, Klonsky and Muehlenkamp (2007) suggested that this relationship is rather "modest" (p. 1048). Nevertheless, it should be acknowledged that childhood abuse has been considered as a serious risk factor for both self-injury as well as more severe mental health difficulties (Allen, 2001).

1.5.2. Emotion Dysregulation

Klonsky and Muehlenkamp (2007) characterised negative emotionality and a deficit in emotion regulation as psychological factors displayed by those who self-injure. Very often, these have been linked to childhood traumas. It has been recognised that an unstable childhood environment may influence a person's ability to express and regulate emotions, which can lead to the development of self-injurious behaviours. Research in the field has repeatedly shown that those who self-injure reported heightened emotional states compared to those who do not self-harm (Andover, Pepper, Ryabchenko, Orrico, & Gibb, 2005; Gratz & Roemer, 2004; Klonsky et al., 2003). Individuals who self-injure also appear to struggle to experience (Gratz, Conrad, & Roemer, 2002), think about (Lundh, Karim, & Quilisch, 2007), and express (Gratz, 2006) their emotions. Research described self-injury as a way of coping with emotions, which suggests its regulatory function (Gratz, 2007; Kleindienst et al., 2008; Klonsky, 2009). Qualitative research helped to reveal that participants used self-harm as a way to deal with environments that were invalidating and abusive (Alexander & Clare, 2004; Gratz, 2006; Scourfield, Roen, & McDermott, 2008; Sim, Adrian, Zeman,

Cassano, & Friedrich, 2009), further pointing at the risk associated with an inability to tolerate and regulate emotional reactions.

1.5.3. Self-Derogation

Another factor that has been identified as linked to self-injury is self-derogation (Klonsky & Muehlenkamp, 2007). Self-derogation can be understood as a perception of oneself as having little or no worth (Oxford Dictionaries, 2010). Research found that those who self-injure often reported high levels of self-criticism (Glassman, Weierich, Hooley, Deliberto, & Nock, 2007; Klonsky, 2007). Moreover, self-injury has been associated with low self-esteem (Lundh et al., 2007). Qualitative research by Horne and Csipke (2009) showed that self-injury can be a form of self-punishment. The self-derogatory risk has also been linked to the childhood upbringing, where those providing care are being experienced as harsh and critical. This may lead a person to develop the same critical and perfectionistic attitude towards oneself, which both play an important role in self-injurious behaviours, as shown in a study with a group of adolescents (Flett, Goldstein, Hewitt, & Wekerle, 2012).

1.5.4. Psychiatric Position

Self-injury has been linked with other forms of self-harm, such as substance use (Hasking, Momeni, Swannell, & Chia, 2008) and eating disorders (Sansone & Levitt, 2002). It has also been observed in association with some mental health problems (Nock et al., 2006), such as anxiety, depression (Andover et al., 2005; Rodham, Hawton, & Evans, 2004), and schizophrenia (Haw, Hawton, Sutton, Sinclair, & Deeks, 2005). The strongest association has been observed with a diagnosis of Borderline Personality Disorder (BPD) (Andover et al., 2005; Klonsky et al., 2003). Some claim that often those presented to mental health services are given the diagnosis of BPD based only on the fact that they self-injure (Proctor, 2010), even though self-harm is one of the nine diagnostic symptoms of BPD. This heterogeneity of diagnostic symptoms for arriving at diagnoses of BPD, coupled with high comorbidity of BPD with other severe mental health disorders, are the

main lines of critiques of the validity of the BPD concept (Becker, Grilo, Edell, & McGlashan, 2000; Bradley, Conklin & Westen, 2007).

Only recently, in changes proposed to DSM V, self-harm appears as a separate diagnosis under the name of “non-suicidal self-injury” (American Psychiatric Association, 2012). This was supported by research showing independence of self-injury from diagnosis of other mental health difficulties (Muehlenkamp, 2005; Ross & Heath, 2002; Whitlock, Eckenrode, & Silverman, 2006). However, it has been argued that mental health care professionals have to try and acknowledge the traumatic experiences and social contexts that contribute to development of self-injury, rather than focusing on diagnostic labels (McAndrew & Warne, 2005).

Self-injury has also been considered to be highly associated with suicide. It has been suggested that from 40 to 60% of people who attempted suicide have a history of self-harm (Hawton, Zahl, & Weatherall, 2003). However, research looking at the other side of this relationship found that less than 5% of people who self-harm make an attempt on their life (Cutliffe, Brainthwite, & Stevenson, 2008). Further, a longitudinal study based on children and adolescents by Haavisto et al. (2005) showed a strong association between suicidal ideation and self-injury, which suggested that, for some people, the act of self-injury can be a way of reducing suicidal ideations. Self-injury has been seen as a life force which aims to sustain life (Menninger, 1938), whereas the aim of suicide or attempted suicide is to end life (Walsh & Rosen, 1988), although, as mentioned before, there are also other reasons that people commit suicide, such as to “make others better off” (Brown et al., 2002, p. 111), perfectionism, to express anger, and for manipulative reasons, for example, punishing others (Boergers et al., 1998). However, it has been concluded that suicide is death-oriented and self-harm is life-oriented. This adds to the argument that these two are separate and very different concepts (Freeman, 2010). However, self-harm may still be a risk factor for suicide.

1.5.5. Biological Factors Predisposition

There have also been attempts made to establish the risk factors for self-injury in terms of biological basis underlying this behaviour. One such explanation

proposes that those with lower serotonin levels are at higher risk of engaging in self-injury (Sher & Stanley, 2009). Low serotonin levels have been linked to irritability and are considered to be the cause of aggression and impulsivity, which are both linked to self-injury. Another explanation is that it is a deviation in the opioid system, which is linked to the lack of pain reported by some individuals who self-injure (Crowell et al., 2008; Simeon et al., 1992; Villalba & Harrington, 2000). However, Chandler, Myers, and Platt (2011) highlighted that research trying to support those theories were mainly conducted with clinical samples, and they lacked precise definitions of self-harm, making it difficult to establish what kind of behaviours were included and formed parts of these research. Furthermore, some research, such as that undertaken by Simeon et al. (1992), was conducted with people who also had diagnoses of BPD, and it is difficult to establish whether biological predisposition for BPD and self-injury are the same or different.

1.6. Functions

Lloyd-Richardson et al. (2008) conducted a research review and concluded that functions of self-injury could not be generalised to different types of populations due to the lack of research that examined this. However, Sutton (2007), in her book, based on a number of clinical examples, proposed eight main functions of self-injury, namely, coping, communication, control, cleansing, calming, confirmation of existence, numbing, and chastisement. Further, Gallagher and Sheldon's (2010) research added revenge and expression of aggression to this list as functions that may be more specific to patients in a clinical secure setting. However, this research focused on analysis of staff notes' entries onto a computer system; therefore, those functions seem to be representing staff views rather than those who self-injure. Klonsky's (2011) research showed that most adults reported that they self-injure to release emotions, punish themselves, communicate with others, and as form of escapism, in that order, whereas a qualitative study by Horne and Csipke (2009) showed that self-injury is a way in which a person involves their body in the experience of emotion.

Motz (2008) postulated that the main function of self-harm is to communicate distress and anger, and hope that is associated with this act for others to respond

to this communication. Moreover, she argued that the main function is to “alleviate mental pain and channel [persons’] anger” (p. 197).

1.7. Understanding and Treatment

In trying to find an explanation for self-injury, Turp (2002) pointed out that the complexity of this behaviour should be taken into consideration, and argued against the use of a single approach. It seems that the search for understanding of self-injury is very tightly related to different treatment models. There are no interventions that are specifically designed and empirically supported to treat those who self-injure (Hicks & Hinck, 2008). However, due to the association of self-harm with other mental health problems, there are a number of approaches that have been utilised by clinicians to work with adults. Every model offers slightly different explanations of causal factors, which will then influence the treatment techniques used. They have been grouped into biological, cognitive-behavioural, psychodynamic, and feminist therapy explanations. Only those models that attempted to conceptualise self-injury and assess effectiveness are included here. Lastly, the service users’ and narrative therapy perspectives on self-harm are presented.

1.7.1. Biological Explanation and Pharmacology

Favazza (1996) found that people who self-mutilated had lower levels of serotonin compared to those who did not engage in self-harming behaviours. Serotonin levels are thought to regulate impulsivity and aggression, and Groschwitz and Plener (2012) concluded that serotonin levels are more connected to those behaviours rather than self-injury.

Further, it was found that self-injury causes the release of endorphins in the brain, which gives an immediate reward and decreases stress level. This process is also observed in drug use and, therefore, some conceptualised self-harm as an addictive process, which explained the repetitiveness of the behaviour (Sher & Stanley, 2009).

Nock (2010) proposed a way of understanding self-injury as a regulator of effective and social components occurring in a stressful condition. This suggested that self-harm is related to a stress response caused by a stimulation of the central nervous system. However, a recent study by Bloom, Holly, and Miller (2012) does not seem to support this. Their research on rats found that manipulated stress conditions did not have an effect on the rates of self-injury. They concluded that caution needs to be taken when developing pharmacotherapies based on central nervous system stimulant models.

There are no medications at present being proven to treat self-injurious behaviours and NICE (2011) recommends: “Do not offer drug treatment as a specific intervention to reduce self-harm. Provide psychological, pharmacological and psychosocial interventions for any associated conditions” (p. 269). The same was concluded by Groschwitz and Plener (2012), who reviewed literature related to neurobiological research into non-suicidal self-injury.

1.7.2. Cognitive and Behavioural Perspective

There are two approaches that attempted to conceptualise self-harm and fall under the umbrella of cognitive and behavioural treatment methods. These are Cognitive-Behavioural Therapy and Dialectical Behavioural Therapy. An explanation of self-injury is provided below from each of these therapeutic perspectives with presentation of the research assessing these models’ effectiveness in working with people who self-harm.

Cognitive-Behavioural Therapy (CBT) is a time-limited approach that focuses on the connection between cognitions, emotional responses, behaviours, and physical reactions in the context of environments. Kennerly (2004) devised a model of understanding self-injury in terms of a cycle of negative thinking patterns that maintain the behaviour. He proposed that those thought cycles should be the target of therapy. However, it was recognised that still more research is needed to support this claim (Slee, Arensman, Garnefski, & Spinhoven, 2007). Further, randomised control trials showed best results when emotion regulation was the treatment target (Slee, Spinhoven, Garnefski, & Arensman, 2008). This does not

support the idea of focusing on cognition and cognitive restructuring with this client group. However, the research by Slee et al. (2008) defined self-harm as inclusive of acts with suicidal intent, and based on previous discussions, those two concepts may be driven by different mechanisms. Nevertheless, they concluded that time-limited CBT is effective for self-harming behaviour inclusive of suicidal attempt. A similar definition of self-harm was adopted in a randomised control trial by Tyrer et al. (2003). They found, however, that CBT was not more effective compared to treatment as usual, but it was more cost-efficient. All of the above leads to the suggestion that the data within the field is inconclusive. Furthermore, due to the definition of self-harm employed by the above-mentioned studies, it is hard to draw far-reaching conclusions with regard to explanation or treatment for self-injurious behaviour itself based on the CBT model.

Dialectical Behavioural Therapy (DBT) was developed by Linehan (1993) on the basis of the failure of CBT in treating people with a diagnosis of BPD. DBT assumes that BPD and behaviours such as self-injury develop as a result of an emotionally vulnerable individual being exposed to an invalidating environment in which a person's emotional needs are attended to inappropriately or in an inconsistent way. As a consequence, the person is not able to understand and learn to control emotions, and they also fail to gain skills that are needed to develop emotion regulation (Paris, 2009). Many randomised control trials conducted with patients presenting with BPD showed that DBT brings significant reduction in self-damaging impulsive behaviours, which include self-injury (van den Bosch, Koeter, Stijnen, Verheul, & van den Brink, 2005; Verheul et al., 2003). However, one randomised controlled trial showed a significant reduction in suicidality but not self-injurious behaviours (Linehan et al., 2006). It has also been noted that DBT would be the best treatment option for those who want to stop injuring (Brown & Bryan, 2007), as it often requires commitment not to self-harm during the treatment. Furthermore, a meta-analysis of the effectiveness of DBT showed that this treatment has a moderate effect on self-injurious behaviour (Kliem, Kröger, & Kosfelder, 2010). These ambiguous results suggest that more research evaluating the effectiveness of DBT in treating self-injury is needed. Further, all research assessing the effectiveness of DBT was conducted with people presenting with BPD. Due to the fact that not all individuals who self-injure

have a diagnosis of BPD, more research is needed that would evaluate the effectiveness of DBT for people who self-injure and do not fall under the BPD label.

1.7.3. Psychodynamic Theory and Treatment

Another group of approaches that try to present an understanding of self-injury and assess the effectiveness of treatments fall under the umbrella of psychodynamic approaches. In this section, Transference-Focused Psychotherapy and Mentalisation-based Treatment are described.

Transference-focused Psychotherapy (TFP) was developed to treat BPD patients and its main aim has been to focus on an interpersonal relationship between a therapist and a client that is believed to shed some light onto patient relationships and experiences of other people outside of the therapeutic room (Kerr, Muehlenkamp, & Turner, 2010). Through this, a person learns behavioural and emotional ways to form and maintain healthier relationships. TFP sees self-injury as resulting from stress caused by those interpersonal relationships and, therefore, its aim is to reduce the experience of chaos, self-harm, and suicide. Clarkin et al.'s (2001) research into the effectiveness of this approach showed that even though self-injurious behaviour decreased, this change was not significant, whereas a randomised control trial by Doering et al. (2010) showed no change in self-harming behaviours. Moreover, it has to be noted here that all the participants in both studies were also diagnosed with BPD and, therefore, it is difficult to make definite conclusions with regard to the usefulness of this approach for working with people who self-harm. Other research into the use of TFP failed to report data with regard to the impact of the treatment onto self-injury (Bateman & Fonagy, 1999; Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Levy et al., 2006). All of the above suggests that more research is needed to assess the effectiveness of this approach and plausibility of explanation for self-injury.

Mentalisation-based Treatment (MBT) was also developed to treat BPD patients and this approach explains self-injury through the attachment theory. It is thought that during the early years of our lives, we develop attachment with our caregivers. If this process is smooth, then we are likely to have secure attachments; however,

if not, it is possible that those attachments will be insecure (Bowlby, 1978). Early attachments may be developed as a result of many factors, including biological predisposition and environmental factors, such as neglectful and abusive environments. Insecure early childhood attachments have been associated and identified as an important risk factor in the development of different types of difficulties, including self-injury (Allen, 2001). It has been proposed that this type of attachment does not allow a person to develop their ability to recognise the feelings and thoughts of oneself and those of others. This process is called mentalisation (Fonagy, Gergely, Jurist, & Target, 2004). As a result, the ability to regulate emotional states is effected, which leads to self-injury as a way of regulating them. This theory is widely plausible; however, it needs to be taken with some caution due to a lack of research supporting it. Although it has been observed that the capacity to mentalise is evident in people with a diagnosis of BPD (Bateman & Fonagy, 2006), there is no research that would look into whether this is also true for those who self-injure and do not have a BPD diagnosis. Research into the effectiveness of this approach showed a significant impact on self-injury incidents; however, these were conducted with individuals who had diagnoses of BPD (Bateman & Fonagy, 2001; Bateman & Fonagy, 2009). Therefore, more research that would involve an assessment of this approach for self-injury alone is needed.

1.7.4. Feminist Therapy

Feminist Therapy (FT) conceptualises self-harm as a coping mechanism developed in response to a complex trauma. The main aim of self-injurious behaviour is to take care of oneself (Brown & Bryan, 2007). This explanation is tied to an understanding of self-injury in the light of personal history of abuse and early childhood invalidating environments, which are understood as complex traumas. FT stresses the concept of psychopathology as a social rather than an individual construct; therefore, self-injury is seen as a way to resolve a lack of power in the context of social, political, and emotional environments (Brown, 1994, in Brown & Bryan, 2007). As a result, it is claimed that self-injury can serve a number of different functions, such as emotional regulation, preventing suicide, calming oneself, preventing or inducing dissociative states, and is therefore

connected to the ability of the person for self-soothing and self-care (Brown & Bryan, 2007).

There has been only one qualitative research found that claimed the effectiveness of the use of the feminist therapy with self-injury (Craigen & Foster, 2009), and there is a lack of randomised control trials. Therefore, more research assessing the effectiveness of FT is needed.

1.7.5. Service Users' and Narrative Therapy Perspectives

The Self-Harm Survivors' movement has produced a number of texts and research, which offer a view of self-harm from the service users' perspective. As pointed out by Cresswell (2005), this literature places the individual experience of a person who survives a condition at its heart as they represent the expert view. This is in contrast to the traditionally collected knowledge gathered by the application of 'scientific' methods and representing professionals' views. Survivors' understanding of self-harm is inevitably attached to an exploration of intent and meanings behind the behaviour (Lefevre, 1996; Pembroke, 1994; Spandler, 1996). They postulated that a testimony of a person is the truth (Pembroke, 1994). The evidence is drawn on experience (which is called the politics of experience) and the movement calls for an attitudinal shift. They promote a view that evidence coincides with experience (Campbell, 2005).

The Survivors' writing points out the politics of self-harm, where power plays a crucial role, and the question that needs answering focuses on understanding how those who self-injure are violated and how they survive (Spandler & Batsleer, 2000). Therefore, politics is a task of identifying those who violate people, in order to prevent those violations and to then care for those who survive through self-harm (Cresswell, 1994). Spandler and Heslop (2007) pointed out that exercise of power and control is crucial for those who self-harm and they postulated that support for people should be based on providing autonomy and a sense of control.

Self-harm from a survivor's perspective can be seen as a way in which people sometimes manage to deal with feelings of powerlessness, and to manage

feelings and distress, and can therefore be understood as having an adaptive function (Warner & Feery, 2007).

LeFevre (1996) wrote that self-harm is an act of survival rather than a suicide attempt. This is also in line with Pembroke's (1994) description. She wrote: "There are two distinct types of self-harm. Firstly, self-harm with suicidal intent (or attempted suicide). Secondly, self-harm without suicidal intent…. The second category may lead to a suicide attempt but, in itself, is usually quite the opposite. An attempt at self-preservation" (p. 2). Harrison (1995) described the bodies of those who self-injure as a battleground.

Moreover, service users promoted a view that self-harm is a reasonable response to an unbearable distress, rather than an attempt at suicide or attention-seeking behaviour (Pembroke, 1994). They argued that self-harm releases tension and helps to calm a person down (Cameron, 2007). Survivors' literature also opposed self-harm being seen as pathology, but rather as lying on a continuum together with socially accepted forms of it, such as reckless driving, overworking, or piercing. Moreover, they postulated that self-injury should be placed in human experience of searching for meaning in different contexts, which produces different responses, with self-injury being one of them (Cresswell, 2005).

This view seems to be in line with a narrative therapy approach developed by White and Epston (1990). The aim of this approach is to help a person to develop and clarify meanings and construct a narrative of their life and the problem. This type of philosophy places a great emphasis on the importance of stories that people tell as a mediator of constructing a person's identity. Therefore, the externalisation of the problem is thought to help a person to see themselves as separate from the problem, which should empower them to make changes. Hoffman and Kress (2008) proposed the use of narrative therapy for work with clients who self-injure and illustrated some of the techniques of this approach on a single case study. They did not attempt to explain the behaviour, but rather proposed the idea of externalising the problem as a way of reducing feelings of guilt and shame, which are very commonly observed amongst those who self-harm, and regaining the agency of the individual, which should foster their belief in

their ability to make changes. Unfortunately, research has not revealed any other studies that would employ this type of approach with people who self-injure.

1.7.6. Summary of the Understanding and Treatment Section

It seems that the biological explanation sees self-injurious behaviour as originating within the person, whereas most of the psychological explanations construct and understand self-harm as a symptom of underlying difficulties. Further, Turp (2002) highlighted the importance of looking for meaning hidden behind the behaviour, rather than being pre-occupied with the behaviour itself. This is in contrast with biological and pharmacological-based treatments that are aimed at the behaviour.

There is a lack of agreement with regard to the effectiveness of psychological treatments, and some of those who reviewed the literature in this field concluded that psychological therapy is proven to be effective (Hawton et al., 2007), whereas others argued that, due to the majority of the research being conducted with clinical populations, it is rather difficult to make definite assumptions with regard to the general effectiveness of treatments (Kapur, 2005). Some also concluded that the best method involves brief psychological therapy (such as CBT) (Owens, 2006). From psychological-based interventions there is the most evidence for the use of DBT in reducing self-harm. However, even this intervention does not have much research with non-clinical populations and those not having diagnoses of BPD. It is important to mention here that systemic therapy has been identified as potentially helpful in reducing the rates of self-injury in children and young people due to an estimation of poor family relationships being a serious risk factor for self-injury (Webb, 2002). A family-based approach assumes working with the entire family and one study found it to be more effective than treatment as usual (Huey, 2004). However, this study looked at the broad definition of self-injury that included suicide attempts. Another study found no effect on rates of self-injury when family therapy was employed (Harrington, et al., 1998). This indicates that further research to establish the usefulness of this approach for working with young people is needed.

It seems that still-limited research on the effectiveness of treatments makes it difficult to arrive at a conclusion with regard to the plausibility of any of the explanations presented in this chapter. However, this does not mean that the interventions are not effective, but rather that more research is needed (Bosman & van Meijel, 2008; NICE, 2004; Prinstein, 2008), especially research targeting non-clinical populations without a personality disorder diagnosis. It seems that this could also help to clarify understanding of self-harm that is not related to other mental health problems. Furthermore, there seem to be many different theories that conceptualise self-injury; however, many of them are very specific to the models of treatments. More qualitative research is needed to develop better understanding of self-injury and to devise a model that is independent of treatment models and could be understood by clinicians and clients alike. This seems to be in line with the views of Warner and Spandler (2011), who argued that research comparing models of treatment may not be helpful as self-harm serves different functions and has different meanings depending on the personal context. They argued that it might be more helpful to identify some "principles" (p. 15) that would guide work with those who self-harm.

2. Hope

Hope is a complex phenomenon, which has been studied for years by anthropologists, philosophers, and theologians. Even though it has long been recognised that hope is of crucial importance for healthcare professionals, it was only recently that it started gaining interest amongst the social sciences. This is attributed to the inability of investigation methods employed in social sciences to capture this multifaceted concept (Law, 2004). In this section, I attempt to conceptualise hope, including its comparison with other related concepts, and show the importance of it for research and clinical practice.

2.1. Complexity of Hope

Even though hope is widely used as a word and its meaning appears to be clear, it is considered to be ambiguous. This can be well illustrated with a famous story of

‘Pandora’s Box’. The Greek myth says that when Pandora opened her box, she released all the evils, apart from one – hope. Some argue that hope is one of the evils, whereas others argue that hope would have been an anodyne to all evils if it had been released.

Nietzsche (1984) agreed with the former. He described hope as the worst of all evils given by Zeus (a Greek god) to people. He explained that hope is responsible for prolonging the human suffering because as people hope for things to get better, they do not end the suffering. This view can be also associated with the idea of ‘false hope’, when a person hopes for achieving certain outcomes that are unrealistic or are based on fantasy (Clarke, 2003).

The contrary argument to Nietzsche’s can be illustrated by philosophers such as Bloch (1986), who postulated that hope is present in all areas of human life, in utopian ideas of architecture, art, religion, and also social and political ideas (such as the ones of Marx and Lenin).

Cousins (1989) offered a different view from both of the earlier mentioned philosophers; he postulated that as human beings, we do not know enough to give up hope.

Complexity of hope also lies in the way this concept is influenced by diverse social, cultural, and geographical backgrounds (Baumann, 2004; Duggleby, Williams, Wright, & Bollinger, 2009), which indicates that hope is a socially constructed phenomenon (Little & Sayers, 2004). This can be well illustrated when thinking about differences between collectivistic and individualistic cultures. The former would express hopes that are related to collective values and pursuits, rather than individualistic ones. Furthermore, people’s hope is influenced by a specific culture that they are a part of. Within those cultures that celebrate their past and their heroes, people’s hopes related to the culture seem to be higher (Elliott & Sherwin, 1997).

2.2. Definition

It is not an easy task to define hope due to the number of ways in which it has been understood in literature and writing. Oxford Dictionary (2010) states that hope is “a feeling of expectation and desire for a particular thing to happen”. Another most basic way to describe hope is that it appears when a person desires for future matters to be a certain way, when the desired future is possible but not certain (Day, 1991). From these definitions it can be concluded that hope has some elements of probability and uncertainty. It also seems that orientation towards the future plays an important role in this concept. The above-mentioned definitions are in line with the way Clarke (2003) talks about hope “as a longing and believing for something that is not certain, but at least possible” (p. 165). Further, Dufault and Martocchio (1985) added that those future outcomes (goals) have to have a great significance for the individual.

However, even those definitions do not seem to make the concept of hope any clearer, and their application in research remains questionable due to vagueness of some of them, e.g. how one can know what Clarke’s longing for something might look like and what to search for. Therefore, further clarification and understanding of hope needs to be developed.

2.3. Understanding

In the search for a way of conceptualising hope, different theories needs to be looked at more closely. In this section, the focus was placed on the most current developments in the field of social sciences and hope. The effort was made to develop an understanding that has been used for research and clinical practice to date. Therefore, first, Snyder’s theory of hope is discussed and, later, other theories are also presented.

2.3.1. Snyder’s Theory of Hope

One of the most popular and well-known ways of conceptualising hope in the field of social sciences is the one developed by Snyder (2002). In psychology this theory has been the most widely used in research and literature for studying hope

in different areas due to its robustness and its attempt to capture the complexity of the hope concept in depth, combined with a number of scales developed by Snyder to measure levels of hope in adults and children based on his theory of hope – the Dispositional Hope Scale (Snyder et al., 1991) and the State Hope Scale (Snyder et al., 1996).

Snyder (2002) defines hope in terms of goals or anchor points, agency, or motivation to achieve those goals, and pathways or thoughts directed at planning to achieve goals. In a more simple way, in Snyder's hope theory, hope is understood as a person's ability to set goals, and it also involves the belief that he/she can achieve these goals (understood as agency/motivation), and then an ability to plan specific steps in order to reach these goals is needed (defined as pathways/thoughts). It is important to note here that these processes do not need to involve actual actions but can happen on a cognitive level only. In fact, Snyder argued that hope is mostly a way of thinking in which an emotion plays an important role, rather than an emotion itself. In his model, hope is seen as the consequence of goal-directed activities and thoughts (Snyder, 2000). Therefore, without a goal we could not have a rise to hope. Rand and Cheavens (2009) observed that goals "can be verbal or visual" (p. 324). They can be short- or long-term, or even conscious or unconscious, and they differ with regard to their importance. In terms of types of goals, they can be approach goals (directed at achieving something) and avoidance goals (directed at avoidance of something, e.g. an illness) (Snyder, 2002). In this model there is also stress placed on the importance of the fact that a goal needs to have significance for the person and be achievable, but this should not be certain (Snyder, Lopez, Shorey, Rand, & Feldman, 2003).

Pathways, as described in Snyder's (2002) model of hope, require generation of a route or routes, which connect the present with the future. This means that at least one possible way of achieving a goal is produced. People with higher levels of hope are better and more effective at producing alternative ways of getting to the goal (Irving, Snyder, & Crowson, 1998).

In Snyder's (2000) way of conceptualising hope, agency is seen as a motivational force that would drive a person to reach their goals. This requires a certain investment of mental energy into pursuit of a goal and moving along the pathway towards goals attainment. The agency element produces emotional expression to a greater extent than the pathways element (Snyder, 2002).

2.3.2. Other Theories and Insights

A slightly different view from Snyder's way of understanding hope was presented by Stotland (1969), who saw the concept as being at the heart of motivation. He postulated that motivation is an absolutely necessary component for achieving any goal and hope will drive this process. This is in contrast with Snyder's (2002) model that places motivation as one of the components of hope. This assumption has no grounding in any research to either prove it or disprove it. Moreover, Stotland assumed that hope is any expectation of achieving a goal that exceeds zero and which contains some recognition of importance of a goal/pursuit. This assumption, however, seems rather problematic as it almost indicates that any expectation equals hope, which simply is not the case. An example could be false hope discussed earlier. Therefore, Stotland's way of conceptualising hope seems somewhat vague and overly simplistic.

Scioli and Biller (2009) also developed a concept of hope, which is a much more integrative model compared to the one by Snyder as it is based on many different disciplines, including art, biology, philosophy, history, religion, psychology, and anthropology. This model of hope consists of survival, spirituality, mastery, and attainment, which are all assumed to be future-oriented. Scioli and Biller saw hope as a complex network of emotions based on different levels of psychological, social, and biological resources. A different view was proposed by Snyder (2002), who conceptualised hope as fundamentally a way of thinking with feelings being an important component of it and a by-product. Scioli and Biller's way of understanding hope seems highly complicated and rather elusive to be applicable for a research purpose.

Schrank et al. (2008) analysed forty-nine definitions of hope from the published literature, which he synthesised and then developed a way of understanding "hope as a primarily future-orientated expectation (sometimes but not always informed by negative experiences such as mental illness) of attaining personally valued goals, relationships or spirituality, where attainment: i) will give meaning, ii) is subjectively considered realistic or possible and iii) depends on personal activity or characteristics (e.g. resilience and courage) or external factors (e.g. resource availability)" (p. 426). It seems that the only element that this model adds to Synder's theory of hope is the focus on the external factors.

Interestingly, Bernardo (2010) also noted that Snyder's hope theory assumes that agency and pathways are expected to be purely from within the person. Therefore, he proposed to extend Snyder's theory to add the internal and external locus of hope; however, the internal locus is one that is already included in Snyder's theory. Bernardo's (2010) research supported the idea that agency can also come from outside of a person, from other people, or even spiritual things and beliefs (e.g. destiny, Feng Shui, God, etc.), which he named as an external locus of hope. Additionally, some predicted that "pathways and agency of hope may operate as cognitive expressions of individuals' motives for social connectedness and growth" (Garcia & Sison, 2012, p. 56). Schrank et al. (2008) noted the lack of relational component in them.

2.3.3. Summary of the Understanding Section

There are a number of different ways to understand hope. However, as pointed out above, many are either overly simplistic and, as a result, they fail to catch the complex phenomenon of hope, or over-complicatedness and elusiveness, which reduces the ability of writers and researchers to study the phenomenon of hope. The model that seems to be most robust and has gained the most attention is the one by Snyder (Schrank et al., 2008). Therefore, in the present study, this will be the primary model adopted for analysis of research findings.

However, it seems that Snyder has missed an important aspect of hope: the environmental influence on personal levels of hope. Many writers and researchers

thought that hope is based on the philosophical or spiritual system of a person and considered hope as something that is within a person that cannot be given or taken away as it continues to persist in the face of live adversaries (Pruyser, 1986). However, this seems to be somewhat contrary to the idea of instilling hope used especially in contexts of nursing and therapy. Therefore, Bernardo's (2010) external and internal locus of hope seems important.

2.4. Types of Hope

Snyder (2002) pointed out that hope is a system organised in a hierarchical way. He found three levels of organisation of hope: dispositional (or trait) hope; state hope, which can be divided into domain-specific hope; and goal-specific hope. He argued that trait hope is more general and it is based on a person's evaluations of their ability to develop pathways and generate agency thinking towards goal attainment. This type of hope is not directed at any specific goals or pursuits, but rather it refers to the belief in one's own ability to find pathways and agency if required. Trait/global hope is gained and established by the age of three. He claimed that this type of hope is stable over time and is not influenced by changing social and personal circumstances (Snyder et al., 2005). Snyder et al. (1991) developed the Hope Scale to measure trait hope in adults, and there has also been a version for assessing this type of hope in children (Snyder, Honza et al., 2007).

In contrast, state hope is related to a particular event or moment in time or area of a person's life, and is likely to fluctuate over time depending on circumstances (Snyder et al., 1996). Domain-specific hope refers to different areas of a person's life that particular hopes can be mentioned for, and Snyder identified six different areas: social relationships, romantic relationships, family life, work, academics, and leisure. The goal-specific hope refers to hopes directed at the attainment of specific goals and pursuits.

All of the above-mentioned levels of hope do not necessarily have to go together in the sense that a person having high global hope does not need to have high

domain- or goal-specific goals. Moreover, domain-specific hopes can even be varied between different areas of a person's life.

Marcel (1962) described two types of hope: concrete hope and transcendent hope. Concrete hope is one that is directed towards the achievement of specific goals or results, whereas transcendent hope is not directed towards specific goals or results. Barnard (1995), in his attempt to describe Marcel's concept of hope in the context of illness, compared concrete hope with the way it is widely understood and described in psychological literature as reaching desired results, e.g. successful treatment. He described transcendent hope as not related to results, but rather as the ability of a person to live and celebrate 'the here and now' without the need to look into the future, but with openness to what it can bring, and embracing the unknown. An ill person with a transcendent hope is the one who can see the illness as challenge, but also a state of new opportunities, whereas ill people presenting with a concrete hope would be focused on usually getting well and returning her/his body and life to the state from before the illness. It seems that concepts of concrete and transcendent hopes can be compared to those proposed by Dufault and Martocchio's (1985) definitions of particularised and generalised hopes. Particularised hope is defined as one directed towards a goal/desire, and generalised is one not attached to any specific goal or event and is more stable over time. Dufault and Martocchio (1985) made a distinction between generalised and particularised hopes, the former being understood as a belief in a positive but uncertain future, the latter a belief focused on a particular desired goal/pursuit/outcome.

Lemma (2004) wrote about the concept of "mature hope" (p. 109), which she defined as a "state of mind of expectant possibility" (p. 109). She claimed that this kind of hope symbolises a person's confidence in the ability "to manage the uncertainty generated by internal conflict" (p. 111). In Lemma's writing, mature hope is situated in the realisation of loss and disappointments. According to her writing, hope requires a person to give up past hope and come to the realisation that regardless of the circumstances, difficulties can be overcome. She argues that mature hope has its roots in reality.

2.5. Birth of Hope

Scioli and Biller (2009) stated that hope is active rather than passive and “it offers a real alternative to surrender borne of pain, suffering, or loss” (p.13). Furthermore, they described that this has nothing to do with blind optimism, but rather hope is borne from human basic desires for connections and attachments, agency and security, and love and care.

Shorey, Snyder, Yang, and Lewin (2003) conducted an empirical quantitative research that found an association between early attachment styles and the development of hope. They found that secure attachments facilitated goal-directed hopeful thinking. Hope is thought to start developing in childhood from relationships that a child has with people around them, such as parents, peers, and teachers (Snyder, Cheavens, & Sympson, 1997). Furthermore, Rand and Cheavens (2009) postulated that this is related to the most basic human drive and the most central of human goals; that is, one of being connected with other people. Based on these, it can be concluded that one of the first goals of a young individual is to connect with others, and attempts made at achieving this would serve as a basis for the future adult-life. If we are surrounded by those who respond to our attempts to connect, this becomes the basis for hope. Furthermore, Edey and Jevne (2007) concluded that hope is grounded in our past successes and the reverse of hope is anxiety and fear (Stotland, 1969).

Morse and Doberneck (1995) proposed that hope is a response to a threat, and an act that allows to one overcome the despair (Fitzgerald Miller, 2007) and lessen the suffering (Coulehan, 2011). Therefore, in this context, hope can be seen as being borne from suffering and despair. Simultaneously, all of these factors are also considered as threats to hope. This can be better understood in the light of Barnard's (1995) understanding of hope, which is defined not as something stable, but rather a state of oscillating between hope and despair. However, when a person experiences total despair, this suggests hopelessness, which is related to the total loss of any hope and acceptance of “the feared or threatening outcomes as inevitable” (Korner, 1970, p. 135). Hopelessness is thought of as a passive state, unlike hope, which is considered an active one. In the total loss of hope,

“death follows” (Clarke, 2003, p. 164). The relationship between hope, hopelessness, and despair is discussed below in a separate section.

Some writers also positioned hope and anxiety as being linked very close together, with hope as a belief that things might happen and anxiety as a belief that those hoped for things may not happen. Both concepts are based in future expectations and uncertainty, and Lazarus (1982) suggested that these two exist at the same time and cannot be separated, with hope being a way of coping with stress and anxiety. Research based on college students shows that hope and anxiety are negatively related and students with higher levels of hope have lower anxiety levels (Snyder et al., 1999).

Benzein and Saveman (1998) wrote that hope occurs after an event, and in order to fully understand hope, the events that gave rise to it need to be examined. It has been found that things such as loss, stress, life-threat, and even despair can became a starting point for hope. He also argues that the outcomes of person’s actions have to be considered and he pointed at an ability to cope, new strategies, and improved quality of life as a consequence of hope. They conducted a concept of hope analysis from the literature and identified antecedents, critical attributes, and consequences of hope. They named “stressful stimuli, loss, life-threatening situations, temptation to despair” (p. 326) as antecedents. Benzein and Saveman (1998) found that the consequences of hope were “ability to cope, renewal, new strategies, peace, improved quality of life, and physical health” (p. 326). However, they did not manage to explicitly explain what they meant by some of those terms.

An important insight comes from a study by Herth (1996), based on a large number of interviews with homeless people, which found hope to be complex and dynamic, with the power to move forward an individual. He identified a number of things that gave rise to hope, such as a sense of connection with others, setting achievable and realistic goals, individual qualities and ways of thinking, possession of hope objects, and respect from others. He found that when people were low in energy, others deemed their situation as hopeless, or treated them disrespectfully, and, as such, hope was not likely to grow.

In summary, it is argued that hope is born from experiences of suffering (Lohne & Severinsson, 2006) and production of hopeful moments is considered to be dependent on the attempt to repeat past moments of hope (Miyazaki, 2004). Therefore, it is believed that “hope is inherited from the past” (Miyazaki, 2004, p. 139).

2.6. Related Concepts

Hope has been recognised as being related to a number of different concepts. Below, the attempt is made to explore a few ideas that hope has been mostly associated with, namely, optimism, self-efficacy, wishful thinking, and coping. The effort is made to investigate the similarities of these concepts to hope and, importantly, what makes hope different in relation to them. Further, the dynamics between hope, hopelessness, and despair are discussed.

2.6.1. Concepts Related to Outcome Expectations

There are three concepts that seem to share with hope an element of outcome expectations for things to happen or to take place, namely, optimism, wishful thinking, and self-efficacy.

Hope and optimism are both related to expectations of future positive outcomes and are often treated as the same concepts. The Oxford Dictionary (2010) defined optimism as “hopefulness and confidence about the future or the success of something”, which does not seem helpful in an attempt to separate these two concepts. However, Scheier and Caver (2003) stated that optimism refers mainly to cognitions, which seems to be less complex than in an earlier-described hope theory where hope refers to generating thoughts of the agency and pathways towards goal achievement. Moreover, it seems that hope also includes an emotional component, even if only a by-product of thought processes. Further, unlike optimism, hope does not need to be related to expectations of success, for example, in the case of a patient who is able to look forward to the future regardless of suffering, which provides a state of mind of exceeding the present (Bunston, Mings, Mackie, & Jones, 1995). Moreover, Tutton et al. (2009), based

on a literature review, concluded that hope does not have to be associated with expectations at all as hope could even be unrelated to expectations. However, it could be argued that these also involve an element of expectations for the unforeseen future, or a state of expectant possibilities of what the future might bring. Nevertheless, Scioli et al. (1997) argued that optimism is grounded in rationality, evidence, and efficacy; whereas hope is viewed as something more complex that does not depend on logic. Therefore, even though hope and optimism are related and there seems to be some overlap between them, they are different concepts.

Korner (1970) makes a distinction between hope and wishful thinking, which is to do with the expectancy of the outcome and commitment. He argued that wish may happen, whereas hope must happen, and that a person does not necessarily have to be committed to his wishes but is committed to his hopes because “hope specifies that a future event will solve problems, give gratifications, and provide solutions” (p. 135). Wiles, Cott, and Gibson (2008) argued that there is a distinction between hope expressed as a ‘want’ and hope as an ‘expectation of an outcome’. However, Leung, Silvius, Pimlott, Dalziel, and Drummond (2009), based on an extensive literature review, concluded that as much as hope and expectations are related, they are, nonetheless, different constructs.

Self-efficacy is closely related to outcome expectations and it can be understood as a person’s belief in their own ability to complete a task and a level of motivation to follow through with it (Sarkar, Ali, & Whooley, 2007). It seems that components of self-efficacy resemble those of hope in Snyder’s (2002) hope theory of agency and pathways thinking. The difference seems to be that in hope these both are necessary elements, whereas, in efficacy, these do not have to go together. Further, as mentioned earlier, hope also contains an emotional component, whereas self-efficacy is a mainly a way of thinking; and research showed that even though they are related concepts, they are, however, different (Magaletta & Oliver, 1999).

2.6.2. Relationship with Coping

Coping is an important concept for health professionals and it is understood as a strategy that an individual adopts to deal with a stressful situation. Research with cancer patients showed that these are responses based in reality and serve an adaptive function to changing and challenging circumstances (Magarey, Todd, & Blizard, 1977).

Onwuegbuzie and Snyder (2002) investigated a relationship between coping strategies for exams and hope in college students. They found that those who scored low on a hope scale also scored low on study and examination-taking scales. Based on this, they concluded that those with low hope may find it difficult to develop ways for studying and experience blockage in generating study and examination goals, and agency to achieve these.

There are two strategies for coping identified by Folkman and Lazarus (1988): emotion-directed and problem-oriented. The former is targeted at removing emotional distress (could be via some defensive techniques such as denial), whereas the latter is aimed at modification or removal of stressful stimuli/problem. In reality, people use many combinations of both of these and often emotion-focused coping needs to be used before problems can be tackled.

In light of this, it seems that techniques employed at problem-oriented coping require generating goals and, later, developing ways to achieve these goals and directing some energy to do so. This very much resembles Snyder's definition of hope and, in this way, problem-focused coping and hope seem to overlap. However, this cannot be concluded regarding emotional-coping as this might involve unconscious level processes, such as repression or denial of stressful emotions or the cause of pain. Further, research suggests that people with low hope levels may employ more emotion-oriented coping (Scheier & Carver, 1987). Moreover, it needs to be noted here that coping might not result in the production of emotion (e.g. mechanical way of solving a problem), as in the case of hope (Snyder, 2002).

In summary, as mentioned in previous sections, hope has been recognised as an important coping strategy with life adversaries; however, this does not equate as coping is a different construct from hope, with hope being more complex and nuanced.

2.6.3. Hope, Hopelessness, and Despair

Hopelessness in the Oxford Dictionary (2010) is considered to derivate from the word hopeless, which is defined as “feeling or causing despair”, and despair is defined as a “complete loss or absence of hope” (Oxford Dictionaries, 2010). Even though concepts of hope, hopelessness, and despair seem to be linked even by those definitions, they also carry their own understandings and meanings (Staniszewska & Henderson, 2004).

It has been identified that despair is more easily awakened, and is much stronger and deeper than hopelessness (Kylmä, 2005). However, Kylmä, Vehviläinen-Julkunen, and Lähdevirta’s (2001) research with patients having HIV positive diagnoses and their carers revealed that hope is a dynamic process. They identified dynamics of hope as a complex construct that includes hope, despair, and hopelessness. Based on this, it can be assumed that these three go very closely together.

Furthermore, Kylmä (2005) argued that despair has two possible paths: “The destructive path of giving in to hopelessness, and constructive path leading towards hope” (p. 816). In this model, the upwards sub-process is one towards hope, with categories including ‘fighting to rise’, ‘fighting against sinking’, etc. On the other hand, the path towards hopelessness is called the downward sub-process, with categories such as ‘stopping and being stuck in a situation’, ‘sinking into a narrow existence’, ‘losing future perspective’, etc. Hope, therefore, is expressed in action towards dealing with a situation (Tutton, Seers, & Langstaff, 2009). According to this concept, people constantly oscillate between hope and despair in the road towards recovery (Lohne & Steverinsson, 2004). Morse and Penrod (1999) claimed that hope was preceded by hopelessness and despair.

This confirms the idea of hopelessness being the opposite of hope, and that “hope saves persons from the agony of despair” (Miller, 2007, p. 14).

2.7. Importance of Hope

The interest in the concept of hope has been growing following an interest in positive psychology, which is a branch of psychology interested in studying “what goes right in life, from birth to death and at all stops in between” (Peterson, 2006, p. 4).

O’Connell-Higgins (1994) wrote a book based on interviews with 40 individuals with histories of what could be seen as highly traumatic and unstable childhoods, and yet were healthy and functioning adults. Based on analysis of these interviews, she placed hope in the centre of resilience. She described people’s ability to maintain hope in a face of adversities to be of crucial importance. She also pointed out that the ability for hope can be built outside of parental relationships.

Hope seems to be of crucial importance within health providers, and in this context, it is understood as coping with life adversaries, such as trauma, illness, setbacks, loss, etc. The concept has been named as central for counselling, nursing, and psychiatry (Fitzgerald Miller, 2007; Larsen, Edey, & Lemay, 2007; Schrank, Stanghellini, & Slade, 2008). Hope is considered as one of the four elements common to all therapeutic approaches, next to theory of practice, therapeutic relationship, and external therapeutic factors (O’Hara, 2010; Snyder & Taylor, 2000). Hope is of special importance and interest in health care as it is considered to play a significant role in the recovery process. Therefore, those conducting research on hope believe that the insight into this concept can help to devise treatments programmes, with staff offering a support that fosters individual recovery process (Tutton, Seers, & Langstaff, 2009). However, Lupton (2003) also pointed out the negative consequences of hope as a preferred discourse for those affected by a serious illness. She suggested that those diagnosed, for example, with cancer, may be ‘blamed’ for not trying to ‘fight’ if they struggle to maintain their hope in the recovery process. It seems that this type of discourse is the one that is preferred within Western society and is maintained by the media covering

stories of those who ‘win the battle with illness’, or are surviving but coping. However, it has to be acknowledged here that hope harboured by people may have crucial importance, as shown by research into ‘the placebo effect’ (Humphrey, 2002).

Coulehan (2011) observed that in a history of medicine, doctors often controlled or withheld information, wanting to maintain patients’ hope that was perceived as “fragile” (p. 159). However, based on research conducted with palliative care patients, he observed that hope is much stronger and flourishes even when people face certain death. It gets awakened in times of uncertainty, despair, fear, or hopelessness.

Studies on hope showed a number of associations. People with a higher level of hope had a higher level of self-esteem, and hope levels had been negatively associated with depression (Snyder et al., 1997). Hope was found to be predictive of academic achievements amongst university students (Day, Hanson, Maltby, Proctor, & Wood, 2010). It also plays an important role in connection between life events and psychological well-being (Valle, Huebner, & Suldo, 2006). It has been shown that hope is essential for continuing progress and development after suffering a spinal cord injury (Lohne & Severinsson, 2006). It has been associated with a successful method of coping with illness (Edey & Jevne, 2007). Hope has also been found to play a crucial role in the experiences of caregivers to deal with the day-to-day responsibilities of caring for an ill person, as it balances everyday stress (Duggleby et al., 2009). Finally, hope has been considered to be of crucial importance for therapeutic work (Frank, 1968). Moreover, hope has been found to be a single factor that best predicted the client’s satisfaction from a therapy (Talley, 1991), and is seen as a psychological strength (Valle et al., 2006).

3. Summary and Rationale for the Research

Many have seen self-harm as a dangerous (Hawton, 2004), self-destructive behaviour (Linehan, 1993) and psychopathology (Nock, 2010). This has been entrenched by association between self-harm and mental illness. Very often,

people who receive a diagnosis of post-traumatic stress disorders, personality disorder, dissociative identity disorder, bipolar disorder, and sometimes schizophrenia self-harm (McAllister, 2003). However, it has to be noted that this assumption comes mainly from research and data obtained from inpatient and hospitalised populations. There is insufficient data from community samples to fully support this notion, as it is estimated that many of those who self-harm do not get in touch with mental health services (Boynton & Auerbach, 2004). There is a fairly common view that those who self-harm contravene the basic human drive for self-preservation (McAllister, 2003; Nock, 2010). This negative view of self-injury, coupled with a lack of knowledge and little understanding, contributes to negative attitudes amongst society and those who care for people who self-injure (McHale & Felton, 2010). Furthermore, Long et al. (2012) pointed out that these generalisations have developed as a result of the majority of research on the subject of self-harm being conducted with a hospital population. They argued that it is possible that those who do not get in touch with mental health services may differ significantly from clinical samples.

However, there is also a view, which is not as widely shared, that gives attention to the positive aspect of self-harming behaviour. Babiker and Arnold (1997) postulated that self-injury is an attempt to survive. The behaviour has been confirmed by qualitative research to be a form of self-care by which a person attempts to end the suffering and free themselves from a psychic pain (Schoppmann et al., 2007).

Motz (2009) argues that self-harm is a silent language which has a function of communicating to others and oneself a person's emotional states. The memories of trauma and suffering are being written on the body of a person who self-harms (Straker, 2006). In this context, Motz postulates that self-injury is a hopeful behaviour. This view can also be supported by the writing of Winnicott (Abram & Karnac, 2007), who claimed that an antisocial act, which self-harm in this case can be seen as, is a hopeful behaviour, as the person is trying to test the environment's ability to tolerate changes, and to connect with something stable, with the self, and with the other. In this context, the person's body is seen as the environment that has to be repeatedly tested. Motz (2009) proposed that a person

who self-injures hopes that he/she will be understood and cared for and that a meaningful relationship with the self and others can be formed. This view of self-harm as being hopeful behaviour that has a role of sustaining life has also been supported by Sutton (2007) in his book, with a number of clinical examples and patients' quotations.

In searching the current literature, no studies have been found which looked at the phenomenon of hope within the self-injurious behaviour. There has been one piece of qualitative research undertaken by Herrestad and Biong (2010) with the words 'hope' and 'intentional self-harm' in its title. However, this study looked at participants who were recovering in the hospital after a recent suicide attempt. Following on from the previous argument against classification of self-injury as the same as suicide, suicide is considered to be associated with hopelessness, and Korner (1970) argued that hopelessness indicates a person's acceptance of unavoidable feared and threatening results. Although there are also other reasons that people commit suicide, such as to "make others better off" (Brown et al., 2002, p. 111), perfectionism, to express anger, and for manipulative reasons, for example, punishing others (Boergers et al., 1998), some argue that a suicide attempt can be treated as a sign of loss of hope. However, self-injury without suicidal ideation indicates that the hope is still there. This can be illustrated with the words of Motz (2009), who argues that "self-harm is about trying to stay alive despite the pain…" (p. 216).

Lack of research looking into the phenomenon of hope within self-injury makes it impossible to generate hypotheses for conducting quantitative research. Therefore, a qualitative methodology was chosen to investigate both phenomena. Furthermore, in reviewing the literature, Long et al. (2012) called for qualitative research that would aim at presenting the perspective of those who self-injure in order to "deepen understanding of the issue, enabling people to share their experiences, advancing practice in a meaningful way" (p. 7). It seemed that qualitative research in the field has been mainly conducted to investigate functions, attitudes, and perspectives on self-injury. However, the majority of the research is still based on adolescent and adult clinical samples, often investigating self-injury as a part of other mental health problems. Therefore, those reviewing the literature

in the field of self-injury call for more attention to be given to the “natural history of self-injury in the general population and beyond adolescence” (Chandler et al., 2011, p. 102).

4. Research Question and Aims

Based on everything that has been discussed in this chapter, the main question used to guide the present research has been formulated as:

How is hope constructed in the narratives of people who self-injure?

The main aim of the study is to explore the narratives of those who injure themselves in order to deepen the understanding of self-injury and shed some light onto a concept of hope within their narratives. The detailed research aims and the method through which the research question is answered, together with the rationale for the choice of this method, are included in the next chapter.

Methodology

This chapter provides a detailed explanation of the aims, philosophical assumptions, process of the design, conduct, and analysis of the research. The focus is to provide background information for the reader to have a clear understanding of the context of this research and the rationale for making certain types of decisions. This chapter ends with the researcher's reflexive account on the process of involvement in the narrative research.

1. Research Framework and Rationale

1.1. Research Aims and Design

The aim of the research is to explore how hope is constructed in the narratives of people who injure themselves. The study objectives are:

- to explore individuals' experiences of self-injurious behaviour;
- to explore the phenomenon of hope in those who injure themselves;
- to interpret the experience of self-injury and hope in those individuals;
- to deepen the understanding of self-injury and the phenomenon of hope within it; and
- to understand the role of hope within the experience of self-harm.

As the research involved the gathering of participants' stories of self-injurious behaviour, this study employed a qualitative method to analyse the data. In particular, the Narrative Analysis method was used to analyse the participants' stories on their experience and engagement in self-injury, as well as the meanings they attached to it.

1.2. The Rationale for Qualitative Research

Qualitative research continues to grow in strength as a response to the prevalent positivist tradition of a scientific enquiry method in research that has been questioned since the second half of the 20th century (Riessman, 2008). The main

line of critique sees scientific methods of quantifying human experiences as unable to capture the rich and diverse range of experiences and their contexts (Smith, 2008). In contrast, qualitative methods are used to ascertain the meaning of experiences to the individual, and give attention to cultural and social contexts that people live in (Dyer, 2006). As the present research is interested in individuals' subjective experiences, the qualitative method of inquiry was deemed to be the most appropriate method. This way allowed the researcher to capture studied phenomenon through the richness of the presented data (Biggerstaff & Thompson, 2008).

Further, there was a study conducted by Herrestad and Biong (2010), who looked into hope with people who 'intentionally self-harmed'. However, this study looked at participants who were recovering in the hospital after a recent suicide attempt and the definition adopted in the present research for self-injury excludes suicidal intention. Consequently, due to the lack of research into hope with people who self-injure, it was not possible to make definite assumptions about the research hypothesis, which further supports the use of a qualitative method (Howitt & Cramer, 2008).

1.3. Narrative Analysis

A growing interest in qualitative research methodologies in the field of psychology and social sciences also gave attention to narrative methods of inquiry. Smith and Sparkes (2006) argued that one of the main reasons for this increased interest is that these methods present both epistemological and ontological stances.

The term 'narrative' comes from the Latin verb 'narrativus', which means 'telling a story' (Oxford Dictionaries, 2010). Therefore, the terms 'story' and 'narrative' are synonymous and used interchangeably. One of the most important functions of stories is their ability to organise events in a sequential order, which "brings order to disorder" (Murray, 2008, p. 114). Therefore, the term 'narrative' can be defined as a "way of organising episodes, actions and accounts of actions; it is an achievement that brings together mundane facts and fantastic creations, [in which] time and place are incorporated" (Sarbin, 1986, p. 9). Many authors have argued

that the creation of a narrative is an inseparable element of human lives and we produce accounts of ourselves that are storied. Murray (2008) stated that “we are born into a storied world, and we live our lives through the creation and exchange of narratives” (p. 113). Moreover, it is assumed that stories that people tell are of crucial importance in the process of identity creations, and it is precisely through the process of generating narratives that people form their identities (Ricoeur, 1987). Through storytelling we give meaning to events, choose things, experiences, and relationships that are important to us, and decide what would not feature in our narratives. This assists us to clarify our sense of who we are, what our values are, what is important to us, and what we stand for. All of these help us to start defining ourselves (Crossley, 2007). This process of identity construction is influenced by our constantly changing personal and social contexts (Murray, 2008).

The term ‘narrative analysis’ is an umbrella term for methods of analysing a story from texts (Riessman, 2008). Stephenson and Kippax (2008) described that even though there are many forms of narrative analysis, they all share a common view of perceiving stories as a way of creating meaning in a person’s life. Therefore, narrative analysis aims to look at how people make sense of experiences so that the experiences become true to them, especially experiences that they struggle to tell (Parker, 2004). Therefore, this process is not about uncovering the empirical/objective truth (Stephenson & Kippax, 2008). As an example, two people could witness the same event but their experience of it could be very different, and perhaps one of these people experienced it as traumatic, but the second person did not. Narrative analysis attempts to find out how these two people made sense out of the event and the meaning that they attached to it through the process of events interpretation and re-interpretation (Ricoeur & Kearney, 1996). The struggle to make sense out of an event or experience would therefore be evident in a difficulty or inability to tell a coherent story (Crossley, 2000b). Thus, narrative analysis operates on the assumption that the story becomes true because it is meaningful to the person telling it, rather than the story being meaningful because it is true. In summary, when people experience events in their lives, they try to make sense out of them through the process of creating stories. This gives a meaning to events and allows a person to express their agency. According to Reavey (2010), “Agency is an important aspect of memory practices, as it enables

the individual to locate themselves, as a subject in a wider political landscape. This includes how people identify themselves as active participants in their own stories" (p. 132). If people are not able to tell these stories and express their agency, they experience suffering (Murray, 2008). Following on from this, it is evident that one of the main objectives of narrative analysis is to give back agency to the narrators of their own stories.

Narrative analysis is a method that places a considerable amount of importance in the sequence of action and language that people use to tell their stories (McLeod, 2011). Therefore, a researcher is interested in how an interviewee "assembled and sequenced events and used language, and/or visual images to communicate meaning" (Riessman, 2008, p. 11). Narrative analysis investigates how and why events are storied, not only the content of the stories, in order to allow a researcher "to think beyond the surface" (Riessman, 2008, p. 13). The present study is interested in gaining an insider's perspective of not only what was said but also how it was said, and in such cases, Elliott (2005) recommended the use of narrative analysis to analyse the data. Further, literature research has revealed that at the time of writing, there was a dearth of research in the area of self-injury with an adult population employing the narrative approach.

There is no standard approach or a list of procedures that is generally recognised as representing the narrative method of analysis, but it is rather a multitude of different ways in which researchers can engage with narrative properties of their data (Aarikka-Stenroos, 2010). Those within the field of narrative approaches noted that "there is no singular or best way to define and study narrative. […] There is a need to open up the exploration of what we may learn from other approaches as we pursue our own particular one" (Mishler, 1995, p. 117). This view is also supported by Chamberlain (2012). The essence of narrative analysis can be well summarised with a quote from Murray (2008): "The aim of narrative analysis is to take the full narrative account, to examine how it is structured and to connect it to the broader context" (p. 129). However, regardless of those claims, the literature is filled with guidelines of well-defined steps for conducting narrative analysis, such as those proposed by Langdridge (2007) or Hiles and Čermák (2008). However, these methods are used for identity work and exploring

narratives in a more general way. Therefore, taking into consideration the present research topic, which has not been explored using narrative analysis, the researcher felt compelled to find a way of analysing the data that would target exploration of the phenomena of hope and self-injury.

In order to describe a specific method of analysis, it is necessary to consider the epistemological position of the present research, as this guides the choice of specific analytic steps (Willig, 2012).

1.4. Epistemological Position

Epistemology is concerned with the concept of knowledge and it is a branch of philosophy (Crotty, 1998). Different research methods have diverging assumptions about knowledge, which influence the way in which research data is handled and its results interpreted. Therefore, it is of crucial importance to establish what kind of knowledge any given research produces (Willig, 2008). Below, I present a brief summary of different epistemological positions in order to later present the researcher's own stance that guided this research.

One of the epistemological positions mentioned earlier is 'positivism'. Positivism accepts that there is a simple relationship between our perception and the world. Therefore, it assumes the possibility of gaining accurate knowledge through employing appropriate methods. Another epistemological position is 'empiricism', which adopts a position where knowledge can be gained through collection and categorisation of our perception. Both positivism and empiricism produce knowledge; that is, the 'truth' about the world (Willig, 2008). In response to this, the concept of 'hypothetico-deductionism' was developed, which assumes that a hypothesis needs to be generated and tested in order to develop knowledge. The above epistemological positions are called 'scientific methods' (Hayes, 2000). They have in common assumptions of the researchers' objectivity and neutrality, which allow accurate knowledge of the world to be uncovered. The critiques of those gave raise to 'nomothetic approaches', which generalise results considered as objective phenomena, and 'idiographic approaches', which try to gain an insight through examination of individual cases (Coyle, 2007). Further, many turned to

‘phenomenological methods’, where the main aim is to gain an in-depth description of an individual’s experience. However, some also wanted to look for ways in which social factors could have been taken into account as well, acknowledging that they shape individuals’ experience. This led to the development of ‘social constructionism’, which assumes that the way we construct our perception of the world and self is through certain social processes, and this is expressed through the use of language (Willig, 2008). Henwood and Pidgeon (1994) identified another epistemological position that is often adopted in psychology, called ‘contextualism’, which assumes that knowledge is grounded in individuals’ meaning in different contexts. Madill, Jordan, and Shirley (2000) claimed that epistemology can be seen as a spectrum with ‘naïve realist’ on one end of the spectrum and ‘radical constructionist’ on the other, representing all the above-mentioned positions with extreme versions of positivism and constructionism on the opposite ends of this spectrum. All the research methods’ epistemological positions fall somewhere on this continuum.

This research is interested in understanding people’s experiences of their self-harming behaviour, and it assumed that this was a significant feature in people’s lives that would drive them to produce narratives. Therefore, the study adopts a position that is grounded in both social constructionist and phenomenological philosophy. This means that it assumes that participants created their reality while the researcher was trying to explore this reality. It is a position that is close to contextual constructionism and it lies somewhere between the naïve realist and the radical constructionist positions (Lyons, 2007a). This means that this research assumes that the knowledge is influenced by the person’s own experiences of the world, and that this is also context-dependent. The research sees language as an important medium of expression of meanings that participants give to their experiences of the world, self, and others. At the same time, it recognises that the process of accessing this individual set of meanings is a difficult one, and it requires the researcher to make interpretations of the data. Therefore, even though this research is interested in the “discursive function of certain linguistic practices” (Crossley, 2007, p. 135), it is also concerned with the content of the narratives.

1.5. Narrative Analysis Method of this Study

Following on from the previous discussion points, the present study did not employ any one method of narrative analysis. Furthermore, taking into consideration that "ultimately, it does not matter which approach is taken as long as narrative analysis is systematic and clear, and as long as it generates insights into the structure of narrative, its functions and its social and/or psychological implications" (Willig, 2008, p. 133), the presented method is a result of an extensive literature research on what can be used and looked at when pursuing narrative analysis, bearing in mind research aims and questions.

It was identified earlier that there is currently no research exploring the hope phenomenon through narrative analysis. However, as hope is believed to be something that would emerge from narratives (Mattingly, 1998), it felt important to look at the beginnings, middles and ends of the self-injury stories and identify sub-stories. I believed that this might help to elucidate and understand the phenomenon of hope. This particular way of looking at the data was proposed by Murray (2008). Additionally, it was decided that a brief summary of each narrative account would be prepared, which should help the researcher to get a better feel for each interview and further assist with the analysis, as recommended by Mishler (1986).

Moreover, the decision was made to include a reflective paragraph for each of the interviews, following Langdridge's (2007) method. This is also supported by Parker (2004), who considered reflexivity to be an integral part of qualitative research that helps researchers to think about their own assumptions and knowledge, which influence their interpretations of the data.

Following recommendations from Willig (2008), I have also decided to look at four areas, namely: content, tone, themes, and functions of each narrative account. There were questions prepared for each of these areas, which were taken mainly from Willig (2008), Murray (2008), and Crossley (2000b). For the detailed list of analytic questions (and an example of an individual transcript analysis), please see Appendix 1.

It was felt that it would also be important to synthesise the findings and connect "the narrative[s] to a broader theoretical literature that is being used to interpret the story" (Murray, 2008, p. 120).

And, lastly, in order to present the results of the analysis, efforts needed to be made to put all the findings into a coherent story, as recommended by Crossley (2000b).

2. Method

2.1. Sampling Strategy

The research employed purposive sampling, which allowed the researcher to choose participants with specific characteristics (Denscombe, 2010), namely, people who considered themselves as reliant on self-injury. Therefore, the purposive sampling method of recruitment guaranteed to generate a high quality of information on the researched topic.

With regard to the number of participants, qualitative research tends to recruit small numbers due to the large quantity of data produced from interviews. Smith, Flowers, and Larkin (2009) recommended a recruitment of eight participants for a doctoral level thesis. It was initially aimed that a minimum of six to eight participants would be interviewed, depending on the response rate. Eventually, eight people were interviewed. It was felt that a number larger than this would not have allowed for the depth of analysis required for the purpose of this research.

As the majority of research in the field of self-injury was conducted with a clinical population, this study was interested to obtain data from a non-clinical adult sample. It followed Erikson's (1994) model of psychosocial development, which defined adulthood as starting at the age of 20. This is also in line with Moran et al. (2012), who conducted a cohort study and separated adolescents (up to the age of 19) from young adults (starting at the age of 20). They observed a significant drop

in rates of self-harm between these two groups. Based on this, they concluded that self-harm is resolved naturally for many adolescents. This finding suggests that there may be a difference in the phenomenon of self-injury at the transition into early adulthood.

Based on this, in the present research, one of the inclusion criteria was that a person needed to be 20 years of age or above. It was decided that in order to ensure homogeneity of the sample and ensure access to the non-clinical population, the research would include people who were working at least part-time on the basis that if a person works, this would indicate that they are coping with everyday life situations because they are able to maintain a job. Furthermore, another inclusion criterion was that a person should not have suicidal ideations, which again confirmed their ability to manage their lives and was in line with the definition of self-injury employed in this study. Moreover, it was also a criterion that participants were not undergoing therapy or counselling for their self-injurious behaviour. All of the above-mentioned criteria allowed a researcher to assume that people who took part should not have been acutely distressed and constituted a non-clinical sample. However, steps were undertaken to monitor this throughout the interview process and an action plan was prepared in the event someone became distressed as a result of taking part in the present research (please see section 3 - Ethical Consideration of this chapter for the details of this). Participants also needed to consider themselves as continuing to rely on self-harm at least from time to time. The researcher did not want to restrict the frequency or the time the person self-harmed as it was more important that the people who took part considered reliance on it, regardless of the time they last self-harmed. Moreover, included in the present study were only those people who primarily self-injured in a way that was in line with the definition of self-injury adopted by the present study (see the Introduction chapter, section 1.2., Terminology and Definition, for the details of this). This definition excluded behaviours such as piercing, tattooing, overdosing and self-poisoning, substance abuse, eating disorders, or harm to oneself that does not cause destruction of the body tissue.

2.2. Recruitment Procedure

Initial recruitment procedures involved approaching a number of websites that supported those who self-harm to ask for assistance in advertising the research. From a number of them, only one responded, which generated the first interview. After a few months, the decision was made to apply for an extension of the ethical approval to include other forms of advertising, such as flyers, magazines, and social networking sites. For this purpose, a website was created and leaflets were designed (Appendix 2). The decision was made to extend the interview method, allowing interviews to be conducted via Internet using Skype if the geographical distance would not allow the participant to take part in the research, as recommended by Nosek, Banaji, and Greenwald (2002). A number of different organisations were approached and asked to help with advertising the research. Those organisations which agreed to assist distributed flyers via their emailing lists, placed the advertisement on their websites, and gave a link to the research website via the Facebook and Twitter social networking sites. One online magazine dedicated to health issues included an article about the present research. Flyers were also placed on the advertisement boards in central London close to busy communication links.

A total of twenty-one people expressed an initial interest in taking part in the study, of which only one was male. All of them contacted the researcher via email; therefore, the initial screening involved this form of communication. Four of them did not meet the inclusion criteria of age (as they were 18 years old) and the form of self-harm used (they reported self-poisoning, overdosing, and refusing medical treatment as the main forms of self-injury); therefore, they had to be excluded. There was a large drop-out rate. Of the remaining 17 people, seven did not confirm their interest after receiving an information sheet from the researcher, and two people failed to turn up for the interview. In all these cases, two emails were sent two weeks apart from each other. None of the people in question responded to those emails; therefore, it was difficult to establish the reason for the drop-out. However, a large proportion of those expressing an interest indicated in the initial contact that they had never spoken about their self-injurious behaviour with

anyone before. Therefore, it was possible that this affected the decision of some people not to partake.

2.3. The Sample

A total of eight participants were interviewed, which comprised of seven females and one male. Five of them were of British origin (including one living outside of the UK), two were Americans, and one was Canadian. It appeared that one of the participants was Asian and the remainder were Caucasians. They were all aged between 20 and 29. Even though an attempt was made to recruit participants with a range of characteristics, this was limited by the response from participants who agreed to take part in the research. Further, it is possible that people older than this study sample have been hiding their self-injury for a very long time; therefore, they might be less likely to take part in a research due to the risk of exposure.

Four participants responded to the researcher's call for participants after seeing the advertisement via user-led support websites (this included Facebook). Two participants said that they followed a national self-harm organisation on Twitter and saw the link to the research website, which they used to contact the researcher. One participant responded to the email sent by one of the organisations with distributed research leaflets, and another participant saw the research advertisement on a student-based forum.

2.4. Gathering Data Procedure

2.4.1. The Way of Collecting Stories

There are a number of ways in which stories can be collected, with interviews being the most popular one (Riessman, 2008). The main goal of the narrative interview is to gather a detailed account of people's life events (Riessman, 2008). This can be used to focus on a particular event or experience from a person's life (Murray, 2008), such as in the present study. This is termed the episodic interview (Flick, 2009).

The present research utilised semi-structured interviews. The justification for this came from narrative theory. From a narrative perspective, it is argued that a person is not simply a social role, but he/she is in a process of becoming that role (Mattingly, 1998). This means that one is not defined by a social role that one plays but is actively becoming that role (e.g. a father strives to be a good father). Therefore, a person carries certain hopes about what the future will uncover and what he/she may become. Based on this, Mattingly (1998) makes an assumption that "hope is […] a narrative thing" (p. 70). Hence, the researcher needs to have some level of flexibility in the direction of the interview. This was one of the main reasons behind the decision of conducting semi-structured interviews that could give an interviewer the access to the narratives of self-harm and hope. Conducting semi-structured interviews allows a researcher to follow participants' stories in order to gain a greater understanding of studied phenomena (Smith, 1995) and gives freedom and flexibility to be led by participants and what they considered as important (Riessman, 1993).

2.4.2. Data Collection

After expressing an interest, the potential candidates were sent an information sheet (please see Appendix 3) and a consent form (please see Appendix 4), and were asked to read through both of the forms and let the researcher know whether, after careful consideration, they wanted to take part in the research or had further questions. Only those individuals who met the inclusion criteria and gave consent were invited to take part in the study.

If a person met the criteria and agreed to take part in the study, the location, date, and time for the interview was arranged. The choice of location and interview form (in person or via the Internet) was given to individuals. Three participants were interviewed at City University, and five interviews took place via Internet using Skype. In the latter group, all except for one participant had their video cameras switched on. The researcher's video camera was switched on for all five interviews. In this group, all participants spoke from their homes with no one being around. The researcher also conducted interviews from home with the use of a headset to ensure interviewees' anonymity.

In cases where the agreed meeting location was City University, the name under which the participant was entering the university building was agreed upon in order to preserve participants' anonymity. The consent form was given and must have been signed before the interview took place. In the case of face-to-face interviews, this was done on the day, whereas the Skype interviews were done before the interview took place. All the interviews were voice-recorded.

Before the interview started, the researcher went through the consent form and inclusion criteria again, and the opportunity was given to the participants to ask any questions.

The time commitment required from participants was about an hour for the interview and about twenty minutes for obtaining the initial consent and debriefing after the interview (for the interview guide, please see Appendix 5). The first interview took slightly longer than one hour. In this case, the interviewee informed me before we started that he/she had three hours reserved for the interview. However, fifteen minutes before the first hour expired I asked whether we could carry on beyond the one-hour, and a verbal consent was given. After the first interview, the question of whether participants wanted to carry on should an interview overrun was included in the brief for the remaining interviews. One person did not wish to exceed the time specified and every effort was taken to ensure this. In those instances when the interviews were taking longer than the expected one hour, participants were asked again fifteen minutes before the hour whether they wished to overrun the time initially specified, or would they rather finish as initially agreed. The information was provided that they had the right to refuse. All participants in question gave their verbal consent for increasing the interview time. The interviews ranged from 49 minutes to 87 minutes in length and it seemed that this depended on how much details the stories contained; also, some interviewees told many stories, which extended the length of the interviews.

After the interview, the recording device was switched off and a debriefing was provided. At this stage, an opportunity was given to the participants to ask any questions that arose during the interview, and the interviewer also asked a few reflective questions (see Appendix 6) to assess the potential distress and elicit any material that may have impacted on participants. All the participants described the

experience of taking part in the research as positive, with three people stating that it was somewhat easier to talk about their difficulties than they had expected. No one reported feeling distressed at this point. The participants received an information leaflet (please see Appendix 7 for an example of this) that included a list of website addresses and helpline numbers, as well as the researcher's email address and contact number in case they felt that they wanted to talk to someone after the interview. For participants from abroad, the researcher also included local country-specific helplines and websites in order to obey the ethical obligation towards participants in case of distress.

2.5. Analytic Procedure

The analysis followed a method that was presented earlier in this chapter (please see section 1.5.). This can be broken down into a few analytical steps: transcripts, individual narrative analysis, synthesis and theoretical level stage, and, finally, writing up. Those stages correspond to those proposed by Willig (2008) of textual analysis, cross-sectional analysis, theoretical level stage, and writing up. The textual analysis stage looks at each individual interview in terms of transcription and analysis. At the cross-sectional analysis stage, common themes are searched for. This stage connects with and leads to the theoretical stage, where the attempt needs to be made to consider the findings in relation to the existing body of knowledge. In the present study, the cross-sectional analysis and theoretical stages are presented together as the synthesis and theoretical level stage. This leads to the writing-up stage, which involves making decisions with regard to presentation of the findings.

It is worth noting that in the present study, these stages were not chronological and they overlapped. The researcher switched from any one stage to another and back if there were new things emerging from the data, as recommended by Crossley (2000b; 2007). This process continued and included the writing-up stage as well.

These stages are described in detail below.

2.5.1. Transcribing

Firstly, the researcher transcribed each interview. Riessman (1993) advised to make a “rough transcript” (p. 56) as a first step. Therefore, the first transcript was brief, but there was more emphasis placed on removing any participant’s identifying details. Interview transcripts were given a number from A1 (for first interview) to A8 (for the last interview). Then, the audio recording was listened to more carefully a second time and the transcript was corrected, but this time the importance was placed on getting all the words on paper, and correcting the first transcript to reflect the original interview as closely as possible (for the transcription and citation key, please see Appendix 8).

It is interesting to note that in the case of narrative analysis, the ‘transcription’ stage cannot be separated from the ‘analysis’ stage (Hiles & Čermák, 2008); therefore, during the transcription an attempt was also made to identify narrative structures, and a note was taken if there was anything that ‘jumped out’ of the interview. The researcher also reflected on the transcription process after each transcript was completed.

Each line of the interview transcript was numbered and the transcript was printed with a large margin on the right side of the text, as recommended by Crossley (2000b). This allowed the ease of referencing specific quotes via line numbers, and space for some analytic comments.

2.5.2. Individual Narrative Analysis Stage

This stage involved analysing individual narratives by looking for the beginning, middle, and end of the self-injury stories, listing side-stories (which are stories that do not directly form a part of self-injury stories), preparing a brief summary of narrative, reflexive engagement of the researcher, and looking at a number of questions concerning tone, content, themes, and function of the stories (as described in section 1.5. of this chapter). An example of the individual transcript narrative analysis can be found in Appendix 1.

The transcript was read numerous times until the researcher felt familiar with the text. During the readings, the researcher made notes, observations, and reflections in the right-margin of the transcripts.

First, the beginning, middle, and end of the self-harm stories were identified, together with any other 'side' narratives of the interview. Next, the transcript was read repeatedly, each time focusing on different issues concerning tone, content, themes, and social and psychological functions of the stories. At the same time, the researcher's brief reflection on the transcript was recorded regarding any thoughts or feelings that the texts evoked, overall observations, and the meaning of the texts for the researcher.

Additionally, following Murray's (2008) recommendation, a short narrative summary of each story was prepared based on the initial analysis of the beginning, middle, and end of the stories.

This procedure was repeated for each interview separately.

2.5.3. Synthesis and Theoretical Level Stage

When the individual analysis stage was completed, the next step was to synthesise the findings.

First, the beginning, middle, and end of each story were printed out separately and grouped together in their classifications (i.e. 'beginning', 'middle', and 'end') (see Appendix 9). The summaries were also printed together with reflections of each interview. Each of these was read multiple times and the emerging themes were noted.

Next, earlier mentioned answers to questions concerning tone, content, themes, and functions of each interview were divided and grouped together in their classifications. Each category was read a number of times, allowing the researcher to draw common themes to all the interviews and note the interactions between them. As an example, all the data regarding the 'tone' of all the interviews

was gathered together and read a number of times, which allowed the researcher to generate some common features of all the narratives and differences between them regarding their 'tone'. Then, all the content, functions, and themes were treated in a similar fashion and were attended to separately. This method allowed the researcher to generate hypotheses with regard to the direction of the narratives and the function that this manner of telling stories played.

During the stage of synthesis and theoretical engagement, all the transcripts were read another three times to immerse with the data and a further theoretical level reading was conducted. At this level, the researcher was looking at the common themes and the direction of the narratives. This process generated some hypotheses and themes that were repeatedly put together and revised. Some of them were collapsed and merged together through the process of synthesis, reflection, the researcher's own interpretation of the data, and literature search. All those steps allowed the researcher to generate themes that were considered to form a part of what was constructed across all the narratives as a self-injury story. This stage and process involved creative engagement with the data (see Appendix 9), as described by Murray (2008), who postulated that "rather than imposing a framework and rather than simply describing the accounts, narrative analysis requires the analyst play with the account" (p. 121). The results of this process and the researcher's 'play' with the data led to the development of themes, explanation of self-injury, and a narrative type presented in the analysis chapter.

2.5.4. Presenting the Findings

In order to present the findings, the researcher decided to follow some of Langdridge's (2007) recommendations for structuring the findings around the main narratives that emerge from the texts, subdividing the description with the themes that are produced as a result of synthesis and theoretical level stages. It was also important to show how the narrators made sense out of the concept of hope within self-injury; and therefore, this is presented in a separate section.

3. Ethical Consideration

The ethical clearance for conducting this research from the City University Ethics Committee was obtained. The project did not require any additional ethics committee approvals; however, it complied with the ethical and good practice guidelines of the British Psychological Society (2010; 2009).

Obtaining informed consent, confidentiality, and avoidance of harm are three main ethical issues that any researcher needs to address before conducting their research (McLeod, 1996). There were steps undertaken in order to minimise risks of breaching ethical conducts in each of these areas.

All candidates who expressed an interest in taking part in the research were sent an information sheet that highlighted the research aim, purpose, and procedure of this study, together with a consent form prior to the interview. The researcher ensured that the language used on these forms was easy to understand and all the technical jargons were explained or removed. Participants were asked to read through these forms and encouraged to ask any questions. They were also asked to contact the researcher to confirm whether they were still willing to take part in the research after familiarising themselves with the information received. Upon agreeing to take part in the study, participants were asked to sign an informed consent form before the interview started. The researcher verbally went through all the points on the information sheet and consent form. Participants were given an opportunity to ask any questions.

Participants were informed that they had the right to refuse to answer any question and/or stop the interview at any point, and that they had the right to withdraw from the study without any prejudice, in which case all their data would be immediately destroyed. The participants were also informed that their participation in the research was confidential and all the necessary steps would be taken to ensure this (e.g. all their identifying details were removed from the transcripts; instead, a coded system was used). It has to be acknowledged here that the researcher was trying to achieve a subtle balance between preserving an individual's confidentiality and faithful presentation of his/her story. Even though some of the

identifying details were changed or deleted, it was not possible to remove or change all of the identifying features. It is in this light that the interview transcripts were not included in this thesis.

All the hard copies of the consent forms were kept at home in a hidden, secured location away from the digital information. All digitally stored information was stored on a personal computer in a password-protected folder to which only the researcher had access. Participants were also informed that all the data would be stored for a maximum period of six years. Participants were told that anonymous quotes from the interview could be used for the purpose of writing a final report and publication. Participants were also made aware that the interview constituted a research investigation and should not be treated as a therapy session.

If any of the participants started to self-harm during the interview (including the interviews done over Skype), the interview would have been stopped, the recording device switched off, and the researcher would have encouraged the individual to seek help and the offer to call emergency services would have been given by the researcher. In case of interviews over the Internet, the researcher would have stayed online until a participant was calmer. None of the narrators started to self-harm during the interview process.

Throughout the interview, sensitivity to participants and their stories was maintained. The researcher was watching for signs of emotional distress, and if this was observed, the opportunity to stop or withdraw from the interview was offered. No one wished to stop or withdraw from the interview process.

After the interview, the participants were given a debriefing to allow any concerns or questions to be raised. There was also an opportunity given to the participants to express their views on the interview and give feedback to the researcher. Participants were given information with available resources and support that they could access if needed. This would also contain the researcher’s contact details in case the participants had any questions, concerns, or other issues arising as a result of the interview.

Conducting narrative research also requires ethical consideration that is specific to this methodology. Smythe and Murray (2000) argued that the central issue in this type of research is narrative ownership, namely, who has control over the interpretation and presentation of the data. Whilst there has been a considerable effort made to represent participants' stories to reflect them as faithfully as possible, it is important to acknowledge that the final results constitute the researcher's own interpretative process. Someone else analysing it may have come up with a different set of themes.

4. Analytic Rigour, Quality, Credibility, and Usefulness

Quantitative research is evaluated in terms of criteria such as reliability and validity, and it assumes objectivity of the researcher from the research topic as he/she is trying to access the truth of the research phenomenon (Feast & Melles, 2010). However, in qualitative research, it is assumed that a researcher is very much involved and present in the research (Parker, 2004). Therefore, it would not be appropriate to assess qualitative research against the same criteria of reliability, validity, objectivity, and generalisability as it is for quantitative research (Yardley, 2008). Lyons (2007b) argued that qualitative research should be assessed on two dimensions: first, the study's rigour and quality; and second, its credibility and usefulness. She posed an important question that allowed better understanding of interaction between the two dimensions: "How can we show the rigour and quality of our research so that our academic peers accept the credibility and usefulness of its findings?" (Lyons, 2007b, p. 6). I address each component of these two dimensions in turn.

Rigour: This can be understood as the degree of a researcher's scrupulosity of data collection, analysis, and presentation of results (i.e. how thorough the research process is) (Yardley, 2000). It is hoped that the researcher achieved this through the process of organisation and presentation of all the stages of this research, including his/her own position with regard to each phase of conducting this research.

Quality: Meyrick (2006), based on an extensive qualitative research review, concluded that two core principles of quality are research transparency and systematicity. The researcher tried to be transparent with regard to the decision-making process leading to the development of the research question, research design and recruitment, process of analysis, and presenting the results. Moreover, an effort was made to ensure that the process of research was conducted in a systematic way and everything was documented thoroughly.

Credibility: As mentioned earlier, narrative research is not interested to uncover empirical truth. It rather assumes that people's stories and the way they make sense out of their experiences are true for them (Parker, 2004). Moreover, narrative research assumes that the data obtained via the interview process is co-constructed by the researcher and the narrator (Riessman, 2008). The final results are based on the researcher's own interpretative process, and it is hoped that through the process of checks and thorough documentation of all stages, the reader can conclude that the research and its findings are believable. Bearing the credibility of the findings in mind, the researcher's supervisor was consulted at all stages of conducting this research. Moreover, the findings were presented to clinicians and peers, and feedback from them was sought. This was useful during the process of writing up and helped to further expand some of the themes to show greater data-grounded evidence to ensure their plausibility.

Usefulness: The relevance of this research has been discussed in both the Introduction and the Conclusion chapters. Moreover, to ensure a wider audience of this research, it is aimed that the results will be published in a peer-reviewed journal and a draft of the paper for publication can be found in Part Two of this thesis portfolio.

5. Researcher's Reflexivity

Engaging in the process of employing narrative analysis turned out to be extremely challenging. Transitioning from a business background into psychology, my main strength lies in statistical methods to analyse the data. This was also my

method of choice for my dissertation at the undergraduate-level education in psychology. Statistical analysis is an approach that is fairly clear and straightforward in a sense that there is a very specific set of steps that needs to be taken in order to achieve the final results. Statistical analysis also assumes that there is a right and wrong way of doing it. As an example, one may choose an inappropriate test for analysis or define wrongly the group of participants.

Having experience in conducting quantitative research, I was very clear from the moment I started the doctorate programme that I was interested in conducting a qualitative research for my final project in order to gain a different experience and set of skills. Moreover, this type of analysis seemed to be more suited to my developing identity as a counselling psychologist. Not knowing 'what I was getting myself into' at the start of the process, I was rather naïve with regard to the amount of work that this type of research requires and the anxiety that the process of engaging in a qualitative inquiry would evoke in me. I found myself underestimating the amount of time it would take to first prepare the project, recruit participants for my research, transcribe and analyse interviews, and write up the research results.

The first difficulty came after several self-injurious websites were initially approached. Even though many of them were sent an email request to advertise for participants for the interview, only one website responded. After a few months of trying to reach more websites to help with the recruitment of potential participants, I had to face the fact that this way of reaching potential participants would not be enough. It turned out that my initial research proposal and ethics approval did not include any additional forms of advertising and I had to ask for an extension of the scope of recruitment methods to cover other forms of advertisements in writing. This seemed to be in contrast with the ethics approval for my previous quantitative type of research.

Another challenge emerged from using Skype to conduct interviews. Although, I did not think at first that this should pose any difficulties in terms of losing some data, I was worried that others may see it this way. I wondered (led by comments of some peers) whether the data obtained this way would be as full and rich as

data from interviews where participants and researchers meet in person. As a result of these initial comments made by peers, I did not discuss this way of collecting data for a long time, as I felt ashamed of it. It struck me how similar my feelings with regard to this issue were with the feelings of my narrators with regard to their self-harming behaviour. In the end, this worry did not turn out to have any ground as my most 'rich' interviews were done over Skype. When I reflect on this now, it seems that the Internet has possibly allowed people to be more open and take risks about what they disclosed, and perhaps speaking from a familiar environment helped to put participants at ease. I wondered if the safety of homes and indirect way of communication (via Skype) allowed people to be more open. Further, it is interesting to note that whilst self-injury can be seen as an indirect way of expression, the Internet also represents an isomorphic way of expression. I wondered whether these forms were more manageable for the narrators.

Being used to having a very well-defined and established analytical procedure, I was looking for a 'recipe' when I first started to look at how to do a narrative analysis. I wanted to find a list of steps that would constitute narrative analysis. The longer I looked and the more I read on the topic, the worse my anxiety became. It was not because I could not find any 'recipes'. I actually managed to find a few. However, I quickly realised that I could not tell whether they were appropriate for answering the questions that I had asked of my data. Only after speaking to one of the supervisors, I was encouraged to look for my own way of analysing the data. At first, I was relieved, but very quickly anxiety crept in again. I started to question my ability to work in such an unstructured way and trust my judgement, considering my still somewhat limited knowledge on the subject of narrative analysis. As I decided to persist with it, I did much more reading, and finally managed to prepare a list of analytical steps I wanted to work through when analysing my transcripts. This made me feel better as I finally had my own 'recipe'.

After completing the analysis, I started to synthesise and needed to decide how to write up what I found. However, the difficulty that arose here was about how to present all the research findings, bearing in mind the research question. Yet again, I was encouraged to engage in a creative process of looking for meanings and common themes emerging from my analysis. The process of generating themes

across all data was a very difficult one. I have struggled to put all the themes into thematic priorities, worrying that whichever decision I make I will lose some meaning out of my data and will not be able to give justice to my participants and their stories and present their stories in a meaningful way. I felt unable to make decisions, and my anxiety was paralysing. During this time, I went back to my transcripts, as I started to doubt whether I sufficiently remembered them and whether my analysis was appropriately based in my data. From this period I had numerous pages of notes, drawings, and diagrams. I felt overwhelmed with all the data and I struggled to find a way to meaningfully present what I found. During this process, I also did more reading, mainly on different studies that used narrative analysis. I felt lost, and this felt like chaotic. The periods of feeling like I was making progress were followed by periods of despair. I felt that I would not be able to complete the process. During this time, my meetings with my supervisor were of crucial importance. She encouraged me to stay with the struggle.

One day during this struggle I was sitting in the library looking at the themes emerging from one of my interviews and, suddenly, I thought about the suffering that self-harm communicated, unbearable suffering that no other meaningful way could possibly express and suffering that words could not be found for. I wondered how one could make sense out of something that did not make sense. Somehow, from this moment I started having more moments of clarity. All those notes, drawings, and diagrams started to slowly make sense and I started to see patterns and connections, but not all of them at once. This was more like doing a puzzle and finding the right place for one small piece a day. On a good day I was able to match a few pieces, but on some days I would realise that one piece did not fit where I thought it would. Finally, very slowly I found a way of writing all that I had found. This process made me appreciate the meaning of the process of hope as a state of balancing between despair, hopelessness, and hope.

After I wrote the ‘Analysis’ chapter, I realised that the way I struggled and how overwhelmed I felt were the same processes that my participants were going through. They struggled to make sense out of experiences that did not seem to make sense, and then they tried to convert them into self-injury to give a meaning to the experience and impression of agency. They, like me, seemed to be going in

circles with the way they told their stories, where every clearing was covered by a shadow, but then another clearing could be seen and after that another shadow, and so on. The hope that another clearing was possible to reach was the force that drove me forward, the same way as it allowed my narrators to carry on with their lives and not give up. This was how the story unfolded for those who told me their stories and for me to get a grip with this research and understand their experience. This thesis is about that struggle and hope that this process of searching for meaning communicates.

Analysis

In this chapter, the researcher summarises what has been produced as a result of employing narrative analytic procedures to data collected from the interviews. The goal of analysis was to gain a better understanding of the narrators' self-harming behaviour, and the phenomenon of hope within their individual stories. However, it needs to be noted here that those narratives were co-constructed between the researcher and the narrators. Presented in this chapter are the researcher's findings from analysis of the narrators' accounts.

First, the type of story that was told by the narrators about their self-injurious behaviour is being discussed. Next, the four overarching themes with their constituent categories that emerged as a part of the self-injury story is presented. These themes also illustrate stages of experience that the narrators constructed as going through whilst engaging in the behaviour. Simultaneously, the concept of hope is discussed throughout. Lastly, the hope and hopelessness from the narrators' perspective in relation to self-injury is shown. All the findings are discussed in relation to the existing literature and research throughout this chapter.

1. The Type of Story Being Told

It has been noted that all of the narrators' accounts had a direction that was cyclical in nature. The stories were told in such a way that different things happened over and over again within them. There has been no narrative type found in the literature to describe this kind of movement within a story. Therefore, for the purpose of this research this has been named as a cyclical narrative.

The cyclical narrative in self-injury can be illustrated by the way some participants reflected on the idea of self-injury being a cycle of stop and start, and low and high-intensity moments. They spoke about long or short breaks between an act/a series of acts of self-injury over some period of time. This cyclical nature of self-injury is illustrated in the excerpt below.

> ***Sophie:*** *"It sort of comes at intervals, where I do small cuts, and then when something triggers really hard, I start cutting really hard, and so it comes as peaks and troughs, and I could stop for about a month, or like six weeks and then I start again, so I guess that's the progression of it."*

For Sophie, the cycle is not only about breaks in the occurrence of the behaviour, but it also refers to the strength and severity of her cuts. Her recognition of the cyclical nature of her behaviour allowed her to refer to it as "*peaks and troughs"*. Interestingly, the use of this metaphor emits a sense of self-injury as always present, something that does not disappear, but rather it is on a continuum and it is connected.

Some narrators, however, constructed the cycle of self-injury as something much more scattered and intermittent rather than continuous. In the extract below, Anna describes the periods of stopping and starting as the process of three-monthly cycles.

> ***Anna:*** *"It kind of started and stopped over the course of the year. When I felt better I would stop and it kind of worked in a cycle, where about every three months I would start again and maybe for three weeks I'd be cutting and I'd be like 'Ok, I don't want to do this anymore. I'm sick of this'. And I'd stopped and it would be three months and something all over again."*

The cyclical nature of narratives was also evident in the way people spoke about the position that the self-injurious behaviour occupied in their everyday routine and in response to stressful events.

> ***Ruby:*** *"Whenever I needed to deal with something, usually something quite explosive, like an argument, or something like that, I would then, it got to the point, where I would sort of engrained in my sort of consciousness, that's how I dealt with things. If I start arguing I would get craving for cutting, rather than just thinking 'What shall I do? Maybe I should try cutting' I would get an immediate craving. I would think 'I need to cut myself, I need to cut myself'."*

Ruby describes thoughts of self-injury as occurring automatically, every time she needed to deal with something. Thus, the cycles reoccur to become habitual and reflexive. This excerpt also contains very strong reference to hope, where a goal is to deal with 'things' in the future. There is an indication and subtle reference here to the emotional suffering these situations evoke. Ruby states that she knows a

way to resolve this (indicating of the pathway of hope) and would not hesitate to use this way (pointing at the agency of hope).

Some narrators spoke about phases that they went through, which also gave an impression of cyclical movement within narratives.

> ***Olivia:*** *"I go through those phases where it's like a heavy and then it'll all happens at once and then I'm calm again and I don't understand why I did it. […] I mean the last time I did it was roughly three weeks ago but before that was like six months ago, you know it's something that rarely happens, but I would say that every six months."*

Olivia, in the above excerpt, also referred to and specified the time break between her self-injury. This suggests the temporality is of importance in allowing the narrators to experience a sense of understanding or control over the habitual cycles. Moreover, the cyclical narrative indicates the powerlessness of the person to escape the cycle.

Interestingly, the idea of cycles is also evident in the way some of the narrators described how they harm themselves. There is a repeated notion within those descriptions.

> ***Olivia:*** *"And I just hit myself and I start thinking again, and than I hit myself again, and then I cut myself, and eventually I calm down."*

The excerpt from the interview with Olivia also shows the pathway of hope in a sense that harming leads to her feeling calm. The actual act of cutting is an expression of an agency of hope.

The interaction between different stages of the cycle of self-injury is illustrated in figure one. These stages also corresponded with the overarching themes that emerged from analysis and are described in the following section. They all form the 'cyclical narrative'.

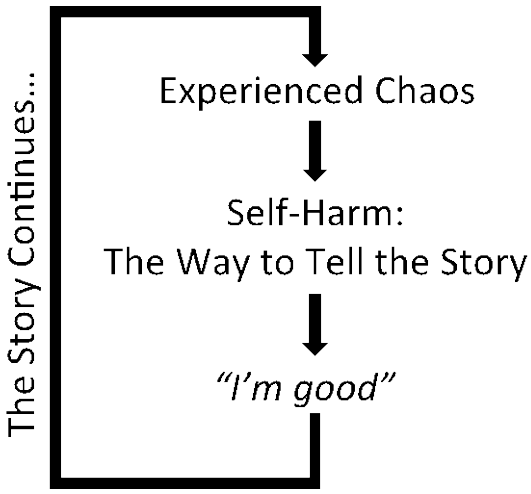

Figure 1: The Cyclical Narrative

The self-injury cyclical narrative can also be analysed through the lenses of hope concept. The goal the narrators aimed at was to get to an *"I'm good"* point, which is a future-oriented, possible, and realistic goal, but its attainment is not certain. All these elements form a part of the hope concept. Furthermore, as shown in the 'Introduction' chapter, hope is borne from suffering and despair, in this case from the experiences of chaos. At these moments, the narrators generate a route (pathway) to get to 'I'm good', which, in this case, is though self-injury. The pathway (self-injury) connects the present with the future. Through the act of self-injury, or even just thoughts related to the narrators' readiness to take the action if needed, the agency is expressed. This process evokes feelings of hope, which is to do with the narrators' beliefs that they have a way that should help them to feel better. Therefore, this cycle is about experiencing chaos, despair, hopelessness, and hope, and the state of oscillating between these with self-harm as a mediator of this process.

2. Thematic Categories of the Self-injury Story

There were four overarching themes identified in section one, namely:

- Experienced Chaos
- Self-injury – The Way to Tell the Story
- Resolution of the Story – the Paradox of *"I'm good"*
- The Story Continues…

Each of the themes and their subthemes are described in more detail below.

2.1. Experienced Chaos

It was identified in the narrators' accounts that they have experienced chaos in their lives. Chaos was evident in the way people told their stories. They presented their situation and events in their lives as being overdetermined. Everything they told only reinforced the idea that everything was wrong and getting worse in their lives.

In order to present my argument, I would like start with an excerpt from an interview with David. This was his full answer to my question about his self-injury story:

> ***David:*** *"I can, umm I can tell you what I know so far. Umm, it started when I was around twelve. Umm umm, I didn't even know what I was doing. I remember I was on a church trip and I was (.) all the emotions were taking over, and it got a little bit too much and I had taken apart aayy the shaving razor that someone brought for this church trip and base in little shallow cuts on inside of my arms and I tried to cover it up with the bandana but, you know. Everybody knew, and the youth pastor was taking to me: 'are you suicidal?', and I'm like 'I don't think so, I don't understand what I'm doing' and it kind of developed over there. I don't remember much. Like I can't remember my childhood. Umm, in the past couple of years I've remembered some umm sexual abuse, in the day care I went to, and I think that contributes a lot to the fact that I dissociate a lot, but I remember around eighteen, nineteen umm when I got kicked out off the military, it got really bad. I had joined the army and I thought I'd be able to keep it under control by myself for a while, but that didn't work. I ended up getting discharge on personality disorder. Then after I got out of the army, I thought that I lost everything and I got real bad. I was hospitalised a few times but (.) This is pretty much all I can remember."*

This excerpt illustrates the chaos that David lives in. The way he explained his reality was that events do not make sense and they just seemed to happen to him. He struggles to understand his experience, make sense out of it and he struggles to tell this story. The sentences are mainly short and cut, which brings to mind the act of his self-injury. Later in the interview, he told me how he usually makes a very quick series of cuts. Moreover, childhood experiences of abuse preceded the start of David's self-injurious behaviour, but in the excerpt above, the chronological order of these events has not been preserved. Chaos does not allow David to

experience his life in a chronological order. Furthermore, he used the present tense when talking about his past, which reinforces the idea of the past being alive in the present and therefore the idea of chaos.

Chaos was also evident in the syntactic structure of some narratives, such as repetitions of words and breaks in sentences. In the case of Lily, this is present throughout her account; however, there are exceptions, moments, and stories she told that do not feature these. It appears that repetitions of words and breaks in sentences, etc. increase when she spoke about how she started to self-injure:

> ***Lily:*** *"I was about 14, 15-14 umm when ayyyy I was stressed, my mum and dad were arguing about something, and then I hurt myself and then realised what this (.) actually makes me feel better, ummm and realised this is the way of expressing what I couldn't so (.) And then because I was older I I kind of realised what it was, and that at that time it worked, it helped me deal with things. And then kind of realising it made it worst because then I knew that this was a way of coping and this was something I could use, and I did use it more. And it became more often or more severe, or something like that."*

This excerpt is structured with repetitions, sudden breaks in sentences, and repetition of single words and entire sentences, which serves to reinforce the impression of the chaos in which Lily lived and which surround her behaviour. The constant repetition of 'then' seemed to be used as a way to guide her narrative and give some order to events. This is coupled with how she finished this description, indicating the confusion that she experiences around her self-harming behaviour and some recognition of having limited insight, which both seem to be characteristic of chaos narratives.

Moreover, in the above-mentioned excerpt, it is evident that the time sequence is not preserved. An example of this is when Lily gives the age when she started her account as fourteen, fifteen-fourteen, or when she introduces the present tense when reporting her story: "makes me feel better."

The above excerpt also includes hints at feelings of being stuck in the situation before discovering self-harm, and this is one of the elements of hopelessness and despair (Kylmä, 2005). It also alludes to hope in a newly found way of dealing with some of those feelings that injuring herself provided.

Chaos in narratives was evident in the difficulty to establish beginnings, middles, and ends of participants' stories. The elements of each were found in different parts of the interviews. Some narrators, like David, found it rather difficult to speak spontaneously about their experiences. It seemed that in order to be able to understand the stories, I had to ask probing questions to most of my narrators. It was only Chloe and Emily who spoke spontaneously, expanding on different themes and introducing side stories. However, even though at first their accounts appeared to be full, they were full of gaps and I observed that many of the stories that they told were either not related to the topic discussed or very loosely related. This meant that I did not always manage to get answers to some of my questions and it was difficult to follow a sequential order of exploring meanings. Both types of responses to questions, either speaking a lot or needing prompting, gave an impression that something was to be avoided, or not spoken about. This further reinforced the idea of experienced chaos that did not allow the story to be told.

As if being able to recognise the chaos, Olivia said whilst concluding her story:

> ***Olivia:*** *"I'm very like (laughing), I'm really random when I talk because I just don't know what to say exactly, yeah. That's my story basically (laughter)."*

The majority of the narrators presented themselves as victims. This indicated the importance of the way in which events were being interpreted by the narrators and emphasised experiences of chaos. The narrators spoke about themselves as though they did not have much agency and things just happened to them. Therefore, the victim position can be associated with feelings of hopelessness. As victims, participants constructed themselves as being harmed by, or made to suffer from, an act, agency, circumstance, or condition and these are also indicative of a lack of hope. This way of telling the story does not seem to allow the narrators to take responsibility for their actions and behaviour.

> ***Emily:*** *"If you are not somehow right, and sometimes you don't know what, I could never get it right, I tried, I almost tried too hard actually, which is, you know, one of the things you're most likely to be punished for it is trying too hard. So I just had hideously very low self-esteem, so I've never asked for help, and that's probably the root of it."*

In the above excerpt, Emily expresses an idea that regardless of how hard she tried she was being punished. The idea of *"trying too hard"* and yet not being able *"get it right"* reinforces her position as a victim. Regardless of what she does she is doomed to fail, which indicates experiencing suffering and despair. She attributes the start of her self-injury to these. However, in this excerpt, Emily expressed that she kept trying, which also showed some push towards hope (looking for pathways of hope). As she is not able to do anything 'right', she starts sinking into feelings of despair, which became so great that Emily is not able to ask anyone for help at the time.

This theme of placing blame on external factors was common amongst those who positioned themselves as victims. This is also indicative of feelings of hopelessness as the future perspectives are being lost, as indicated in the excerpt below.

> ***David:*** *"Someone was taking my dreams away from me."*

One of the important factors in victim positioning seemed to be the feeling of lack of control. Some participants reflected in an open way about the importance of feeling in control.

> ***Olivia:*** *"I have no control, like there is, I just go into that that anger and I can't think properly, I can't think rationally because I would never never hurt myself or I can usually say 'ok, you know, my mum is stressed and that's why she's reacting the way she is so I don't need to react'. But it's like I can't control when the stress build up, but the, it's just comes out in like a rage of anger and yeah."*

Olivia described feeling as though she has no control over her emotions, which then leads her to feeling that she cannot reason with herself.

The need for some order and control in life is well illustrated by David and his choice of a job.

> ***David:*** *"I'd gotten out of the high-school, finding out who I was. I yyy, hmm, the stress got too much, I just wanted to get away, I joined the army."*

Interestingly, David's response to chaos was to *"get away"* and join the army. The army can be associated with an environment that provides routine and structure; in other words, order that was otherwise lacking in David's life.

The research by Lindgren et al. (2011) also found that women who self-injure used "victim repertoire" when they spoke about themselves and what led them to self-harm.

Not all of the narrators presented themselves as victims. Ruby and Chloe seemed to construct themselves as tragic heroes. They also experience chaos, but the way they spoke about themselves is as though they are fighting even though their destinies seem to be already determined.

> ***Ruby:*** *"Umm, and it's just it's just that idea, that feeling that I have with my parents that I can't disagree with them, even on a political or philosophical level. It's not about disagreeing with their decision as a parents and criticising their way of parenting. I can't, I feel like I can't even be able to be a person with them. And that's probably I can't deal with because I have developed very very strong personal philosophy and very very strong outlooks on things, and very strong, you know, feelings on what's right or wrong, and and (.) So having that sort of identity taken away from me in those arguments, it would make me feel very angry and very hopeless, umm, and very resentful. And would lead me into storming upstairs and virtually made me wild."*

During the interview with Ruby, she described how she tried to fight and defend her views, which led to arguments with her parents. She constructed herself in the interview as a *"rebel"* and *"strong-minded"*. Her voice, however, was not being heard by her parents. Ruby also refers here to feeling hopeless, together with other emotions, as preceding her self-injury. She, however, chooses not to let herself suffer or sink into those feelings; instead, she tries to fight. After other forms are unsuccessful, she seemed to have no other option left than to self-injure, which she referred to here as *"going wild"*.

Some participants described having a sense of disconnection from the world, which seemed to further reinforce the idea of chaos, where events could not be fully experienced or thought about, and they could only be lived.

> ***Lily:*** *"I'm kind of detached from (.) I don't remember a lot of things. Umm even more recently, I don't, I'm not so so attached to what's going on kind of. Things happened but they, I know I remember them but it is like a story, it's*

like it happened to somebody else or I read in the book or (.) so even to be really present and really there in a situation it's kind of difficult."

The narrators spoke about self-injury in a way that indicated that they were unable to think about their behaviour. A few people used language such as *"urge"* (i.e. Sophie), indicating an action that excluded thought. In a similar way, Olivia said that hitting herself was her *"first reaction"*.

The theme of Chaos is consistent with other research and literature and views of self-injury from a user-survivor's perspective. Pembroke (1994), in her collections of stories by people who self-injure, postulated that the behaviour is a response to chaos in people's lives and their fight to gain some sense of control.

There were three main subthemes that were identified as contributing to experiencing life or life's events as chaos, namely, being tormented by events, experiencing unbearable emotions, and having highly confusing relationships with self and others. It has to be noted that even though, for some narrators, these were separate, this was not a case for all. Therefore, at times, these themes were intertwined. Further, it seemed that it was usually a combination of all three factors that most exacerbated the experience of chaos, despair, and hopelessness. However, as those were not always jointly presented, they are described below separately.

2.1.1. Tormented by Events

Participants gave a number examples of things and events to which they were subjected. There was a sense that things happened one after another and they seemed to have no end. Most of the participants described the beginning of their self-harm stories as filled with bullying, abuse, setbacks, and disappointments. Most of the narrators' lives were presented as a struggle.

David: *"I know that from the young age, I'm not sure when it started, I was abused by by dad physically and my mum emotionally, and then (.) I got to the day care, and I stayed there at that when I was around fourteen, sexually."*

For David, life is a series of tragic events that happened to him one after another. As his story unfolded, he described being faced with a number of difficulties in different areas of his life. It seemed that his story was filled with tragic events.

Similarly, Chloe described her experiences of being bullied at school.

> ***Chloe:*** *"I was I was bullied quite badly by a lot by a lot of my so-called friends erm. It was never physical bulling and I was never hit or punched or kicked, they were very erm erm psychological, the way they bullied me. They found out what my weakness was and that was I was a very paranoid person and they plead on it. They really plead on it, like they would wrote notes about me and I knew that they were about me because they automatically missed me, erm and made noises behind me."*

The above excerpt from the interview illustrates that the individual's perception of the person's experiences is of a crucial importance. As if Chloe was able to recognise this, she described herself as *"paranoid"*, indicating her sensitivity to external factors and overanalysing environmental cues. This does not mean that she was not bullied but only that she would be more likely to be affected by events that may not have affected others.

However, not all participants described such challenging events in their lives preceding the start of engagement in self-injury. Olivia said that she scratched for the first time because she was *"curious"* and only later described a couple of events at school during which she scratched herself as a result of disappointment and feeling treated unfairly. However, even in her account, there was a sense that she was subjected to experiencing events that 'just happened to her'.

This sense of events happening to the narrators dominated all the narratives. It was described as being a part of the narrators' lives, often starting even before the first act of self-injury took place. As an example, Emily said that her self-harm started as a combination of academic and social pressures. She described being bullied at school and not having too many friends. She also mentioned that her mother had depression and Emily was diagnosed with it as well when she was in her teenage years. One of the most dominant feelings in depression is hopelessness and this feeling is well captured by the way Emily concluded her account during the interview when she stated:

Emily: *"I think things have been fairly consistent on a downer since then."*

Interestingly, for Sophie, even the beginning of self-injury was just yet another event that brought disappointment, as she described not being able to harm properly.

Sophie: *"I felt really bad because the first time I cut I used those serrated fruit knives and I didn't even break the skin, so I felt really bad, and I felt even more inadequate like I can't even do it properly."*

This theme of being tormented by events seems very closely related and resembles a few of the despair categories as indicated by Kylmä (2005); that is, "being stuck in a situation", "losing future perspective", and "living in an exhaustive agony" (p. 816).

The theme of the Torment by Events has been somewhat confirmed by other research in the field that found that self-harm is used as a way to deal with invalidating and abusive environments (Alexander & Clare, 2004; Gratz, 2006; Scourfield, Roen, & McDermott, 2008; Sim, Adrian, Zeman, Cassano, & Friedrich, 2009).

2.1.2. Unbearable Emotional States

Across the narratives, there was an impression of the narrators being subjected to emotional rollercoasters, as they experienced their feelings as being out of their control. The narrators constructed themselves as being recipients of those emotional states.

This is how Anna described the time just before she started to self-injure.

Anna: *"I just felt like I was worthless and not contributing, and the pre-existing problems I brought with me were just so overwhelming that I did not know how to deal with anything, so umm I pretty much spent the majority of my time in one room in the apartment. I couldn't sleep most of the time. I was just kind of existing in there, and it was killing me."*

This excerpt is a very vivid description of despair, with Anna giving in to hopelessness by her isolation and inability to do anything, as she indicates by

saying that she just existed. In Anna's interview, it was evident that both strong emotional reactions and feeling that everything was out of her control led her to turn to self-injury. Anna spoke a lot about feeling overwhelmed by everything that went on in her life and struggling greatly with her emotions. She presented herself as unable to do anything about her emotional states. Furthermore, she admitted that even though she lived with her friends at the time, she found it difficult to take advantage of their social support.

The narrators described themselves as struggling with a lot of emotions from various life events. This is illustrated in the excerpt below.

> ***David:*** *"My mum was pregnant with my oldest sister, and they [parents] were fighting and I, pretty much, were told that the only reason they were staying together was for the kids. And with, you know, new school, and we've just moved in, everything was just kind of (.) It was too much to deal with at the time. And I didn't want to die but I was I was so stressed out. I didn't want to live like that."*

Similar to what David expressed in the above excerpt, many narrators expressed unbearable emotions, very often giving these as an explanation for the start of engagement with self-injury. David explicitly mentioned that he wanted something to change for him, and above is how he justified the start of self-injurious behaviour. There is a wish there for something to end and for a new order to be reinstated, and this is a glimpse of hope.

Nevertheless, those unbearable emotions that led to self-injury were not always described as being intense. It seemed that there were two sets of feelings that would lead to self-harm. One set included those that were very intense almost uncontrollable, and the other was more of a build-up that eventually led to self-injury.

> ***Chloe:*** *"I'd say, when I have time to think about what it was that it was stressing me out then it would be more (.) than it would be more the structure. When it would be more of a hack, when I'd be hacking away it would be if we had a massive row about it and I and I physically can't control myself. That's when I would be, I'd go straight upstairs, run a bath, and that's it (.) I'd just go for it."*

For Chloe, those different sets of emotional states were also associated with the way she cut herself. The more heightened the emotions, the more difficult it was

for her to bear them, and the more uncontrollable her self-injury appeared to be. The way she cut herself mirrored how she felt. Other narrators also described those two types of emotions leading to self-injury; however, some resonated with just one of them, whereas others resonated with both.

The Unbearable Emotional States theme gets its confirmation in a research that shows that self-harm is a response to people's difficulty to tolerate their emotions, suggesting that these are experienced as being overwhelming and have no form of expression other than harming one's body (Grath, 2007; Kleindienst et al., 2008).

2.1.3. Confusing Relationships

Throughout the interviews, participants' descriptions of their relationships with other people and themselves emitted a sense of confusion, feeling out of control, chaos, and despair.

Some narrators reflected on the fact that many of their closest relationships seemed to be the main cause of self-injury. It appeared that they struggled to make sense out of the ambiguity in those relationships. Those were described as both loving and supportive, as well as harsh and critical.

> ***Ruby:*** *"I do have a good relationship with my family, I do have a good relationship with my mum. It just sometimes there is a turn and we have a set of arguments and then we best friends again."*

Ruby described having a very close relationship with her mother and later in the interview she also named her relationship with the mother as being the main trigger for her injuring herself.

> ***Ruby:*** *"it could be an accident, things that are really personal, even having just stuff like critical debate or my mum reading an article or a newspaper and I disagree with it, and then she would disagree with me. It start of like a debate or a little family banter and then very quickly turns into 'No, you're wrong! You're an idiot! How can you believe this? How can you say this? Why are you so irrational?' and becomes very very personal."*

In this excerpt, Ruby indicates how little space there was for exploration and acceptance of her own ideas and opinions in the relationship with her mother.

Some narrators presented their relationships with their parents as just invalidating and expressed a struggle to have such relationships. The lack of understanding transpires in interactions with some narrators' parents. Those were described as not allowing for any attempts at explanations due to a lack of space where a person could feel listened to or/and understood.

> ***Sophie:*** *"I told my dad I was really suffering and I hated it, and during Christmas he said maybe suffering is good for you, but he didn't (.) I was so angry that he didn't understand the extent of my suffering and whatever I said, he just really patronised it [suffering] or belittled it (.2)"*

Sophie described during the interview both of her parents as harsh and critical. They are being spoken of as figures that expect full obedience and exercise their power over Sophie. She presents herself as unable to defend herself in any way. The above excerpt illustrates Sophie's attempt at resolving her suffering through conversation in a hope that, together with her father, they would find a solution. Her attempt is, however, met with lack of understanding, and the hope that her father can help is lost, leaving her in a state of despair and rage.

However, it was not only relationships with the narrators' parents that appeared to be confusing. Some participants spoke about their teachers as making judgements on them and creating additional pressures.

> ***Lily:*** *"I'm dyslexic but we didn't know that until I went to university. So (laughing) nobody noticed, they just thought I was (.2) teachers just told me I wasn't very smart and to try harder."*

Later in the interview, Lily described also being bullied by peers at school and feeling stuck between her parents, who argued a lot at home. Lily positioned herself as lacking support and not having much experience of nurturing and supportive relationships.

Further, some narrators also named their relationships with siblings as confusing and a source of distress.

> ***Olivia:*** *"My parents, my mum and my sister, would get me the most and I think it's because we're just so close, and I've always, they're opinion has always been very important to me but they're not perfect (laughing), they're not perfect. And, you know, my sister especially, like it's hard to deal with her because of her anger and I know that it was hard for my mum to control herself, yeah. But I don't really get angry like that with anyone else."*

Olivia named her sister and her mother as the only two people in relation to whom she self-injured. For her, it was the relationships with the closest ones that triggered very strong emotions and feeling out of control, which is indicative of hopelessness.

Confusing relationships were also described by the narrators in relation to their peers, especially at younger age, and school friends. Most of the narrators spoke about being bullied at school, and some mentioned being close friends with those who bullied them.

Furthermore, some narrators also spoke about the way they treated and related to themselves as highly confusing.

> ***Sophie:*** *"I can invalidate myself like I use what they [parents] used to tell me and just apply it without them, so just makes me feel really awful and all around."*

The above excerpt shows Sophie's reflection on the idea of internalising her parents by being harsh and critical towards her in the same way as her parents were towards her. This was interesting, given that Sophie was very clear about how deeply hurt she felt every time her parents related to her in this way.

Confusing relationships referred also to the discrepancy between how the narrators saw and described themselves and how they related to and treated other people. As an example, some of them described bullying others.

> ***Ruby:*** *"I've always felt like I'm on some level umm, you know older, wiser that kind of thing, and it's them disagreeing with me and them being difficult and not, as I said, not the same way of attack as being with my parents."*

Ruby described herself as not popular and being bullied at school and later she said that she also bullied her younger siblings. Even though she said that these relationships with her younger siblings never caused her engagement in self-injury, it was striking how she was not willing to talk about her situation at home at first during the interview and insisted that *"home was great"*.

The research by Sim et al. (2009) confirms this theme of the Confusing Relationships. They found that there was a link between self-injury in adolescence

and family dynamics. Further, it is shown that people who experience their care as harsh and critical often adopt this style of relating towards themselves, which has a very important role in self-harm (Flett at al., 2012), and is also a crucial component of the Confusing Relationship theme.

2.2. Self-injury – The Way to Tell the Story

Experiences of chaos described above led the narrators to engage in self-injurious behaviour. In this context, self-injury was constructed as something that allowed them to express what could not be told and, as such, became the way to tell the story about the chaos and a way to care for the self. As with any story, self-injury needs a witness; therefore, the body became the witness of suffering. Below, I describe those four main sub-themes that emerged from the narrators' accounts.

It is interesting to note that the narrators constructed themselves as experts of their own body, behaviour, and life. They spoke about being aware about the kind of things they needed to do to feel better or how to take care of themselves without involving other people. This gave an impression of self-injury, giving them a sense of agency, which was in contrast to the victim and tragic hero positions discussed in earlier sections. Furthermore, all these are indicators of both pathways and agency thoughts of hope. Based on this, it can be concluded that self-harm helped to make a transition between chaos, hopelessness, and despair into hope and realisation that life can continue. This means that thoughts of self-harm became a pathway thinking, whereas thinking that a person can self-harm indicates an agency thinking. Both pathways and agency thoughts towards achieving a goal of feeling better and overcoming suffering produce hope.

2.2.1. Difficulty Communicating and Expressing: Scars as a Voice

The narrators referred to self-injury as being a coping mechanism, something that allowed them to deal with experiences and emotions on a daily basis. It seemed that self-injury provided a way to express and communicate what could not even be thought about.

> ***Sophie:*** *"It's my coping mechanism, I guess. And because I read a lot of books, when I wasn't eating properly, I was reading a lot of books about it, and I realised that some people starve themselves and some people over exercise, some people overeat, and some people have healthy things like they can punch pillows and cry and stuff, but I can't. Or they can sort of just start bitching to their friends about it. Once they vent, they feel better but I can't do that either, but I have self-harm and I guess I'm not ashamed of it. But I don't want to tell everyone about it."*

Sophie here described having real difficulty in finding a way to express herself in a *"healthy"* way, utilising techniques such as crying or 'venting'. She recognises here that her way of reaching a goal of feeling better is different from those of other people. However, this also contains an element of hope when she stated that even though she is not able to use methods that others utilise, she can do something: she can self-harm. It is interesting how she makes a claim to her self-harm as though it was an object. Furthermore, even though she said she was not ashamed of it, she added *"I guess"* before it, which seemed to indicate that her position is not well established. She appeared to be regaining her agency by concluding that she simply chooses not to tell anyone about her self-injury.

The narrators reflected on their difficulty communicating and expressing all that they hold inside in any other way than through self-injury. There is a hopeful recognition here that things have to be expressed somehow. Some openly attributed this to themselves and their perceived lack of skills.

> ***David:*** *"I look at all my friends and they have, you know, healthy coping mechanisms, like they can just sit down and talk to somebody, and it's all ok for them. I don't think I have those communication skills, or I'm not sure what as.. [cutting] it's just sometimes the only thing that give me back to where I need to be."*

David seemed to make sense out of the fact that he did not deal with his life in a 'healthy way' by stating that he lacked communication skills. The phrase that David uses at the end of this excerpt suggests that injuring pulls him from something. This brings to mind the upward process of despair leading towards hope, which he chooses instead of sinking into hopelessness; and this is an active process.

This lack and inability to tell about one's experiences was not always perceived as coming from a person's lack of communications skills. It was also presented as an inability to talk about those experiences, for example, in the case of Lily.

> ***Lily:*** *"I knew that if I was stressed or upset then this [self-injury] was a way of expressing it because I couldn't talk about it, I couldn't. I could write it down, yet I didn't know what to do, what else to do so…"*

Lily's excerpt seems to contain a different message from the one above by David. She recognises the need for expressing her emotions and therefore connecting the present with an anticipated but uncertain goal in the future of feeling better and overcoming suffering. This in turn represents one of the definitions of hope (Day, 1991; Snyder, 2002).

As mentioned earlier, difficulty in communicating had also been presented as a part of a personal make-up and how the narrators saw themselves.

> ***Olivia:*** *"I'm really like introverted person, I don't (.), even now I I don't (.) like to be around a lot of people, I don't have a lot of girlfriends or, you know, that I spent time with. I'm very (.) I like my solitude, I guess (laughing), you know."*

Olivia defined herself as being an introverted person who would rather spend time on her own. However, this also indicates that she did not tend to share her feelings and experiences with other people. For her, as with three other narrators, taking part in the present research was the first time to tell the story about her self-injury. The research provided an opportunity to tell a story in a safe and indirect way, the same way as self-injury offers them.

The narrators also expressed a difficulty in reaching out for help and leaving things to the point where things became unbearable.

> ***Anna:*** *"My problem is that a lot of the times I don't go to him [fiancée] soon enough. I'd just be like 'this is my problem. I need to take care of this by myself. I don't want to bother him. He shouldn't have to deal with this.' And finally when I'm sobbing I just feel like there is no other way to do stuff, I'll go up to him and be like 'Please give me a hug. I don't know what to do anymore. Can you talk to me for a little bit?"*

Anna felt that she should be able to deal with things on her own, and even when she had finally found a supportive partner, she continued to struggle to

seek his help soon enough, although it seemed that she was getting better at this.

The way people made sense out of their self-injury was by constructing themselves as not having communication skills, lacking in other ways to express themselves, or seeing themselves as introverted. It appeared that self-injury takes over the reflective function of communication or other forms of expression. Self-injury seems to also represent the way of connecting the present with the future of uncertain goal of feeling better, which are all elements of hope (Day, 1991).

However, the inability to talk about difficulties was also a result of people around the narrators who found it difficult to hear their stories and tolerate their self-injury. This is what David said had happened after his parents found out that he was cutting:

> ***David:*** *"Umm, they did what I called 'egg shell therapy' for a week and a half for two weeks. They would, I mean, they would tip toe around me like that walk on an egg shell, they wouldn't mentioned it, 'Can I get you anything?' and after about two weeks, they would forget about it and everything would go back, and now they just treat the problem like it doesn't exist. They ignore it, it's not true, so (.)"*

David's parents did not even attempt to find out what was going on for him and why he was resorting to self-injury. They were not able to hear and notice his suffering, possibly reinforcing the idea that things needed to be hidden and that other people were not able to cope with his behaviour. This could also be seen as a way of preventing the narrators from exploring other pathways of reaching their goal of getting better. As mentioned in the Introduction chapter, other people can instil or prevent hope from flourishing.

This theme is evident in Lily's story about how her parents approached her self-injury.

> ***Lily:*** *"Umm and especially, like my mum and dad, they don't, we didn't talk about it in first place. My mum's a nurse umm when she first found out she said 'People like you we used to just bandage them up so they couldn't move and they couldn't do anything to themselves, so (.) that's what will happened to you if you keep doing this'. So (.) then she never spoke about it again, and*

I could think that I just hid it better, or she didn't noticed, because it was an awful long time, ummm but I don't think that's possible because we lived in the same house. They just decided not to enquire so (.)"

It was interesting that even though Lily's mother was a nurse, she was not able to approach this topic and hear Lily's voice. Instead, she put Lily in 'a box' with others who self-injure, alienating her even further.

It seemed that even people who were the closest to the narrators were presented as finding it difficult to engage and start a conversation about self-injury.

Chloe: *"I think she [wife] chooses to ignore it now because she knows that she's not gonna get any sense from me by trying to talk to me, and trying to get me to stop."*

Chloe makes sense out of her partner's lack of engagement in any form of conversation with her about self-injury by constructing herself as someone who is not taking other people's opinions into consideration. This may reduce the pain of a close person not being able to bear the discussions about the underlying self-injury pain and it seemed to reinforce the idea that the behaviour needs to remain hidden.

The narrators justified keeping their behaviour secret by presenting their worries with regard to consequences that they may encounter if they were to reveal their engagement in self-injury.

Olivia: *"it's like everybody it's just looking at you differently, you know. They think you're this fragile person that, you know, needs constant, you know (.) And I'm not like that I don't need somebody (.) I mean maybe I'm a little bit, but I don't like people thinking that they that I'm, yeah, crazy or that I have some-something that's not fixable or that I'm going to go crazy in a moment. That they have to be on a guard or something."*

Olivia seemed to be concerned about the stigma that surrounds the behaviour and the fact that people may react to her differently. This was common across all the narratives. The narrators often referred to self-injury being misunderstood and leading to others' concern about them. They worried about what others may think of them if they were to find out about their engagement in self-harm.

This theme ‘Difficulty Communicating and Expressing’ has been also found in a study by Hill and Dallos (2012). They interviewed and examined stories of young people who self-injured and found a theme of an inability to communicate. They recognised the difficulty young people had in generating coherent stories and talking about what caused and led to self-injury. Further, Klonsky (2011) found in his study with adults that self-injury was serving as a way to communicate with others, suggesting the difficulties of people who self-injure to find other ways to express and communicate.

2.2.2. Giving a Meaning to Chaos

Due to the difficulty in communicating and expressing themselves, the narrators appeared to see the process of self-injury as a way to give meaning to their experiences. The narrators told stories in which chaos was translated into something that was *“real”* (Sophie) and tangible for them. This allowed them to make sense out of the experienced chaos and overcome it. This also represents hope with its fighting against sinking.

> ***Lily:*** *“I was just sitting and my mum was arguing about something [with her dad] and I just scratched until it really hurt and then I realised, like I woke up and ‘Yeahhh?! this hurts! Ok’. And then I was not thinking about how I was feeling, was a kind of release from all the other stuff. So I kind of understood it. (.) I remember after that happened I wrote something like ‘I figured it out, I figured out what can make things better. Now I know that there is something that I can do’.”*

Lily’s description of her ‘discovery’ of self-injury provides an insight into how the meaning was given to chaos. It seemed that self-injury provided the answers for people to overcome experiences and feel that there is finally something that can be done.

This process of giving meaning to chaos and making sense out of events had also been described as a way to take charge over physical body reactions.

> ***Ruby:*** *“I can say ‘Ok, I’ve been really upset about something my mum said or a big family argument so I’m gonna go and I’m gonna take that emotion and I’m gonna make it about something I’ve done’. And so kind of changing the the subject of my anger, or pain, or whatever. It was very calming actually.”*

In this excerpt, Ruby very vividly described the physical gains that accompany her self-injury. She indicated that something that was uncontrollable could be turned into something that she could have a control over; that is, into self-injury. This is also a very explicit description of different hope elements. The problem at hand is the feelings of upset, anger, and pain. She is showing her action thoughts, which is everything in apostrophes. The pathway thought is the route that connects the present with the future, or in this case, self-injury.

The need for control transpired across all of the narrators' accounts. Lack of control is borne out of experiences of chaos where things happen to the narrators. Through the process of developing meaning, control is gained over the events and over chaos. Therefore, all of the narrators spoke about a sense of control that self-injury gave them, which is explicitly verbalised in the excerpt below.

> ***David:*** *"Yeah, it definitely gives me control. It lets me take all that emotional pain that I can't deal with and turn to physical pain, which I know that I can deal with."*

David's excerpt also contains an element of hope, as it shows his route to reaching a problem resolution. Implicitly, this alludes to a feeling of hope, as he understands that there is something that he can do and which will possibly help. Later in the interview, he admits that self-injury does not always help and this uncertainty of reaching a goal of feeling better is a necessary element of the hope concept.

The importance of control is also illustrated in a choice of alternative methods of self-injury, such as replacing cutting with control over food and exercise, essentially another form of self-harm. Three narrators made reference to this.

> ***Sophie:*** *"On the days when I don't self harm, I often start restricting my food and exercising more, and being like really, hmm, like trying really hard to lose weight. So I think if I didn't self harm, I start getting, sort of, my food issues will come back a lot more."*

Lily spoke about her very first experience with injurious behaviours when she was about seven years old and was hiding in a spiky bush from bullies.

Lily: *"I felt in control of what was happening because it was me who went into the bush. Umm, and then it was my fault that hurt, it wasn't the fault of whoever was been mean that I couldn't control. Yeah, so it was some kind of control, I think."*

The idea of the need for control and transforming chaos and all that is done to the person into something that makes sense and is done by the person transpires in the above excerpt of Lily's account. This was a common theme across the interviews. Moreover, Lily's excerpt shows the birth of hope, which appears when a way to deal with chaos is finally found and meaning can be attached to it.

Theoretical literature suggests that self-injury can be seen as a way of resolving the lack of power (Brown & Bryan, 2007), which is the central premise of the Giving a Meaning to Chaos theme.

2.2.3. The Body as a Witness of Suffering

As self-injury was constructed as a way to tell the story, this story needed a witness. The only witnesses for all of the narrators of all the stories expressed via self-injury were their bodies. Therefore, it appeared that wounds and scars had a great significance for the narrators to the extent of some of them taking photographs of the wounds. This theme also represents hope in the ability of the person to find meaning and make connections with something that is stable in their life, that is with their body. As discussed in the 'Introduction' chapter, hope is borne out of the person's desire for connections and secure attachments (Scioli & Biller, 2009), which are found by the narrators in relation to their own bodies.

2.2.3.1. Scars tell the story

The narrators spoke about their scars and wounds as though these told the story of the narrators' suffering, the story of important, significant, and very often painful events and emotions in their lives.

Sophie: *"With it [scar] comes a story, I guess, because all of them is triggered by an event that is, I guess, is more complicated than just one sentence. […] I guess they're [scars] like landmarks or milestones in my progression."*

From this excerpt, it can be inferred that each scar is also a symbol of hope, as it is a visual and tangible manifestation of a person's ability and motivation to reach their goals, and a reminder of a way in which this can be achieved. Sophie's account gives an impression of meaning being developed. The repetitions of *"I guess"* indicate uncertainty and lack of well-defined clarity of what she had said. Sophie gives meaning to her scars as something that allows her to mark the important moments. They represent the different stages in her life.

> ***Sophie:*** *"I remember pretty much most of the situations, and even though the scars here have faded I remember it's there."*

The above excerpt seems to be different from the earlier one in the sense that Sophie appeared more certain with regard to the meaning that she attached to her scars. It seemed that marks on the body persist even if the scar has faded. This is the meaning that she confidently holds.

The narrators spoke about their relationship with their scars. Scars are being constructed as 'something' that one can have a relationship with and relate to. They appeared to have a symbolic meaning for the narrators.

> ***David:*** *"Nine out of ten times I can relate the scar to what caused it, what was stressing me out at that time, and while I hate the scars I also do love them.* {Researcher: Can you tell me a bit more about that?} *I don't know it's it's kind of like a record of my past. There are bad experiences that I've gotten through. And I wouldn't give up the scars that I have now but I really don't want anymore."*

For David, the scars are the evidence of his past written on the body. They are his story of suffering but also a story that this suffering can be overcome, which gives rise to the feeling of hope as they are a reminder of the person's ability to deal with suffering. Hope, in this context, can be understood as being borne from pain, which gives agency/motivation for action and offering self-injury as the pathway though which goals of overcoming chaos and suffering is achieved. Scars are the by-products of this process. Even though the scars remind David of pain, they are also important to him. His wish for no more new scars reflects a desire to stop the suffering and pain.

The narrators also spoke about the idea of the scars being a reminder of the past events that caused them suffering and led to self-injury.

> ***Ruby:*** *"I tend to do several cuts at once. So four or five sets of scars, so I can say I can say 'That was that argument. That was about that person'. And it's it does bring back. It's not really like it's not really a photograph, it's like flash back but I do associate those scars with the event. Yeah, very definitely, I do still remember what each one was about."*

The fact that most of the narrators were able to associate and remember the events or feelings with the scars indicates the importance of the experiences that lead people to self-injure.

The narrators also spoke about how this relationship with their scars is changing and evolving.

> ***Chloe:*** *"When I was younger when it started, it was very much like: 'Look what I've done, I've done this, I've achieved this', it was something to be proud of, then as I got older I suppose it's like a reminder, you know."*

Not all of the narrators had such positive and sentimental relationships with their scars. Some spoke about feelings of dislike that they have for their scars due to the memory that these scars bring to mind, for example, in the case of Emily presented in the excerpt below.

> ***Emily:*** *"They [scars] are associated with a feeling, but they are not associated with specifics, and I think that's partly why I don't like them. I don't really like to be reminded that actually I spent quite a long time feeling like crap (laughter). erm, but I'm also used to them, I don't see them anymore, in a way."*

It is interesting that, for some people, scars seem to be constructed as a symbol of overcoming difficulties and hope, whereas for others, it is a symbol of suffering.

The narrators also spoke about scars as being a way to connect with other people due to the message that they hold.

> ***Lily:*** *"They say that it could be a beginning to explain to people. Umm because some some friends who have asked I could tell the truth, then if they ask and it starts the conversation."*

Lily reflected here on the fact that her scars could start communication and may eventually allow her to open up to people and tell her story. This highlights the communicative functions of the scars and hope for connections with others.

Straker (2006) also suggested that self-injury is a way to write the memories of trauma on the body of a person, which seems to be confirmed by the present research and the theme of ‘Scars Tell the Story’.

2.2.3.2. Wish for a witness

For the majority of the narrators, the body was fulfilling the role of a witness of their suffering. This seemed to be achieved through the marks and scars made on the body.

> ***Ruby:*** *“the scaring is something that in a strange way, I don’t show to other people, it’s something I do myself, I’m a little bit proud of (.) It’s almost like a body modification in that sense. I don’t do it with an objective of having a scar but if I do have a scar than I look at it and it’s like having a tattoo or piercing.”*

In the excerpt above, Ruby created a meaning of being proud of her scars through a process of comparing this to more socially sanctioned ways of harming the body, but unlike the marks left by these methods, she hides her scars. This means that the only witness of her suffering is her body.

Further, for some of the narrators, having the body as the only witness was not enough and they also took photographs of their scars and wounds. These photographs were not shown to anyone, but rather were kept safe and hidden.

> ***Sophie:*** *“I’ve always taken photos. […] Yeah, to remind myself why I did it and I always get worried. This sounds really strange. I always get worried people don’t believe me because scars fade. And they say ‘No, you can’t be screwed up, you act so normal’ or ‘you can’t self-harm. I don’t believe you’. Then at least I have evidence. I feel like I always have to prove myself to do it, in case that I don’t get believed, and if I don’t get believed on something that it’s important to me, I feel really crushed.”*

Sophie referred here to some non-defined ‘them’ who would not believe how badly she suffered. It seemed that even though she did not share her experience of self-injury with anyone, there is a wish for others to know. Sophie hopes to ‘keep’ the scars that fade over time as a proof of her suffering and struggle.

This seemed to be similar in Olivia’s account.

> ***Olivia:*** *“But I don’t know why I take the picture where I like to have them, it’s just maybe it’s because I know that nobody’s going to see them, you know,*

and I'm like at least to have some evidence of what I did, so it's not just going to go away and you forgot about like call the other once, right? Because that bothers me sometimes. […] (becomes emotional) I think it mostly bothers me just that that I've done it and that it's going to go away and it's like nobody will knew, sorry. […] Because I know that I'm the only one that knows how bad it was, so nobody really gets to see all that and they don't really know how bad I feel. That bothers me."

Olivia became emotional when she spoke here. The desperate need for someone to know and to witness her suffering seemed to be in conflict with her saying that she did not want to talk to others about her self-injury or other problems expressed in the other sections of the interview with her. The above excerpt indicates that it is not the self-injury that she wishes to talk about, but rather the underlying difficulties that lead to it, yet again confirming the expressional and communicative function of self-injury.

This theme of the narrators' wishing for witnesses to their suffering has some confirmation in research by Sternudd (2012). He interviewed those who were posting and looking at photographs of self-injury on the Internet. He found that these were related to the idea of remembering and need for proof of the experience. Furthermore, these were understood "as a way of sharing experiences with others and give and/or receive help" (p. 421), which seems to also provide some confirmation of the next theme discussed below: 'A Way to Look After Oneself'.

2.2.4. A Way to Look After Oneself

The narrators stressed the fact that self-injury allowed them to look after themselves. They all pointed at self-injury as being a coping mechanism and, as such, it provided a way to care for oneself, usually without anyone else's help. Moreover, this theme is one of the elements of the hope concept within self-injury. It is one of its goals. The actions and pathways thoughts are directed towards the goal of being able to look after one's self and one's own feelings.

The narrators spoke about this function of self-care as having a soothing element.

Anna: *"It was a relief in that umm that outward pain was a distraction from the inward and I had something to focus on. And I almost felt like I could take*

care of myself now that the pain was only outside and I can see it and I knew what to do about it. It wasn't this inward hurt that I (.) just would be in agony over but didn't know what to do for. It was something on the outside. 'Ok, I put a bandage on it. I'm good'."

Anna spoke about transforming unbearable pain into something that she could take care of, into practical ways of coping with her difficulties. This seems to be the main goal of self-injury. Internal suffering and emotional pain is not tangible, but rather it is abstract. Therefore, the narrators converted this into something that was visible and tangible. This way they could look after themselves. Self-injury is the pathway as described in the hope theory (Snyder, 2002) through which this can be achieved.

Interestingly, this function of self-care is extended beyond just immediately after the act of self-injury. The effect of being soothed can even last days after the injury was inflicted. This shows the ability of the pathway of hope, understood as self-injury, not only to connect the present with the future, but also to connect the future with the past in this case.

Chloe: *"The immediate after effect, the day after, and the day after that, the immediate few days afterwards, it's for me to, if I'm still feeling bad, I can touch it (touching the top of her leg). You know like a day after you could still feel the pain of it, you know, and you can feel the heat coming of it. And and it's like a little secret I've got and nobody else knows about, you know. So and I think that's probably why that's still such a erm erm, such a erm, draw for me, if you know what I mean. Because I'm walking around work and I've got this little (touching leg again), you know, when I bandage it, not bandage it, but sort of take it at myself and I can feel the heat of it. I'm walking around and nobody knows it's there, apart from me. And it's something for me to be proud of, I suppose."*

Chloe described here how the effects of self-injury and the wounds are extended beyond the actual act of self-injury. She stressed the actual touching of the place where the cut was done as something that reminds her of the act, especially if things are still difficult. She also makes a claim on her self-injury and the wound that she makes by stating that it is her *"little secret"*. Whilst other people generate meaning through relationships with others and having secrets within those relationships, those who self-injure create meaning in the relationship with their self-injury. Furthermore, this also resembles the parent-child relationship, where the narrators take over the parental role of caring and they become those who are

being cared for. This also represents hope that allows people to link themselves to the positive outcomes, as pointed out by Snyder (1995).

All of the narrators said that most of the time they were able to take care of the wound themselves without involving other people. Only a few mentioned occasions that required them to seek medical help, but for most those were rather rare incidents, usually occurring in the earlier stages of engagement in self-injury. A few narrators even mentioned that they had first-aid training.

> ***Lily:*** *"I trained in first aid or something, or because my mum does nursing and we had a lot of first aid around. It was never something I couldn't deal with. Umm never something that I had to get somebody else's help."*

Previous literature and research consistently points at self-injury as 'A Way to Look After Oneself'. As an example, feminist theory suggests that one of the main functions of self-injury is for the person to take care of their own emotional states, which is to do with the ability of a person to self-sooth and self-care (Brown & Bryan, 2007). Schoppmann et al. (2007) conducted a qualitative research and found self-harm to be a form of self-care by which an individual ends their suffering.

2.3. Resolution of the Story – the Paradox of *"I'm good"*

The narratives of those who self-injure seem to be leading them to the point where they feel that they are fine and well enough to carry on with their lives. Each individual act of harming themselves leads them to temporarily feel better and therefore feel reassured that chaos is overcome. This is the goal of hope-directed thinking and actions. The state of feeling better gives an impression of regaining control. However, for many, the same behaviour that gives them a sense of control is also a source of creating additional stress and ultimately feeling out of control. At first, it may appear that the point where the narrators can say *"I'm good"* is the resolution of the story. However, very quickly it becomes clear that the sense of chaos comes back and with it the downward process of despair leading towards hopelessness. It was found in the narratives that there were a lot of negative consequences arising as a result of injuring.

2.3.1. "I'm good"

Self-injury was described as something that helped people to deal with their life experiences. The narrators were very clear about the idea that even though it was not the best way to deal with difficulties, it allowed them to cope and carry on with their lives. In this context, self-injury is hopeful as it connects the suffering in the present with an uncertain goal in the future of "I'm good". Additionally, self-injury provides a feeling of hope related to belief that things can be overcome, and even though a person suffers, they can carry on living.

> ***David:*** *"I think self-injury is a coping mechanism but I don't think (.) It's a sign that someone's developed unhealthy coping mechanism, but I don't think it's somebody's crying for help. Because if you're cutting you're dealing with your emotions, maybe not in a healthy way, but you're dealing, versus versus somebody who self-injure and they're going through emotional pain and they're not cutting. It means that they're not dealing with anything and at some point it's gonna reach a climax and something's gonna happen."*

David has an awareness of self-injury being problematic but also reflects on the fact that it helps when nothing else does, which in itself is hopeful. He justified his behaviour through making a link between it and dealing with his emotions. He also hinted at some terrible consequences of not using his self-injurious behaviour. This seemed to be connected to what other narrators understood as a function of self-injury as a survival mechanism.

> ***Lily:*** *"So before, when I felt that there was no reason and I was hopeless and there was nothing, I was using self-harm as a way of controlling the situation, as a purpose 'This is something I can do now to survive the next five minutes'."*

This excerpt from the interview with Lily is a good illustration of the way Kylmä (2005) described association between hope, hopelessness, and despair, as discussed in the Introduction chapter. Lily spoke of the downward process of despair and giving in to hopelessness if she was to carry on this way. However, self-harm allowed this process to be redirected towards hope.

The narrators also referred to the idea of self-harm as being a way of getting out of the situation and overcoming uncontrollable emotions, and therefore giving rise to hope.

> ***Ruby:*** *"Self-harm is.. this is my get out, my way of getting out of situation and because I'm turning into self-harm, because I have a very clear idea of those steps to set out to make myself feel better, and to sort of get myself out of panic or the upset that I feel at that point. Umm and it's very much about calming myself down."*

Ruby, like other narrators, described the feeling of being calm after the injury is done. It seemed that self-injury provided the solution to many difficult feelings and experiences. Yet again, this is also the description of the hope agency and pathway that connect the present with the future goal of feeling better and being calm.

However, it seemed that the resolution of self-injury (as a way of getting to the point where he/she feels better) was not well formulated in all of the narrators' minds. Some narrators seemed to be giving a meaning to their self-injurious behaviours as they spoke about them. This is very clear in the excerpt below.

> ***Emily:*** *"I mean I can't say definitively I feel better afterwards, erm, which is, I suppose, is what people usually ask, and I suppose that's why I said it doesn't help. But actually it's not true that it doesn't help, because it's somehow, I think, and maybe I'm wrong and maybe, I don't know, but it feels like it somehow keeps me safe. Like if I have to do something, it's not the worst thing, you know, I suppose I can control it, it's been about 10 years now, so I'm reasonably good at first aid. Erm, and I don't know, yeah, it's, maybe maybe it keeps things from getting worse, maybe maybe that's its function."*

Emily seems to be creating the meaning of her self-injury as she speaks. This can be inferred from repetition of words in this narrative, which creates an impression of the story being in a process of being created/formed. She finally arrives at the understanding of self-injury as keeping things at bay. It would have been very difficult for her to make sense of the fact that she engages in self-injury if it did not make her feel any better and if it had not had any function.

The resolution of the self-injury story was also presented for some narrators as connected with a successful outcome. The narrators described feeling proud and having a sense of achievement as a result of engagement in self-injury. This was usually connected to visible cuts and marks that were left on the body.

> ***David:*** *"As you go on, the worse it gets, and you kind of can't, you can't share with anybody so (.2) You can become proud of your own*

accomplishments. You work your way from two stiches to six stiches to (.) It's hard to explain."

In the above excerpt, David uses language that highlights even further the sense of achievement by using the expression of 'working his way'. This brings an idea of professional career progression or development to mind and climbing up the career ladder.

Literature and research widely confirms the 'I'm good' theme as constructing self-injury as a way for people to feel better, and SANE (2008) research reported that 25% of their participants felt that they self-harm in order to prevent suicide.

2.3.2. Ambivalence

It seemed that even though the narrators pointed at the benefits of engaging in self-injury, they were also ambivalent about the behaviour. It is worth noting that most of the narrators used a language of externalisation, often referring to self-injury or self-injury behaviours as 'it'. This was very common across all of the narrators' accounts and gave an impression of the behaviour being something outside of the narrators, which allowed them to have a relation to self-injury and distance themselves from it. Moreover, through this process, the narrators placed the blame outside of themselves onto the 'it'. This also seemed to help individuals to justify the behaviour, as it is the 'it' that is responsible and not the narrators themselves. Another way in which those two functions – that is, placing the blame outside of the person and justification of the behaviour – are achieved is through talking about having urges to self-injure. Urges seem to be one of the words commonly used in the discourse of addictions. However, this further reinforces the ideas of external blame and justification of one's actions.

To some extent, this use of language can be helpful to resolve feelings of guilt and shame associated with the behaviour. However, it can also be problematic as the 'it' takes the power away from the narrators and urges them to act in a certain way. This seems to be in contrast to the right the narrators claimed to their self-injury.

The theme of ‘Ambivalence’ is a representation and highlights the fact that even though hope plays an important role in self-injury, the behaviour remains problematic (Klonsky, 2009). As shown in the Introduction chapter, the literature often focuses on just one side of self-injury, constructing it as either just helpful or just pathology. Therefore, it seems important that both of these are acknowledged and brought together, as otherwise the behaviour might be glorified or stigmatised and personal responsibility taken away from the individuals.

The way the language is used within narratives illustrates the ambivalent attitudes towards the behaviour, as shown below.

> ***David:*** *“I hate that I love it.”*

The fact that the narrators were ambivalent with regard to their behaviour can also be inferred from the secrecy of self-harm. Most of the participants kept their self-injury to themselves, or within a very limited circle, which further reinforced the idea of the narrators’ lonely fight.

> ***Sophie:*** *“Nobody knows about this [self-injury] so I feel like nobody can judge me for it.”*

In this excerpt, Sophie also admitted her fear of being judged, which seemed to be used as a justification for keeping the behaviour secret. This is also an acknowledgment of stigma associated with self-injury. The narrators admitted to sometimes hiding the behaviour from people as close to them as a partner who they lived with.

2.3.3. The Paradox

Even though self-injury was described as something that allowed the narrators to continue living and carry on with their lives and, therefore, constructed as hope, it was also presented as a source of problems in the narrators’ lives and constructed as yet another thing that needed to be managed. This is the paradox of self-injury.

This is how Sophie described one of the events when she self-harmed quite deeply, and her reflections from the consequences of this in terms of the

experienced pain and need to hide her scars. What was supposed to help her cope became an obstacle to day-to-day activities and required adjustments to be undertaken.

> ***Sophie:*** *"I think what shocked me was how it puffed up afterwards, and how it looks say half an hour later. It was really different to what I was used to and I realised how damaging it was, I guessed, physically doing it. And because I cut on my forearm and then it's in there, I can't do a lot of things I normally would, because it meant if I rolled up my sleeve my parents would have seen. So that shocked me a lot just how much it would affect my life for the next couple of days or weeks even."*

Sophie also said that she did not feel good about making those cuts and often felt shame and guilt after injuring herself. These feelings were described by Lemma (2004) as accompanying the birth of mature hope, which is based on the acknowledgement of loss and realisation that a person can carry on living. In the case of Sophie, she realises that she lost the way her body looked before she made cuts on it, and this will restrict her in some ways.

Furthermore, some narrators pointed out that, with time, self-injury started to become progressively more severe.

> ***Lily:*** *"I continued the same way and then that stopped really helping because, I don't know, because I got used to it or something. And then it became more severe, like with a, with a blade or something. So it just progressed thinking that I think I was thinking 'If it was more it would've helped more'. Yeah."*

The above excerpt also illustrates how Lily moves from hope to hopelessness and then hope again, which seems to confirm the dynamics of hope as a process of oscillating between hope and despair/hopelessness. Lily also described the progression of her self-injury as something that could get out of hand and control. Paradoxically, self-injury, which was supposed to help her to get things under control, eventually became yet another thing that required to be controlled. This was also indicated by other narrators, with some developing routines in the way they self-injured. Those routines helped the narrators to ensure their safety and provided a sense of agency.

> ***David:*** *"I've gone into making shapes to kind of keep myself in control. Umm, I've been doing stars on the side of my ankles because I know that star is exactly ten cuts and, you know, once once I get the shape of the star I'm done. I have to stop myself, otherwise I know it would get bad."*

However, self-injury was not being constructed as becoming out of control for all of the narrators. For some, the paradox of self-injury was about the emotions that the behaviour triggered. The narrators described self-harm, which was supposed to be helping and was claimed to be a coping mechanism, as triggering more of those feelings that required the need for a coping mechanism. The way to deal with problems became a problem in itself, such as in the example below.

> ***Sophie:*** *"So, hmm, when I've realised that if I stop for a long time, I don't get the urge so much, but once I start again and I cut, hmm, it gets me stressed more easily so things I wouldn't get stressed about before, like say bumping into someone on the street or accidentally dropping something, it gets me more, hmm, my stress levels are higher. I become more sensitive to it, and then I think I want to do it again just to counterbalance it (hmm)."*

Sophie recognised that self-injury over-sensitises her reactions. She highlighted the vicious circle that she fell into. This also leads to feeling stuck and emphasises the cost that the narrators pay as a result of engagement in self-injury.

2.3.3.1. Feeling stuck

Some narrators recognised the difficulty in maintaining self-injury, pointing at the hopelessness of the situation that they found themselves in.

> ***Sophie:*** *"I know it's going to look ugly and I have to worry about cleaning it up and all that sort of thing and it's so much of a hassle, so I don't want to do it but I don't know how to make it better either if I don't do it."*

Sophie seems to be aware of this and talks about feeling stuck and the difficulty to act in another way. This may have been reinforced by the fact that self-injury worked for her, regardless of the feelings triggered afterwards.

It is interesting to look at the excerpt from the interview with David here. After I asked him about hope, he said that it was not associated with self-harm, and then he added:

> ***David:*** *"At times I'd love to just walk away from it and never turn back, but it's (.) it's (.) who was it, Thomas Jefferson, you know from American history, he once described slavery as 'holding a wolf by the ears'. You don't like it but dare not let go. That's kind of how I see it. It's in my life. It's a necessary evil."*

Comparing David's relationship with self-harm as 'holding a wolf by the ears' implies his feeling of being temporarily in control. However, this kind of control is a

deceitful one because in order to exercise it, David is also controlled by the situation. This metaphor also indicates that David is in a no-win position. He cannot maintain this position for a long time, but he cannot disengage either. There is no way out.

The narrators spoke about the battle that they take part in between the two opposite forces that seem to be in play with regard to their self-injury.

> ***Lily:*** *"But I don't think that you can be cured because it's always there, know that it is, I know that it is a way of release and I know that it works. But I also know that it would interfere with my work with young people and would make mean that I would have to lie to a lot of people so (.) even if I have a bad day and I think: 'Yeah I could use this other way to feel better for a little while', I know I can't so it's kind of a fight between the two."*

Lily describes here how, on the one hand, self-injury works, and, on the other hand, this behaviour is a problem. She constructs herself as being torn between these opposing poles. Moreover, this other side of self-injury is what forces Lily to try and find other hope pathways of reaching a goal of feeling better, which would increase the level of her hope.

Adler and Adler (2011), in their book based on over 10 years of research with people who self-injure, also pointed out that participants get stuck as, on the one hand, the behaviour helps; however, on the other hand, it also increases experiences of the lack of control.

2.3.3.2. The cost of self-injury

The narrators referred to the price that they pay as a result of their engagement into self-injurious behaviour.

> ***David:*** *"Always paranoid when I'm out in a public, when I'm in short sleeves. Umm the scars are bad. People look over and, you always feel like somebody's staring at you and you have to question your motives constantly. Umm, they [scars] cost me my job in the army. Umm, they cost me relationships, more than I can count. Umm trouble with my friends, with my family, they obviously want me to stop but..."*

In the excerpt above, David places the blame for all that went wrong in his life on his self-injury and scars on his body. He described a very high price that he paid as a result of his actions.

Some narrators also pointed out the physical consequences of constant cutting and the damage that this caused them.

> ***Olivia:*** *"And now I don't do the top of my leg because I have so many scars and I don't (.2) it makes me feel sick to go over top and because my nerves are so damaged, like I get really sometimes my leg would get sore and I released that it's just because, I'm positive it's just because of the damage that I've done to the nerves from all the different, from all the different cuts and now it's like I go lower on my leg."*

Olivia described difficulty in getting her self-harm under control and feeling that it was out of hand. The pain she experienced as a result of cutting was a constant reminder of the damage she caused to the body.

Based on the fact that, often, those who injure themselves cause a very serious damage to their bodies, many writers and researchers build a view of self-injury as psychopathology, and concluded that it is a behaviour that is against the human basic desire for self-presentation (McAllister, 2003). This argument is strengthened by the fact that those who self-injure are at a higher risk of attempting suicide (Zahl & Hawton, 2004).

2.4. The Story Continues…

The narrators spoke about their self-harming behaviour as something that stays with them, regardless of whether they continue to self-injure or not. This indicates that the story does not have an end, but rather it continues. It seemed that the self-injury story persists even if the behaviour does not. This is also a hope that is within the behaviour.

> ***Ruby:*** *"I'm a little better these days but I don't have many arguments. I'm not living with my family anymore. I live with my partner, who is very very calm, very reasonable, we don't argue so I'm never in the situation where I am in that position. But if I do have an argument with my family, or something really bad does happened, I still would get these carvings. And I have to calm myself down. If I can't calm myself down then I would go to my old patterns*

so it's not like I've stopped I just don't do it very often anymore. I haven't done for about a year."

Ruby's narrative illustrates that even though she had not self-harmed for a long time, she did not construct herself as someone who stopped. She presented her behaviour as being on hold. This is also related to feeling of hope that the thoughts about self-injury evoke. Ruby, like other narrators, knows that when she self-injures she is likely to feel better, which represents the pathway thinking of hope. She says that she would injure herself when needed, which is the agency thinking of hope.

Some narrators also recognised that even though they did not self-injure at the time we spoke, this did not mean that they would not start again. It seemed that this was almost unpredictable and again made an impression of the control being outside of the narrators.

For some narrators, even the idea of stopping was quite terrifying and they did not seem to be able to make such a declaration.

Chloe: *"Look, I mean, I'd like to think, like I said to you before, I can never say I'm going to definitely stop because I don't think I will, but we're thinking of having children now, so, and I don't want to be, I don't want, I don't want, I don't want still be doing that, or have that as a coping mechanism when I've got children. Because I just don't want to, so I'd like to think that I'm not gonna do it again, but I can't promise."*

Chloe said during our interview that she did not want to stop; however, in the excerpt above, she also expressed her hope that she could have stopped if she wanted to. This allowed her not to commit to stopping the behaviour.

Interestingly, the narrators also indicated that there could be some serious consequences of stopping self-injury, which was the reason for this story to continue in cycles. Moreover, they also pointed at ways in which the cycle can be extended and the breaks between each self-injury made longer. Below, I describe in more detail these sub-themes.

2.4.1. When Self-injury does not Work – the Fine Line

There were some interesting insights generated when the narrators spoke about association between self-injury and suicide. They constructed self-injury as a protective mechanism that shields them from things getting worse. This is also associated with the two pathways of despair: one leading to hopelessness and the second one towards hope (Kylmä, 2005). This is explicitly verbalised by Ruby in the excerpt below.

> ***Ruby:*** *"So the only time when self-harm and suicide would be linked is when I'm using self-harm to calm me down to the extent that I stop thinking about committing suicide. So it's like a little bit of damage to prevent further damage, kind of thing."*

Ruby attached a meaning to her behaviour as being something that helps to prevent something else. However, what are unspoken here are the consequences of not having something that could help to stop the suicidal thoughts. This seemed to suggest that self-injury prevents attempts at suicide.

Some narrators spoke about what had happened when they forced themselves to stop their self-injurious behaviour. This was described as having near fatal consequences, which then further justified continued engagement with the behaviour.

> ***David:*** *"The yyy the first hospitalisation after the relationship, was I think it was the turning point, that's kind of when I look back and saw that my life was falling apart. And while that* [self-injury-cutting] *made me feel better it wasn't helping. That's kind of when things changed. I kind of slow down, and I didn't like it as much as I did before. And I tried to stop on my own I just refused to let myself cut for I think about a month, and things get so stressful that I overdosed on, umm, I think it was sleeping pills and I was sent back."*

David described an attempt on his life as a direct consequence of him not allowing himself to cut. David spoke of sinking deeper and deeper into the feeling of despair and hopelessness where there is nothing else left for him.

For Lily, the struggle for survival and for things to be different is apparent in the below excerpt where she talks about her experiences after her suicide attempt. She described taking some pills and calling her friend, who then informed Lily's mother. The mother took her to the hospital and afterwards discharged her against

Lily's wish to stay. Below is a quote from the interview in which Lily explained how things looked for her during this time and why she attempted suicide.

> ***Lily:*** *"I had enough. And I just couldn't (.) I was trying to stop self-harming as well because I knew that it wasn't sensible. And yeah I just wanted the pressure of trying to stop, the arguments with the parents, and (.) I actually just came back from completing my gold's (name of the award) award. So I just finished the whole thing that I have been doing for the past four years, and it was all done and I was going to go and meet the (someone's name) but that was also a lot of pretending that I was ok to everybody. So I also wanted that to stop because I was tired to pretend that 'Everything is ok now, I'm fine' can be very tiring so I just had enough."*

The narrators seem to construct self-injury as a protective factor against things getting worse and they appeared to justify in this way the continued use and engagement with the behaviour. Even though self-injuring is damaging, it also provides a way for the person to move from despair and chaos towards hope. This also explains why the self-injury story needs to carry on.

Even though the narrators felt that there might be very serious consequences of self-harm and alluded to suicide, research showed that, in fact, only less than 5% of people who self-harm make an attempt on their life (Cutliffe, Brainthwite, & Stevenson, 2008). This reinforces the idea that self-harm fulfils its function quite well and for most of the time.

2.4.2. Extending the Cycle of Self-injury

It emerged that the narrators were able to stretch the cycle of self-injury by making the breaks between each act longer. It seemed that this was a very individual thing and different things worked for different people. Furthermore, these different ways represent the narrators developing alternative pathways of hope that can be utilised to reach the goal of feeling better and overcoming chaos, feelings of despair, and hopelessness. Below, different alternatives to self-injury pathways of hope are presented as described by the narrators.

However, it appeared that one of the most regularly expressed things that helped to stretch the cycles of self-injury were relationships with others.

> ***Anna:*** *"So for the most part since I've been with him I haven't cut. […] We would talk to each other. Umm we started hanging out all the time, we would,*

he would get me to talk to him about what was bothering me so it wasn't just pent up inside. I could actually get it out there a little bit better and umm yeah (laughter)."

In the above excerpt, Anna described her relationship with her fiancée, whom she described as very supportive and understanding. She said this was because he was an "ex self-harmer". She indicted above that feelings that have no form of expression and accumulate led to harming. Therefore, when she found a way to express these with the use of language, the need for injuring herself was not as great. Some narrators spoke about not injuring as a result of being in relationships even if they did not share their self-injury experience with those whom they were in relationships with. This represents that hope can be taken from the environment, which Bernardo (2010) named as the external locus of hope.

The idea of emotions being a build up, which can sometimes be expressed and help to extend breaks between self-injury, was also voiced by others.

David: *"{Researcher: You mentioned that you you can feel that it's building up and sometimes you're able to address it, what do you mean by that? How do you address it?} Some of the friends I talk to online I talk to them or I'll go out and do something like, something stupid go bungee jumping, go sky diving, go do something fun to try to take my mind of the stress. It doesn't always work."*

David found that relationships with friends met through Internet communities help him sometimes not to self-injure. He also found some other ways of coping and releasing those accumulating emotions.

Another factor that the narrators mentioned as allowing them reliance on self-injury to a lesser degree was being busy/distracted and having a job. These were considered by the narrators as very important.

Chloe: *"As I got older I got more 'right I'm stressed out now and I'm gonna do it when I get home'. And I get home and I wouldn't feel like doing it then. So I'd be like 'that's fine'. So I think that's how I stopped erm doing it for a certain periods of time because I'd say 'I'll do it later, I'll do it later' then I get home and I'd be like 'I don't need to do it now, I don't feel like I want to do it now'."*

Chloe described in the excerpt above how she can postpone injuring herself as she would not want to self-harm at work.

However, some narrators seemed to be replacing one form of self-harm with another. Olivia described smoking marijuana as a way of helping her to stop self-harming.

> ***Olivia:*** *"I'm smoking pot, a lot of pot that's what I switched over to and that helped me to stop cutting myself because I was smoking marijuana and it calm me down, right."*

She later described that this also provided only a temporary form of relief as she had a sense of guilt from smoking marijuana.

Furthermore, a few people mentioned that at times when they did not cut, they would try to get control over their food, like in the excerpt below.

> ***David:*** *"[...] there are days I go without eating. And usually when I'm doing that I'm cutting less. So, I guess, it's like an alternative coping mechanism that I found."*

Based on all this, it emerged that if chaos could be expressed in some other ways, the need for self-injury was not as great. This is directly related to the concept of hope, with its agency and pathways thinking that lead to a certain goal, which, in this case, is feeling better.

Gilzean (2011) investigated the use of creative writing by people who self-injure and concluded that this may allow individuals to gain a sense of control over experiences of chaos and a way to express it in writing rather than via self-injury. This may then help to decrease the behaviour.

3. Hope, Hopelessness, and Self-injury

In this section, the participants' views of the connection between hope, hopelessness, and self-injury are presented, drawing on the overall tone of the participants' stories.

3.1. There is Hope within Self-injury

Only one narrator associated hope with self-injury. Ruby constructed self-injury as the hope because it allowed her to cope and overcome difficulties.

> ***Ruby:*** *"I use self-harm as a, that is, self-harm is the hope because it's it's, you know, if the tunnel is the argument, than self-harm is the light at the end of it. Because I can say 'Oh, I can go there and then I will come down and then everything will be ok again'."*

Ruby's narrative is well defined and established. She seems to be very certain about the meaning and connection between hope and self-injury. It appeared that her definition of hope helped her to generate the above narrative. This is how she defined hope.

> ***Ruby:*** *"Hope means a chance of solving a problem. Umm realistic, accessible chances of solving a problem, whatever the problem is. I don't have any of this, sort of grand feeling of hope over, you know, umm, hope is very situational. In this case fear is the hope, fear is the hope and it's having that sense that there is a way of making me feel better, there is a way of solving a problem."*

This way of understanding hope as a way of solving a problem seems to be very practical and matter of fact. This resembles the way Ruby told her story. She answered all questions during the interview using very few examples. Moreover, even when asked for some examples, she responded by stating that she had no ready examples to tell and usually repeated her point. This, however, reinforced the idea of chaos and stories that could not be told, and gave an impression that she was avoiding something. The entire interview with Ruby had a very different tone from all the others. She presented her answers in a factual manner and there was a 'news-like' feel to the entire narrative. It appeared that she was very much in control of what she spoke about and did not allow for the conversation to take her places she did not want to go.

Chloe also associated hope with self-injury. However, for her, the distinction was not as clear as for Ruby. It seemed that she was developing her understanding and defining things as we spoke. This is her answer to the question on whether hope was associated with self-injury.

> ***Chloe:*** *"Um yeah, I think. So for me personally, I can only speak for myself, erm, I never really thought about it before. Erm, certainly now that you*

mentioned it. Erm, that I'm thinking about it. That has got to be because, I don't know, I don't really know how to explain it, to be honest with you. It's really complicated. Although there is sort of, they linked. It's hard to link them, if you know what I mean. Erm, all I all I can say is that for me there has to be some level of hope with self-harm because if there wasn't you would've already had the courage to press down harder and bleed until you didn't stop so to a degree […] It's really complicated, you see, trying to get the worlds, trying to hmmm define the world hopelessness. Because a lot of people would use it, like I would say on that night I did feel completely, I lost all hope I'd lost everything. Erm, but then why didn't I kill myself because there have to be an element of hope left. Otherwise, I would've. So I don't, I don't know. I'm finding I'm finding it really difficult to answer that to be honest with you. I don't quite know how to answer it."

The above excerpt illustrated a struggle in the search for meaning and connection between self-injury and hope. However, it was interesting that the moment in the interview Chloe started to search for this meaning she also started to name self-harm, rather than referring to self-injury as 'it'. Intriguingly, the way Chloe defined hope was very different to the way Ruby did.

Chloe: *"Hope is a belief in the future, I would say. That's my personal understanding of hope. Belief in the future and that it can be better. That's how I feel. That's what I believe hope is. And hopelessness obviously you've got nothing, you've got no faith in the future, whatsoever."*

It seemed that this way of defining hope is more general and this may have made the earlier search for connection between self-injury and hope difficult for Chloe. However, she later recognised that hope can be different for different areas of a person's life, such as private life, work, relationships, etc. Moreover, she spoke about the fact that, for her, there were a lot of things being *"born out of bad things"*. Interestingly, when I asked her about something that made her more hopeful recently, she spoke about a re-building of the Twin Towers in the USA as *"a symbol of hope"*. This again re-emphasises a general and more grandiose understanding of this phenomenon, and the idea of hope being borne from suffering.

Chloe's narrative was filled with contradictions and she made many turns in her stories. This gave a sense of the meaning being developed rather then being well rehearsed and defined. I was drawn to her story and felt very much a part of the search for meaning. Moreover, Chloe used a lot of idioms and metaphors (that is, a few words put together that have a very different meaning from each of them

looked at separately) in her speech, such as *"head over heels"*. This brings to mind things being hidden and different from how they seem to be. The overall tone of her story was rather optimistic, even though pessimism appeared in a few places. She stressed that self-injury was a way to help her get though life and difficulties.

3.2. There is 'Only' Hopelessness within Self-injury

The remaining six narrators associated self-injury with hopelessness and the overall tones of their narratives were pessimistic. Most of them change the tone of their narrative into a more optimistic one towards the end when they were asked questions about hope in their life and the future.

> **Anna:** "For me I think that they're [hope and hopelessness] very strongly associated with it [self-injury]. Umm because when I feel hopeless it's when I feel like, that's when I usually end up self-harming. Whereas when I feel like things are going to get better I feel like shit now but I can wake up feeling great tomorrow is usually when I can get myself to move passed how I'm feeling."

Most of the narrators defined hopelessness as way of thinking that things would not get better and associated this with self-injury, much like Anna in the above excerpt. The narrators differ in their understanding of hope and hopelessness within self-injury.

Both Anna and Sophie constructed hope as a belief that one day they would be able to stop self-injuring. This discourse is, of course, influenced by the topic under investigation, the observation effect, as the narrators knew that I was interested in "hope and hopelessness within self-harm".

Emily and David emphasised that there was no hope in self-harm at all. Yet, they both constructed self-injury as the last resort and a coping mechanism. They also hoped for things to get better but could not exactly say what this meant to them.

Olivia constructed hopelessness slightly differently to the previously described narrators. For her, it was related to thinking that she would never get help, be able to fix herself and/or be "normal". She felt like this when she self-harmed. For Olivia,

hope in relation to self-harm was about wanting to get better. However, she did not think that she could. Therefore, her narrative of hope was developed around the idea that in the future, the breaks between self-harm would be longer.

Lily's construct of hopelessness was very different from all of the other narrators. She defined it as a lack of purpose. Initially, she was unable to define hope as she said that she used to believe in God and hope was about belief that things can get better but they never did, they got worse, so she stopped believing in God. She stressed that if she had hope, she would not have self-harmed. She later constructed hope as being busy because this gives purpose and is distracting. She thought that it was not possible to be cured from self-harm, as it stayed with the person for the rest of their life.

Interestingly, for the six narrators, it was hopelessness that became the main character in their narratives after I enquired about hope and hopelessness within self-injury. This, however, seems somewhat in contrast with the earlier outline cyclical narratives of self-injury and the construction of self-injury as a coping mechanism. This will be discussed further in the next chapter.

Discussion

The aim of this research was to analyse self-injury stories and then to look at how hope was constructed within those stories. This was achieved by employing a narrative method of inquiry to analyse the data. First, in this chapter, a summary of findings is presented with emphasis placed on the new type of narrative that this research revealed. There has not been a record in the published literature about the kind of story type named here as the 'cyclical narrative'. Next, self-injury construction from a narrative perspective is discussed. In this context, self-injury replaces the process of telling a story and becomes a story in its own right. The researcher draws on existing literature to support this way of conceptualising self-injury. Further, the concept of hope in relation to self-harm and the cyclical narrative is discussed. Moreover, the limitations of the present study are discussed and some recommendations for future research are offered. The chapter finishes with some thoughts on the implication of the findings for clinical practice and research.

1. Summary of Analysis

The narrators in the present study experienced their lives, or some parts of their lives, as chaotic. There were three main themes that gave rise to this experience: namely, confusing relationships with self and/or others; experience of unbearable emotional states; and torment by events. As a result of these, the narrators felt that they did not have control over what happened to them and they struggled to make sense out of those experiences, leading to experiencing feelings of despair. There are two possible routes from this state: either the path towards total hopelessness, or one requiring reclaiming agency towards hope.

Normally, people generate meanings, gain some agency, and make sense out of events in their lives through the process of telling stories (Crossley, 2000a). This also helps to put events in a chronological order and feel connected with others. The narrators in the present study, however, positioned themselves as unable to utilise narratives and tell stories about experiences through a verbal way of

communicating. This was attributed to difficulties in communicating that was perceived as coming from both narrators and those around them. Inability to communicate was one of the themes that also emerged in a study by Hill and Dallos (2012), who interviewed and examined stories of young people who self-injured. Their research recognised the difficulty young people had in generating coherent stories and talking about what caused and led to self-injury. This is echoed in the present study.

For the narrators in the present research, the story is being told through self-injury, and, as such, becomes a story in its own right. Therefore, self-injury takes over the functions of narratives. Looking at the main reason for this way of telling a story, self-injury allowed the narrators to arrive at the point where they can feel and say that they are 'good' again and can carry on with their lives. When Snyder's (2002) theory of hope is applied to this story, self-injury can be understood as the pathway of hope, and the mental energy that the narrators engage into perusing their goal is the agency of hope. The goal is to get to the point of feeling better. Through the attempt at reaching the goal, the present suffering is connected with the future goal. The narrators' hope is therefore specifically tied to reaching this goal.

Further, I argue that each individual story of a single act of self-harm is a restitution narrative (Frank, 1997). Frank (1997) described a restitution story as "yesterday I was healthy, today I am sick, but tomorrow I'll be healthy again" (p. 77). This type of story is considered to be the most commonly told by those who get sick or unwell and is related to a goal-specific hope, with a goal being success of treatment. The restitution narrative has been shown in a number of previous studies to be a response to illness with a main storyline focusing on being unwell at present but looking to restoration of health in the future (Nosek, Kennedy, & Gudmundsdottir, 2012; Smith & Sparkes, 2011; Thomas-MacLean, 2004; Whitehead, 2006). Smith and Sparkes (2011) postulated that the restitution narrative is one of the responses to chaos, which is also the case in the present study and self-injury stories. However, in the case of people who self-injure, being healthy cannot be taken literally, but rather it has to be understood as a means of returning the self to 'normality', to the state from before the chaos crept in.

As self-harm gives only a temporary form of relief, people start experiencing chaos again. This marks a cycle in the story. The narrators go back to experiencing chaos that needs to be overcome and made sense of by the process of telling a story, which is done with the use of self-injury. The story makes a cycle and continues to be told this way. This story has no end. Therefore, each individual narrative was comprised of a number of restitution narratives. There has been no record in the published literature of this kind of narrative. This constitutes a novel finding, and the narrative type identified within a self-injury story was named a 'cyclical narrative'. This does not exclude the entire story being classified as some other type of story, but rather illustrates the movement within the narrative. The cyclical narrative of self-injury also symbolises the dynamics of hope as a state of oscillating between despair, hopelessness, and hope.

It is important to note here that there are a number of things that are of a cyclical nature. One could argue that almost every human activity is structured this way. However, this does not mean that the stories about them would also be told in a cyclical way or that they would produce cyclical narratives. Moreover, the difference between self-injury and many other activities, or even forms of self-harm, such as drinking or reckless driving, is that self-injury produces hope and can be understood as a hopeful behaviour, unlike other forms of activities. They also might produce some elements of hope but not all of them, such as in the case of experiences of self-harm, which contains chaos, despair, hopelessness, agency, thoughts towards achieving a goal of feeling good again, feelings of hope afterwards, sometimes feelings of guilt and shame, acknowledgement of losses, and realisation that a person can carry on with their life despite the pain. All these elements would need to be present in order to assume that the behaviour contains hope. Therefore, the trajectory that is cyclical is not automatically assumed as hopeful. What differentiates other cyclical behaviours is the absence of one of the components that would make them hopeful, as mentioned above. As an example, drinking would also produce, like self-harm pathways, agency towards a goal of feeling better (giving a rise for some to hope emotion); however, self-harm additionally allows people to really connect the present with the future. This is not the case for drinking, which moves people away from this and its main purpose is to allow people to disconnect with some parts of themselves and from the past.

Another example can be eating, which, of course, is episodic but under regular circumstances does not produce feelings of hope, even though other elements of the hope agency and pathways goal-directed thinking might be there. Further, each of these activities cannot be considered as a way of telling a story, which also differentiates self-injury from other forms of activities.

In summary, self-injury helps to connect all the elements of hope, and hope within self-injury is what differentiates this behaviour from other forms of cyclical or episodic behaviours.

2. Self-injury as a Story

From a narrative perspective, it is argued that self-injury replaces the process of telling a story. Crossley (2000a) drew attention to the fact that stories "are used to restore a sense of order and connection, and thus to re-establish a semblance of meaning in the life of the individual" (p. 542). This is precisely what self-injury does for the narrators in the present research. From this perspective, self-injury can be thought of via the narrative framework.

Hiles and Čermák (2008) noted that, "narratives play a crucial role in almost every human activity. Narratives dominate human discourse, and are the foundation of the cultural process that organises and structures human actions and experiences. They offer a sense-making process that is fundamental to understanding human reality. Narratives enable human experiences to be seen as socially positioned and culturally grounded. […] They offer pragmatic and persuasive responses to deal with life's events" (p. 149). This description helps to shed some light onto the importance of self-injury as a way of telling stories for the narrators. As mentioned in the earlier section of this chapter, the perceived inability to communicate poses a need for exploration of alternative ways of narrating. This is the reason that self-injury occupies such a prominent position in the narrators' lives.

The story told by the narrators about self-injury has no end. It is a story that is on-going. This resembles life stories that can only ever be provisional, with the final

end being the death of the narrator (Murray, 2008). Therefore, the self-injury story as a whole was presented as having no resolution. The cycle of behaviour is being repeated, which does not allow the resolution to be reached. This was also found in Hill and Dallos' (2012) study, who noted the lack of resolution of self-harm stories told by adolescents.

In thinking about self-injury as a way of telling a story, it is helpful to think about the 'what' of this story (that is, the things that are being said), the 'how' of the story (which is the way in which the story is being told), and, finally, the 'why' (understood as the reasons for people to say this type of story).

2.1. The 'What' of the Story

The 'what' of self-injury stories represents the content of these stories. In the present research, self-injury stories for the narrators are stories about chaos in their lives and the suffering that this chaos underlies. These stories are about the struggle and suffering of an individual. The narrators in the present study expressed that stories that are being told by the use of self-injury are those that caused them "the psychic pain" (Motz, 2008, p. 193). The narrators 'say' this way that they suffer a great deal and that this is unbearable. The present research also confirmed the theme of self-care found in other studies (Schoppmann et al., 2007). Self-injury is constructed as something that allowed the narrators to try and end the suffering in the hope of reducing the psychic pain. Self-injury is a story about experienced chaos that has a great significance for the person.

2.2. The 'How' of the Story

Similarly to the way people tell stories through the use of language, self-injury stories represent not only the 'what' of stories, but also they present a very powerful way in which those stories are being told, which is the 'how' of stories. The narrators spoke about experiencing and expressing different forms of events by the acts of self-harm. The stories were 'told' by wounds, cuts, and bruises on the bodies of the narrators, very often with blood accompanying them. A story that was told this way differed from each person and from each experience. Some

people chose different tools each time and different parts of the body to harm; others used the same tool and body part each time. This also referred to the way people self-injured, whether these were structured and controlled cuts, or done under impulse. This is parallel to the way stories can be verbally expressed. Some are constructed 'on the spot', rushed, and others are thought through before being spoken.

2.3. The 'Why' of the Story

The 'why' of the self-injury story represents functions and the role that this story plays. There are a few main assumptions about the role that stories play in our lives, which can be mapped onto the functions of self-injury. These are giving meaning and order to events, constructing one's identity, establishing connections, and social and cultural functions of this way of telling a story. All of these are discussed below.

2.3.1. Chronological Order and Meaning

One of the main and most fundamental functions of any story is to put events in a chronological order in a way that is meaningful to a person and represents that person's experiences. This process allows individuals to make sense out of experiences that are a disruption to normality. Those disruptions "encourage attempts by us to restore some sense of order. Narrative is a primary means of restoring this sense of order" (Murray, 2008, p. 114). Storytelling is one of the ways in which meaning is attached to events and this meaning produces suffering (Crossley, 2000a). If we look at self-injury as way to tell a story, self-harm becomes a way to tell the story about difficulties and suffering, the story about chaos, and the main aim of this is to give some order to them.

Crossley (2000a) stated that one of the most important features of our perception of the world is our experience of time as being a continuum. He then goes on to say that when we experience trauma, such as illness, this perception and assumptions made earlier are shaken. This has been shown in research and writing concerning, for example, chronic pain (Good, 1994), HIV positive

diagnoses (Davies, 1997), and cancer (DelVecchio-Good, Munakata, Kobayashi, Mattingly, & Good, 1994). Therefore, narratives that people construct about themselves became “secure fixed points of certainty in a world where the present seem to be dissolving ever more rapidly into an uncertain future” (Parker, 2004, p. 71). In the case of self-injury, the disruption that people experience does not constitute sudden events, like receiving diagnoses, but rather many everyday things that have significance for the individual. Those disruptions are experienced by the narrators as chaos and bring in a sense of discontinuity. Through self-injury, the narrators tried to restore a sense of continuity and connection to their own life, in the same way that other people would try to achieve this through the use of verbal stories. Both self-injury and scars became those secure, fixed points of certainty that allowed the narrators to experience their life as meaningfully connected, rather than a random series of events.

Additionally, it has to be noted that chaos does not allow a person to experience things in a chronological order (Frank, 1997) and it was apparent that, for the narrators in the present study, the past was present in the here and now, with some being unable to even tell stories about some of their experiences. This has been also found in Hill and Dallos’ (2012) research that recognised the difficulty of adolescents in telling their stories. Further, thinking about the self-injury as a story told about chaos helps to explain why people receiving treatments prefer those treatments that try to tackle difficulties that underlie self-injury, rather than those that try to deal with the self-injury itself, which is presented by Craigen and Foster (2009).

From this perspective, self-injury is a way to try and give meaning, define difficulties, and bring some order to experiences. In other words, it allows people to gain some sense of control over events and put an end to the experience of chaos. As for any story, self-injury needs a witness, and it seems that, based on the present analysis, the body becomes a witness, a witness of suffering. Following from this, the scars on the body have the same role as a written story would have. Those marks become words and sentences, and they are a personal diary of painful experiences and suffering written on the body. They are the accounts of these experiences and a constant reminder of them, which is in line

with verbatim transcripts' analysis of self-injury from a psychodynamic perspective conducted by Straker (2006). She concluded that "self-cutting is an attempt to put in place the elements involved in the building of self-structure. These include mirroring, the establishment of a boundary, the building of a narrative autobiographical memory, and the impregnation of verbal signifiers with signifiers of the flesh." (Straker, 2006, p. 93). Further, Motz (2008) proposed that "scars […] are embodiment of the trauma which they reflect" (p. 197).

In exactly the same way that someone would display varying attitudes towards their diaries, the narrators displayed different attitudes towards their scars; some people felt that they were very important to them and became sad when those 'stories' disappeared from their bodies, whereas other people could not bear the sight of them and would happily get rid of them.

Additionally, it has been claimed that after self-injury, the need for communication decreases (Leibenluft, Gardner, & Cowdry, 1987). This fits into the function of self-injury as a narrative. As the narrators told their stories about chaos through the use of self-injury, they did not feel the need to tell another story about the same experiences. It further confirms that, in this context, self-injury does indeed work. This is also supported by others who claimed that self-injury is used when words cannot be found (Conterio, Lader, & Bloom, 1998; Favazza, 1996; Strong, 2005; Sutton, 2007).

When the narrators described their experiences of chaos, they pointed at the perceived lack of agency, which caused them suffering. Agency helps people to position themselves within a wider social context and can be understood as a perception of oneself as a participant of an event or one's own life, and not just an observant (Reavey, 2010). The sense of agency is usually restored through the process of telling stories (Murray, 2008), and for the narrators of the present study, this was achieved through self-injuring. The need for self-injury arises as a result of the narrators' perceived lack of agency, which causes suffering. Therefore, in this sense, self-injury becomes a way not only to express chaos and suffering but also regain a sense of agency.

Some research pointed out that one of the functions of self-injury is to direct the anger towards the self (Hill & Dallos, 2012). The present research has not confirmed this. Even though some narrators spoke about the fact that their self-injury was associated with feelings of anger, or was undertaken in response to arguments with others, this was not the case for all. Rather, the present research identified unbearable, heightened emotions as one of the underlying factors that contributed to the experience of chaos. Those feelings included anger but also anxiety, sadness, depression, frustration, disappointment, and many others. Even though self-injury can look from the outside as a very angry act, it seems rather simplistic to assume that anger is the only underlying emotion of it.

The way the narrators in the present study constructed their self-injurious behaviour was related to the association they made between self-injury and suicide. Some narrators said that self-injury was a way to prevent things getting worse, or even to prevent suicide. This is in line with research done by SANE (2008), which showed that over a fifth of all respondents reported that suicide prevention is the main function of their self-injurious behaviour.

2.3.2. Identity Construction

Except for providing meaning to our lives and giving order to everyday activities, narratives also are a means to structuring our sense of self, which Murray (2008) called creating “narrative identity” (p. 115). He argued that we can have many narrative identities expressed in a variety of social situations. This allows us to gain some sense of stability, and in difficult times, where one of those identities gets interrupted, we can connect to another of our narrative identities in an attempt to restore this sense of stability. Further, Crossley (2000a) argued that “when disorder and incoherence prevails, as in the case of trauma, narratives are used to rebuild the individual’s shattered sense of identity” (p. 527).

In the case of the narrators of the present study, the narrative identity developed through the process of self-injuring is something that narrators can rely on and repeatedly go back to as something stable in times of instability and lack of coherence. It provides an unchanging base for the narrators, providing a sense of

continuity not only of their lives, as discussed earlier, but also of themselves. Self-injury offers a means for the narrators to experience their sense of self as a whole with a number of parts connected together. Straker (2006) also concluded that building the self-structure is the paramount function of self-injury.

People tell stories about particular events and things in their life that matter to them (Parker, 2004). Through this process of story creation we construct our identities; that is, our 'self'. This is well expressed by Langdridge (2007): "Our identities are constructed narratively through the stories we tell. The self is brought into being through the stories we construct" (p. 138). Similarly, in the present study, the narrators chose which experiences to express through self-injury, and this process is an attempt to define who they are and what they stand for. Through the process of choice to express some events and not others, the narrators show what things matter to them. Furthermore, Haaken and Reavey (2010) indicated that the more we feel we invested in a certain account of the past, the greater importance the memory of it will have for us. The act of injuring a body is a representation of events that a person has invested a great deal in and a visual sign that those events and memories matter to the person. This function of self-injury as a way to construct a narrator's identity is in line with research that showed that self-injury has been a form of self-expression (Gratz, 2006).

2.3.3. Connectedness

Crossley (2000a) stated that "another important feature of creating meaning and order that is characteristic of human consciousness is that of 'relationships' and 'connections'" (p. 531). Thinking of self-injury as a story allows perceiving the behaviour as a way of looking for connection with something or someone. As discussed earlier, self-injury in the present study allows the narrators to create secure, fixed points in the world of chaos. Therefore, self-injury allows the narrators to connect with something that is stable in their life, something that they can always rely on. Furthermore, through this process, the narrators can reconnect with their own sense of self.

Motz (2009) stressed that the main function of self-injury has been communication to others and oneself of a person's emotional states. The present research's findings do not support this fully. As all of the narrators reported to self-injure in the privacy (secrecy) of their own homes and hide their behaviour from sometimes even the people closest to them, the communication with others does not seem to be the primary purpose of the behaviour. However, some writers, especially within the psychoanalytic field, considered the body as 'other'; in which case, the earlier mentioned statement by Motz (2009) could be considered as having some grounding. Further, I argue that for the narrators in the present study, rather than just communication of emotional states, self-injury is about telling a story of chaos, where emotions play an important role as a contributing factor to the experience of chaos. It should be noted here that Motz works with females in a prison setting and her observations were possibly influenced by this. This function of indirect communicating to others, as referred to by Motz, may be more observable in populations such as hospital or prison where the possibility of privacy may not be achievable. Therefore, even though the present study did not fully support this, it is important to note here that this may be the primary function amongst some groups and settings.

It is interesting to note here that some narrators in the present study were able to extend the breaks between self-injury when they found meaningful relationships. It appeared that the more relationships with others provided a space for conversation and openness, the more infrequent self-injury became. This seemed to indicate that relationships might be an important protective factor. Interestingly, to support this, Klonsky (2011) found association between self-injury and being unmarried, with the rates of self-harm amongst the unmarried being higher.

2.3.4. Social and Cultural Functions

Stories are influenced by the social and cultural context in which they are produced. Murray (2008) emphasised that restoration of order is especially highlighted in western societies, which place an importance on linearity and presenting oneself as rational and reasonable. Therefore, narratives tend to express possession of these qualities. This was also the case for the narrators in

the present study. They all presented themselves and their self-injurious behaviour in a way that clearly showed causality. Events may have happened to them, but the way the narrators made sense out of their experiences and self-injury could be explained and understood as a response to events. As such, self-injury is a behaviour in context.

Further, the stories presented here reflect the culture of recent times in which society places an emphasis on an individual's ability to cope with their own life. Self-injury was therefore constructed by the narrators as representing a way in which people attempted to cope with the difficulties of their lives on their own through the process of creating stories about those difficulties.

The dominant medical discourse reinforces the idea of cure and recovery, which also influences the way stories are being told. In medicine there is a strong emphasis on medication as a way to overcome illness. Research into illness narratives showed that many of those narratives seem to be testimonials about medical health care professionals or medications, rather than individuals themselves (Ezzy, 2000). It seemed that the narrators in the present study constructed self-injury in the same way. In their stories, self-injury is one of the main characters. This is, however, also influenced by the research topic. The stories are testimonials of how self-injury helps to deal with difficulties. Crossley (2003), in his research with oral cancer patients, drew attention to the fact that the narratives related to "uncertainty, fear and scepticism in relation to the power of medicine" (p. 339) are not being told. In the present study, a similar phenomenon was also observed. The narrators did not tell narratives that would express anxiety and lack of belief in the power of self-injury. The self-injury was constructed as the powerful, well-working solution to the problems. This seems to be influenced by the medical discourse that places an emphasis on the power of treatment. In the present study, self-injury is the treatment and cure for the narrators.

Lupton (2003) stated that "Western medicine is […] directed towards controlling the body, keeping it from subsiding into a chaos and disorder threaten by illness and disease" (p. 93). The narrators in the present study control their actions, bodies, and minds with the use of self-injury. As discussed earlier, one of the main

functions of self-injury is to end the chaos and prevent things getting worse. The need for stories that give a sense of control seems to be derived from the influence that the development in medicine and science have had on our culture.

Development of scientific methods of inquiry helped to uncover the concept of standards and norms, which also influenced medical fields. Patients started to be compared to the norm and the concept of what was the standard became ingrained into the discourse and social perception (Lupton, 2003). Foucault (1994) wrote that before this time people's functioning was compared against their own general level of functioning rather than any societal norm. This discourse translated into society thinking and analysing what is normal and what is not. The narrators of the present study are influenced by this discourse as well. Self-injury is perceived as outside of the norm and therefore not acceptable. In order to avoid being judged or seen as mad, the behaviour needs to be hidden. This left the narrators to feel disempowered. In contrast, all of the narrators also positioned themselves as experts of their own limits, actions, and bodies. This expertise was not presented as a given, but rather something that was acquired throughout the years of engagement in self-injury. The theme of people who self-injure occupying a position of experts was confirmed in a qualitative research by Lindgren, Oster, Astrom, and Hallgren Graneheim (2011).

Popular discourses in the literature and research on self-harm construct self-injury as pathology and a sign of mental illness, and position those who self-injure as out of control and victims. These positions are so widely accepted that they became also the most dominant way in which the narrators in the recent study positioned themselves in their own stories. This is in line with research by Lindgren et al. (2011), who found that women who self-injure used 'victim repertoire', positioning themselves in a way that did not allow agency to be expressed. In the present research, the narrators presented themselves as victims or tragic heroes, describing having very little, if any, control over their lives. The only way they fight is through self-injury, which is portrayed as the only way available to them. However, even this does not change their position to a great extent. The narrators constructed the self-injury that is supposed to give them a sense of control as out of control as well. Furthermore, Hill and Dallos (2012) found that young people

expressed frustration for not being understood and listened to by others. In the present research, the narrators often also felt that others did not understand and/or did not listen; however, they did not seem to be frustrated by this. They rather occupied a position of some form of acceptance of this state of things, maybe even passiveness. Some narrators even stated that they would not want to talk about their self-injury even if others asked or wanted to understand.

3. Hope and Self-injury

The cyclical narrative gave an impression of the narrators being trapped within this process of experiencing chaos, self-injuring and getting to the point where the narrators could feel 'good'. The function of this way of telling narratives was to show the narrators' struggle for meaning of experienced chaos in their lives.

Frank (1997) argued that chaos can give a rise to loss of any kind of hope, which is also supported by research (Ezzy, 2000; Smith & Sparkes, 2005). All of the narrators, except for one, pointed to the moment they self-injured as the moment when they felt at their most hopeless. The moment of total despair seemed to be triggering the need for action and the need for self-injuring. Hope in this context can be understood by looking at self-injury as a way of getting through the difficulties and allowing a person to carry on with his/her life. One person in the present study, Ruby, recognised and defined self-injury as hope due to the ability it gave to allow coping. Ruby used a metaphor of self-injury being like "a light at the end of a tunnel". The remaining narrators associated self-injury with feeling hopeless. The narrators said that they self-harmed when they felt at their most hopeless, and for some of them, hope was not present in self-injury. However, this is in direct contrast with the narrators' constructions of self-injury as a coping mechanism and something that keeps them safe. This seems to represent the struggle in a search for meaning and understanding of self-injury. It also echoes the negative societal view of self-injury.

An important thing to be noted here is that the story about chaos can be told only from outside of the chaos (Frank, 1997). Therefore, the moment of self-injury

marked a moment which was at least to some extent a way of overcoming and ending the experience of chaos. Even those narrators who constructed themselves as victims were able to show some push towards action and claimed agency through self-injury, however temporary a stage this was. In this context, self-injuring can be understood as a hopeful behaviour.

The person telling a self-injury story is locked in a cycle of experiencing chaos and self-injuring in order to get to the point where they can say *"I'm good"*. I argue that the main function of self-injury is to get to this *"I'm good"* moment. This also corresponds to the way self-injury has been defined and regarded by the narrators. They understood it as a coping mechanism, something that allowed them to go about their daily routines and carry on with their lives. As such, self-injury is hopeful, as hope is often understood and defined in the literature as a coping mechanism (Aylott, 1998). The present study seems to confirm the way the Feminist Therapy approach conceptualises self-injury as the ability of the person for self-soothing and self-care, and having a function of a coping mechanism (Brown & Bryan, 2007).

In this context, self-injuring gives a rise to the experience of hope. Hope here is associated with the act of self-harm in the sense that self-harm provides what is needed for the person to carry on in the hope that things can get better again. Hope here is about getting to the point where a person can say *"I'm good"* again. This type of hope can be identified as a concrete hope, which is defined as a hope that is directed to a specific goal or result (Marcel, 1962). This type of hope was found to be associated with restitution narrative in research in other areas, such as in patients with a spinal cord injury (Smith & Sparkes, 2006).

This type of hope relies on the replication of past moments of hope, which is in line with Miyazaki's (2004) explanation of hope. This is also closely related to repeated utilisation of restitution and use of self-injury as a coping mechanism. The narrators carry on relying on it because of the simple fact that the behaviour fulfils its functions, even if they are not always able to recognise this.

Based on the Lohne and Severinsson (2006) explanation that hope is something that is created out of suffering, we can further connect the narrators' experience of

chaos with this. This experience of chaos gave rise to feelings of no control and struggle, and underlying this is the personal suffering. The narrators seemed to attempt to overcome these feelings with the use of self-injury. Without the suffering, there would be no need for self-injury. This push for action, as discussed earlier, is hopeful. It seemed that without the action and self-injury, hope could not exist.

The discussed earlier societal and cultural constraints placed on individuals indicate that there are not available and socially acceptable storylines for those who self-injure. Therefore, people do not have an available narrative that they could adopt. This means that they struggle to find meaning in their behaviour, and for most of the time, their suffering stories are not well defined. This lack of access to positions can be also inferred from the narrators' difficulty to tell their stories and lack of words to describe them. However, it seems important to note here that within this, the narrators find a way to tell their stories that works for them, even if this is not a 'conventional' way.

The type of hope described here seems to be in line with the description of mature hope by Lemma (2004), which she claimed has its roots in the acknowledgements of loss and arises out of internal conflict. In the case of the present study, the narrators' arrival at the point where they could acknowledge that they suffered, but they could carry on living, became the point at which they would self-harm. Without this acknowledgement, taking the action would not have been possible. Furthermore, many of the narrators in the present study described experiencing feelings of guilt and shame straight after self-injury, and these feelings were described by Lemma (2004) as accompanying mature hope.

Hope can also be presented in accordance with the model of hope proposed by Snyder (2002), who defined it in terms of goals, agency, and pathways. Hope within self-injury can be seen as the narrators' ability to set a goal; it then involves the belief that he/she can reach this goal (agency/motivation), followed by the ability to plan specific steps in order to reach them (pathways/thoughts). In line with this model, the goal for the narrators in the present study seems to be getting to the point of feeling better and overcoming chaos. The pathway through which this is achieved is the process of self-injuring. The act of the narrators' self-harm is

an expression of agency on their part. For most, the moment of self-injuring is the only time when the narrators showed their agency. The narrators find it rather difficult to use alternative ways of achieving their goals other than through self-injury. As Snyder (2002) described, a person who has high levels of hope can find multiple ways to achieve their goals, unlike those with a low level of hope who tend to find fewer ways of reaching their goals, and some may not be able to find any. In the present study, the narrators, most of the time, were able to arrive at the moment where they could feel better in one way only, through the process of self-injury. However, some started to think and consider utilising other forms as well, such as talking to a friend, partner, crying, arts, etc.

In order to further explore hope within self-injury, it is important to consider both concepts in relation to suicide or attempted suicide. Rand and Cheavens (2009) predicted that "hope is likely to be inversely related to deliberate efforts to harm (e.g. suicide, self-injury, violence towards others) as these efforts are not compatible with physical health goals" (p. 328). They supported this claim with a study done with patients recovering after suicide attempts, who presented with lower levels of hope compared to the control group (Vincent, Boddana, & MacLeod, 2004). However, suicide and self-injury are different concepts, with suicide being a sign that an individual has lost all hope and they have given up the fight, although there are also other reasons that people commit suicide, such as to "make others better off" (Brown et al., 2002, p. 111), perfectionism, to express anger, and for manipulative reasons such as punishing others (Boergers et al., 1998).

In the present study, it emerged that self-injury was something that occurred in cycles, with each cycle being a serious of chaos, self-injuring as a means of telling a story about the chaos, and getting to the point of being able to say *"I'm good"*. Therefore, in the most simplistic way, the main function of self-injury is to get to the *"I'm good"* point. However, those who attempt suicide do not aim to get to the *"I'm good"* position, but rather their goal is to stop everything all together, to stop life. As much as self-injury will be a story that continues and this also seemed to be its main aim, suicide does not have a story to be continued as its main aim is put an end to the story of one's life. This places an emphasis on the intent of an action as an important feature in understanding and differentiating self-injury from attempted suicide or suicide. However, it is important to acknowledge that intent is a complex

concept and the boundaries between self-injury and suicide/attempted suicide can be very blurred at times. Moreover, if attempted suicide does not have an end to the person's story, it may also require the person to develop a narrative about this event that incorporates continuity of one's life.
However, in this context, the present study confirmed that self-harm is an attempt to survive (Babiker & Arnold, 1997) and sustain life rather than to end it (Sutton, 2007). This also represents the hope that is associated with self-injury. Menninger (1959) pointed out that "hope is […] the major weapon against the suicide impulse" (p. 485).

Most of the narrators spoke about the future during the interview only after they were asked questions about it. Furthermore, when asked about hope in their lives, even though I did not specify what kind of hope I had in mind, a few people spoke about their hope in relation to their self-injury. This seems to be an interesting story in itself. It is possible that this is related to the cyclical narrative that does not allow for the hopes to be developed beyond achieving the main and immediate aim of ending the chaos and generating meaning.

Based on this, it can be concluded that the self-injury story is a narrative about the cycles of hope and chaos. The hope is associated with arriving at the point where a person can say *"I'm good"* and the use of self-injury as a way to tell a story about personal suffering and chaos. This type of hope has been identified as a concrete hope. Its aim is to get to the well-defined goal and to get there each time. It seemed that telling stories in this way gives some justification for the narrators' continued engagement with self-injury. It can be noted here that the nature of this kind of hope is short-lived. This potentially could explain a large drop-out amongst potential participants, who may not be able to maintain the hope that the research or telling their story would provide what they hoped it would after making an initial contact.

4. Evaluation of the Study

4.1. Limitations

In thinking about limitations of the present study, it has to be acknowledged that only one male narrator was included. Even though no difference was observed between the narrative told by the male and remaining narrators in terms of themes generated and other aspects of the narrative, the male narrator seemed to be the one for whom self-injury was more frequent and severe compared to the remaining narrators. However, analysis of possible gender differences could not be explored fully. It may have been beneficial to balance the ratio of participants in the present study; however, no other males expressed an interest to take part in the research. As discussed in the 'Introduction' chapter, it is possible that male self-injury is more hidden due to the social construction of males as being capable of coping with life adversities.

The stories that were generated by the narrators were co-constructed by them and the researcher. It is possible that some of the themes would not have been brought up, or not in a great depth, without the researcher's prompting. Furthermore, Yardley (2008) proposed to allow the narrators to give feedback with regard to analysis and findings from the research to confirm the emerging themes. However, due to time constraints, this was not possible; therefore, the interpretation constitutes my own understanding of the narratives.

Further, the researcher has not managed to include individual descriptions of each narrator due to the restraints on the length of this thesis. The focus was placed on drawing on commonalities between narratives. It can be argued that the individual accounts were compromised as a result and not presented to reflect the uniqueness of the narrators' experiences.

4.2. Future Work

With regard to recommendations for the further research, it would be interesting to look into the function of language in more depth. The present study noted the

difficulty of the use of language and the functions that it played in the stories, such as justification of self-injury, making a claim to the behaviour, and denying any significance of self-harm. Therefore, an exploration of the use of language by people who self-injure may result in further insights into the functions and constructions of the behaviour.

The cyclical narrative in which self-injury was constructed as one of the main characters is an important finding in the present study. It would be worth collecting narrative biographical accounts of stories by people who self-injure to establish whether self-injury is still preserved as one of the main characters. This could further help to determine whether their life stories can still be classified as cyclical narratives. Moreover, it may be worth replicating this study in different contexts, such as inpatients, prisons, or with those in the community undergoing treatments, to establish how people living in different settings make sense out of their experiences and what kind of stories are being produced in other contexts.

Additionally, interviews with adults who used to engage in self-injury but consider themselves as not reliant on the behaviour could provide some insight into how people cope and make sense out of chaos in their lives and whether chaos persists when the behaviour stops. This may also help to gain some insight and generate ideas on possible treatment options for those who wish to overcome the behaviour.

In terms of further ideas for research, it would be interesting to establish what the construction of hope within different groups are when employing a much broader definition of self-injury than the present research, and with a larger number of participants. Furthermore, it may be beneficial to ensure more balance in terms of the male participants' sample.

Additionally, the cyclical narrative has been something new and this type of narrative may be interesting to look at more carefully. It is possible that other groups, especially those who use their behaviour as a coping strategy, may tell similar types of narratives. This is based on the assumption that if the behaviour is

constructed as a coping mechanism, a person telling a story needs to go back to it over and over again. As a result, this may produce a cyclical narrative.

4.3. Implication for Practice and Research

From the narrative perspective, self-injury is a way of telling stories about personal struggles and difficulties. Looking at the concept of hope within self-injury allowed the researcher to establish that as self-injury can be seen as hopeful, it represents a way in which the narrators can achieve their goals, as represented in the model of hope by Snyder (2000). This seems to provide a rationale for those interventions that teach individuals skills related to setting up goals and planning for their achievement. This also helps to understand why these types of treatment models that focus on goals still contribute towards decreasing frequency of self-injury, even though they do not attempt to approach underlying self-injury difficulties. As a person learns to set goals, is encouraged to develop ways of achieving them, and takes steps to pursue them, his/her hope increases. Therefore, an individual's ability to set multiple ways of achieving goals should increase as well, allowing a person to think of other ways to feel better, not only through self-injury. This should then decrease the behaviour.

The proposed way of thinking about self-injury in this study can be of help to professionals, families, and clients alike in overcoming the lack of understanding of the behaviour, as reported by studies into attitudes (Best, 2005; O'Donovan, 2007; Short et al., 2009; Simm et al., 2008). This way of conceptualising self-injury moves away from seeing the behaviour as pathology and may provide a shared language for all. In the present study, self-injury is a result of an inability to communicate and express in other ways. It seemed that difficulty and interruptions in communicating with other professionals, as reported by a number of studies, mirrors the process that those who self-injure experience. Promoting better communication can allow people to start expressing themselves in other ways and can consequently help to reduce the reliance on self-injury.

Furthermore, this study reinforces the importance of early interventions with children and adolescents. An attempt should be made to teach from a young age

how young people can express themselves and tell the stories of their suffering. Additionally, it seems that the concept of hope can prove to be useful here. However, this would also require those around them to be able to listen and not ignore those attempts at communication. This points to the need for training of teachers, as they become the primary source of contact for many young people, and may help to identify those at risk.

The proposed conceptualisation of self-injury as a way of telling a story about the chaos in people's lives and gaining some sense of control contradicts the idea of treatment approaches that target the behaviour itself, such as that proposed by Berk, Henriques, Warman, Brown, and Beck (2004). In accordance with the present study's results, the treatment options should be directed towards the underlying difficulties, which supports the user-led literature and perspective. This can be achieved in many ways, but it seems crucial that an individual also learns new ways in which chaos can be expressed, whether through the use of language, art, music, play, sports, etc. With this respect approaches that incorporate elements of skills training, such as DBT, or CBT, can be helpful as they allow an individual to expand and explore different forms of expression. However, it has to be borne in mind that those methods have to be in line with what a person wants, rather then being imposed by therapists, as it is possible that individuals may have different views. The misalignment between the goals of a therapist and a person in therapy can explain the reason why some people do not manage to decrease the frequency of self-injury or get back to it as soon as the therapy is over. It is important to note that what will work is a very individual thing and this places considerable importance on good and thorough assessments that would support people in their discovery of ways that can work for them.

The present research adds another argument against the classification of self-injury and suicide as the same concepts, and places importance on clarifying the terminology in the field of research and clinical work. This may further help clinicians working with people who self-injure by informing a clinical practice. It seems that the research world at times forgets about individuals behind the research using language and terminology that further stigmatise those who already struggle with many difficulties, reinforcing the idea that the behaviour

needs to be hidden. Moreover, it takes agency away from those who already feel that they have none. This also highlights the need for more clinicians to get involved in the design and conduct of research.

I think that both the present research topic and the narrative method chosen to analyse the data have a great relevance to counselling psychology and its philosophy, with the most important aspect being an attempt of this study to build an understanding of self-injury that is not constructed around a medical model and psychopathology, but rather around hope. Additionally, this study highlights the importance of having an open mind and listening ear as the stories of suffering unfold. This is the only way to gain a better understanding of people who self-injure.

I wish to conclude this chapter and the research with two quotes from interviews with Lily and David. I feel that they summarise well the main themes of this work:

> ***Lily:*** *"Because it's because it's [self-injury] always there and I think it has to come to a natural stopping. Yeah, maybe I wanted consciously to stop because I thought it was a bad way of coping with things and I think it should be a better way but I didn't have another way. It was the only thing that could help me survive in the situation so even if I wanted to stop I couldn't. Umm so yeah, it turns out that I try to stop and then something would happen that I needed to get through and I needed to use it to get through it."*

> ***David:*** *"[scars] it's it's like a record of my past. They are bad experiences that I've gotten through. And I wouldn't give up the scars I have now but I really don't want any more."*

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Appendix 1: Individual Narrative Analysis Stage

An example of the individual transcript analysis from the interview with Olivia is presented below.

S E L F - I N J U R Y S T O R Y

Beginning:

- first time out of curiosity and sister saw it (when about 11) 96-106; 105
- when playing baseball and not catching the ball – scratching instead of cry 42
- her part taken from her during drama class; not wanting to cry; scratched herself 372-392
- didn't take responsibility 565

Middle:

- 'having psycho-moment' (grade 12) 57-80; 205-242; 508-527
- stopping by smoking pot 571

End:

- not as often as it used to be – maybe every six months 356
- would like to get better and stop harming herself 466
- taking responsibility for her own actions 567
- taking part in the research as first time being open 803
- hopes for longer breaks between self-harm 815

S T O R I E S W I T H I N T H E S T O R Y

- about first time self-harm 42-48; 372-392
- about having 'psycho-moment'; wanting to go dress shopping 57-80; 508-527
- about mother getting her a puppy to stop self-harming 146-151
- about growing up with her sister and how she treated the main character 285-318
- about going to see a psychologist 456-463
- about having a blood clot 483-487
- about wanting to buy a car 496-508
- about school girls relationship 640-651
- about suicide 657-678
- about taking photos 732-754
- about hope
- about hopelessness

C O N T E N T

What type of story is being told?

There are some elements of the restitution narrative – the goal is to stop self-harm altogether, but there is something repetitive in the story. Further, this goal appeared only after I asked about hope. So, it seemed that the story was going nowhere.

Who are the main protagonists and what happens to them?

- person telling the story – has very strong emotions. Others are not able to deal with them; she is being bullied by her sister and mother; directs her anger inwards; rather shy; doesn't share her problems with anyone; doesn't want to be seen as 'crazy' or weak or that others need to help her; doesn't want sympathy from others
- mother – has a lot of stress; doesn't understand what's important for others, her business seems more important
- sister – harsh and critical, a bully; angry a lot of the time and directs this anger outwards; often puts down
- father – not involved in the emotional side of things; works a lot and mainly supports the family financially
- self-harm – powerful; allows the main character to express her heightened emotions; makes her feel better and deal with life; can get out of control and needs to be controlled; needs to be hidden otherwise people would think that the main character is weak and crazy; comes back and is being used every six months
- hope – not very strong; related to getting better and stop self-injuring, but main character settles on hoping that the breaks between her self-injury can get longer

Who is narrating?

- not able to stand up for herself, but also
- someone who appears strong
- have strong emotional reactions
- feels angry, upset and enraged with mother and sister
- would like to be able to express emotions outwards
- explains mother and sister behaviour
- feels not understood

As a victim

- things happen to her
- she is not as good as others
- invalidated by close family

As a victimiser

- bullies herself
- self as crazy

Does the story have a clear direction?

Beginning and middle - kind of circular, no clear direction
End of the story – progressive towards the goal, which is stop to self-harm, but not entirely sure (?)

T O N E

How is the story being told?

- in first person but there are some third-person elements as though she doesn't commit herself to what she says
- a lot of citations, such as I said: '..'; I thought '….' – this is written a little like a play

What kind of language is being used?

repeats "you know", "right" – lack of self-esteem; looks for approval

Using language of externalisation and justification of self-harm:

- self-injury as 'it'
- it's not her, it's self-harm or others
- self-harm is crazy; she's crazy; anger is crazy

- a lot of repetitions of single words – to add dramatic features to the story

Is the delivery flat or emotional?

emotional

- changes in intonations
- becomes emotional on two occasions: 1) talking about her suicide attempt and friend coming to hospital to give her something she had made; 2) started crying when talking about worrying that no one will ever know how bad she really feels
- described having heightened emotions, especially anger that no one can deal with

What is the tone of the story?

- pessimistic and then towards the end optimistic – she hopes that she can stop and have a future; she is hopeful at the end
- tragedy

Does the speaker seek agreement from the listener?

yes, I think this is the function of "right?", indicates low self-esteem and a lack of belief in herself

What may be the rhetorical function of the narrative?

beginning and middle – excuse and justify
end – persuade
entire narrative – to tell her story for the first time

T H E M E S

What are the thematic priorities of the text?

Relationship with the self
Relationship with self-harm
Relationship with others
Relationship with hope
Relationship with hopelessness

What are its key themes?

- interview as a way to say her story for the first time 8
- wants openness and acceptance 20
- want others to understand better 12
- self-harm not taken seriously 18
- others think those who self-harm are crazy 22
- she wants more understanding 23
- self-harm instead of cry (not wanting to show emotions to others) 44; 380
- hiding emotions 46
- hiding self-harm 52; 400
- not wanting others to see 46
- self-harm due to stress 48
- lies to cover self-harm 55; 403 (needing an excuse for others)
- anger, upset, and getting mad leads to self-harm 62; 106
- feeling out of control 73
- self-harm helps to calm down 75
- out of control leads to self-harm 78
- sister moralising about scars and disapproval 103; 106
- others don't know what to say/ how to react 120
- others have a hard time dealing with her self-harm 134
- self-harm prevents thinking about consequences 125
- others don't understand 141
- not admitting having a problem – trivialising self-harm 143; 240
- "it doesn't make me feel good but it does" 177
- self-harm calms her down and makes her feel good 181
- doesn't want to self-harm 187
- regrets self-harm afterwards 188
- self-harm about dealing with pain, scars 194
- hiding from others and not telling anyone 196
- self-harm as build up 201
- invalidated by others 208
- invalidating self 215
- anger, rage, guilt emotions accompanying self-harm 213
- feeling almost empty after self-harm 226
- criticising self 236
- self-harm lets emotions out 252
- angry at self 250

- bullying self 251
- getting urge to self-harm 256; 265
- feeling angry, rage, mad at family members and self 261
- self-harm as build up of energy 265
- self-harm is to do with loss of control 270
- anger and inability to think 274
- being bullied by sister 296
- growing up with angry sibling 291
- sibling and mother took their anger out on others 296
- not reacting to bullying – hiding and self-harm 297
- fighting at home 308
- improving relationships in adulthood 313
- getting angry = going crazy 316
- self-harm related to sister and mother 327
- introverted self 334
- having social anxiety 337; 342
- isolating herself 335;
- defending mother's behaviour 348
- close relationship and attachment with mother and sister 358
- not having these reactions with other people 362
- seeing self as not good as… 377
- feeling disappointed and sad leading to self-harm 386
- effect on life – wearing long sleeves 413
- others would judge if they knew 409
- hiding scars 418
- trivialising 432
- avoiding talking about it 431
- doesn't want sympathy and people to help because of it 437
- doesn't talk about feelings 449
- recognising need for help 453
- admitting having problems 465
- research as invitation to open up 462
- hopes to get better 467
- regrets self-harm afterwards 469
- wants to be able to express her feelings outwards 470
- others can express how they feel 475
- keeps things in and dwells on them 476
- mother doesn't understand importance of things 494
- imagining self-harming in front of family (those who caused feeling) 516
- wish to punish family for hurting her feelings 519
- scars as a reminder of hurt, problem, and damage 549
- after self-harm feeling calm and normal 542
- scars are important 545
- reminder to control herself otherwise she may kill herself 552
- did not used to take responsibility 566
- taking responsibility for actions 567
- stopping self-harm with smoking pot – feeling calm 571

- coping self-harm or smoking pot 571
- attempting suicide 596
- wants to feel one feeling consistently 607
- search for meaning – something to live for 612
- life = energy 620
- recognising the need to face problems 622
- looking into the future – wanting children, marriage, things to be better, help others, fix herself 629
- shying away from people, not wanting closeness 650
- wanting attention leading to suicide attempt 663
- cutting legs because easier to hide 682
- having damaged nerves and soreness result of long-term self-harm 692
- wanting to self-harm badly and see blood 706
- taking photographs 709
- progression of self-harm, when young had a lot of little scratches 716
- pain not as important as damage 722
- importance of scars and after-effect 729
- hopes to delete photos eventually 734
- photos as evidence of emotional suffering 743
- worrying that no one will ever know the pain she is in 747
- wanting for someone to care but not wanting 752
- not knowing the reason for taking photos 769
- feeling hopeless after self-harm 773
- hope hurting herself by her own 794
- interview is a hopeful thing – being open for the first time 800
- never asked for help 804
- wanting someone to help – specialist maybe 810
- not self-harming as often as she used to 813
- admitting the problem 818
- hopelessness as not having control 837
- struggle between hope and hopelessness 842
- self-harm like addiction which gives her hope 848
- self as crazy 862
- self-harm associated with abuse 863
- she wasn’t abused but has extreme emotions 867
- self-harm way of dealing with emotions 869
- others judge those who self-harm 880
- family can’t cope with her self-harm 886
- others would think she’s fragile, treat her differently, be on guard 895
- people’s self-harm different 910
- self-harm as way of coping with problems 919
- doesn’t want to self-harm 934
- wants to stop 945
- self-harming when out of control and can’t control emotions 954
- wanting to care for self and love herself 693
- able to say to others don’t ask rather than lie about scars 977

The function of self-harm:

- to calm down
- to feel normal
- release emotions
- to cope with emotions

Reasons for self-harm:

- loss of control over emotions
- strong emotions
- build up of energy
- anger, rage, upset

Triggers:

- mother and sister undermining main character's needs and wishes
- bullying by them

What's important in self-harm:

- blood
- scars
- after-effect
- not so much the pain

F U N C T I O N S (s o c i a l & p s y c h o l o g i c a l)

What kind of identities are being constructed in the narrative?
(who is the person brought into being by the narrative)
someone not understood; having strong emotions; needs to repeat everything a number of times; she is a victim; bad things happens to her and she is not able to stand up for herself; wants to have some control; wants to punish people for what they do to her

How does the narrative position the protagonist?
weak; avoiding people and conflict; not able to speak up for herself

How does it position other people in relation to the protagonist?
as powerful but also powerless when she harms herself (they are not able to do anything/help her);

How much agency does the narrative offer its protagonist?
main character – not much; she responds to what happens with her, does not instigate it

Who is and who is not powerful within the story?
powerful – self-harm, mother, sister
not powerful – main character, hope

In whose interest do events unfold in the narrative?

in the interest of the main character

Who gains and who loses as a result?

gains: main character

loses: others (as they not able to connect with her, understand her)

R E S E A R C H E R ' S R E F L E X I V I T Y

How the interview makes me feel? My reflections on reading

- I'm not sure about this narrative and interview. There is a way in which she talks that it feels like she is making circles (goes back to the same story a number of times)
- The way she spoke seemed a little confusing. I felt lost at times
- Repeated everything a number of times and I felt as though she thought that I am not able to understand her (this may resemble the way she feels in relationships with other people – not understood, and also confused and lost)
- A lot of repetitions of 'you know', 'right', 'crazy' and laughter
- Maybe she is generating a narrative as she speaks, maybe she does it for the first time
- Explains other people

Appendix 2: Leaflet

Do you intentionally injure yourself?

Would you like to tell your story?

I would like to invite you to take part in a research

My name is Edyta Pazera and I am a trainee counselling psychologist studying at City University London. I am looking into self-injury as part of my research for my doctoral thesis. ***I am researching the phenomena of hope and hopelessness in experiences of individuals who injure themselves****, and I am looking for people who would be willing to share their stories with me in a safe and non-judgmental environment. Your contribution will help deepen the understanding of self-injuries behaviour.*

To take part in this research, you need to be:

- at least 20 years of age
- in employment (part-time or full-time)
- relying on self-injury from time to time
- without suicidal intentions and
- not currently undergoing therapy or counselling

Participation will involve taking part in an **interview** and it will require time commitment of about **90 minutes**. Interviews will be treated with strict **confidentiality** and your identity will be protected at all times. Your time will be much appreciated and travel expenses can be reimbursed.

If you would like to take part in this research or wish to find out more information, please contact me by e-mail or at the number below

This research is supervised by Dr Renata Pires-Yfantouda, email: renata.pires-yfantouda.2@city.ac.uk

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CITY UNIVERSITY LONDON

Appendix 3: Information for Participants

Study Title: "A Narrative Analysis of Stories on Self-Injury"

You are being invited to take part in a research that is being carried out to fulfil the requirements for a doctoral degree at the City University London. This study has been reviewed and given an ethical approval by the City University Ethics Committee.

I would like you to learn a bit more about this study in order for you to decide whether you would like to take part in it. Please take time to read the following information carefully.

What is the purpose of the study?

The purpose of this study is to investigate phenomena of hope and hopelessness within self-injuries behaviour. In particular, I am interested in understanding how people who injure themselves construct meaning when they talk about their experiences. Many research within this field are conducted with a hospital population, and there is insufficient data based on people living in community. Your contribution will add to the existing body of knowledge on self-injuries behaviour and may contribute to the future development of treatment programs.

Who can take part in this research?

I am looking for male and female participants who are in employment (at least part-time) and who are above 20 years of age. For the purpose of this research, I am looking for people who injure themselves but have no suicidal intentions and currently do not undergo a therapy or counselling. By 'injury' I mean an intentional act that causes the destruction or alteration of body tissue. This includes behaviours, such as cutting, scratching, burning, bruising, skin picking or head banging, and excludes tattooing, piercing, alcohol and drug use, and eating difficulties.

What if I am not sure if I would like to take part in this research?

That is absolutely fine. It is your decision on whether to take part in this study. Your participation in the research is voluntary and should you decide to take part in this study, you still have the right to withdraw from it at any time without prejudice. In this case all your data will be immediately destroyed.

What will happen to me and my answers if I take part?

I would like to ask you to take part in an interview that will be voice-recorded. This interview will be conducted by myself and will give you an opportunity to tell your story in a non-judgmental environment. The interview should take about an hour to complete but you will need to allow an additional 10 to 20 minutes for any questions you may have. The interview will be transcribed and all your identifying details will be removed. The materials will then be analysed together with other participant's interviews. Quotes from this interview may be used anonymously in the final report and publication.

All information submitted is anonymous and will be kept strictly confidential. All the materials will be kept for a period of six years from the date of this interview and will be securely destroyed thereafter.

Finally, we will have a short debriefing session after the interview, which will provide information about the sources of possible support and will give you an opportunity to ask any questions that you may have.

What if I decide to take part?

If you decide to take part in this research, I will be asking you to read and sign the consent form before we start the interview. The interview will take place at an agreed time and location (the location can be a pre-booked room at the City University or your home). If you agree to meet with me, I can reimburse your travel expenses (travel card, bus pass, etc.). If it is not possible for us to meet in person we can also arrange to conduct the interview via Skype. In this case you would have to make sure you have a reasonable Internet connection and space where you feel comfortable and safe to speak freely.

Thank you for your time and expressing an interest to take part in this research. Please do not hesitate to contact me if you would like some more information.

Kind regards,

Edyta Pazera

Researcher's name:	Edyta Pazera
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Mobile:	077 0967 7707
Supervisor's name:	Dr Renata Pires-Yfantouda
Email address:	Renata.Pires-Yfantouda.2@city.ac.uk
Phone number:	020 7040 3306

Appendix 4: Consent Form

Title of study: A Narrative Analysis of stories on Self-Injury

Investigator: Edyta Pazera

PARTICIPANT'S CONSENT

Please read all the information below and certify with your signature that you have understood the statements:

- I understand that I must be at least twenty years old to take part in this research.
- I understand that this interview constitutes a research investigation and it is not a therapy session.
- I have been informed of and understand the purpose of this study and its procedures and I wish to participate.
- I also understand that in the debriefing session at the end of my participation I will have an opportunity to ask questions about this study.
- I understand that the data collected for this study is strictly confidential and I will not be identified in any report of this study.
- I understand that quotes from the interview may be used for the purpose of writing up a final report and publication. I understand that this will be used anonymously so I will not be identified through it.
- I understand that all the raw interview material will be destroyed after six years of taking part in this study.
- I further understand that my participation in this study is voluntary and I may stop the interview at any point and/or withdraw from the study at any time without prejudice to me.

Name …… Signature …….. Date……

RESEARCHER'S STATEMENT

I have informed the above named participant of the nature and purpose of this study and have sought to answer their questions to the best of my ability. I have read, understood, and agree to abide by the Ethical Principles for Conducting Research with Human Subjects set out by the British Psychological Society in carrying out this research.

Researcher's signature: …… Date: ……..

Appendix 5: Interview Guide

INTERVIEW GUIDE

1. Could you please tell me what made you take part in this study?
2. Could you please tell me in your own words about your injurious behaviour? I would like to find out things, such as how it started, the progression and where you are at now. There is no right or wrong way of doing it; Basically, I am asking if you could tell me your story.
3. Do you think that hope is a phenomenon present in self-harm?
4. How about hopelessness, is it associated with self-injury?
5. What does hope mean to you? What about hopelessness?
6. Could you please tell me about hope in your life?
7. Could you please tell me about times when you lost hope?
8. Could you please think about something that you had experienced, seen, read or heard that made you more hopeful/hopeless?
9. Is there anything else that you feel I should have asked, or that you would like to add?

Examples of probing questions

- Could you please tell me more about…?
- Could you expand on…?
- What do you mean by…?

Appendix 6: Reflective Interview Guide

REFLECTIVE INTERVIEW

1. How do you feel at the moment?
2. How did you find the interview?
3. Were there any moments that seemed particularly difficult?
4. Is there anything that you think I could have done better or differently?
5. Do you have any questions at this point?

Appendix 7: Debrief

The debrief form for the UK-based participants.

DEBRIEF

Thank you very much for participating in my research.

If you would like some more information you can go to the UK National Self-Harm Network website at www.nshn.co.uk, or you can call their helpline (from UK) at 0800 622 6000 (open 7pm-11pm Thursday-Saturday, and 6.10pm-10.30pm Sunday).

You can also call UK Samaritans at 08457 909 090 (24 hours service) or visit their website: www.samaritans.co.uk.

You can also check one of these websites:

- Befrienders worldwide: www.befrienders.org (offers information about support available around the world)
- First Signs: www.firstsigns.org.uk
- Bodies Under Siege: http://buslist.org/phpBB
- Psyke.org: www.psyke.org

Please do not hesitate to contact me if you have any queries arising as a result of this interview.

Thank you very much for your time!

Edyta Pazera

email address: edyta.pazera.1@city.ac.uk; or research@self-injuryStory.info
mobile: 077 0967 7707

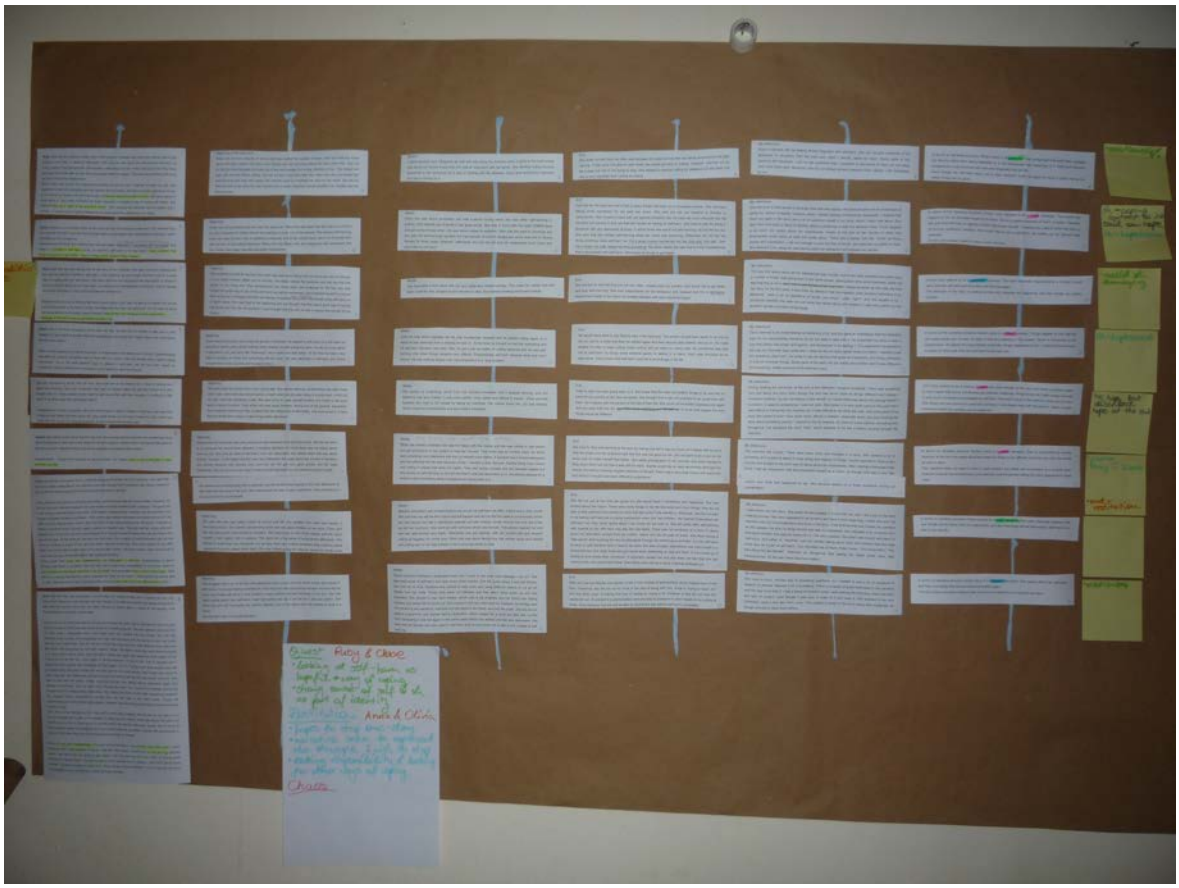
Appendix 8: Transcription and Citation Key

(.)	a short pause
(.3)	a pause lasting three seconds
(laugher)	a participant's laugher
(gesture)	a participant's non-verbal communication
{R: text}	the researcher's speech
[…]	some part of the text/quote removed
[text]	an added comment or explanation
..	suspended sentence
<u>text</u>	overlapped speech

Appendix 9: Synthesis and Theoretical Level Stage

The process of development of themes and the researcher's engagement with the data at the synthesis and theoretical level stage is presented below.


SELF – HARM
OTHERS
SELF
HOPE
HOPELESSNESS
STRUGGLE
CONTRADICTIONS
Not having WORDS
AGENCY
Communication
break!
bond w/ self & other
Doesn't tolerate difficulties
significance of relationships
Ownership of self-harm
Ownership of scars
remembers story behind scar
to stop suicidal thoughts & lesser evil
justification
excuse
anger
about process of cutting
sh – quick fix
enjoyment from pain
enjoyment from 'it'
because of family
additional stress when not sh
having control over it
getting cravings
not ashamed but hiding
not damaging
fear of sh
as way out as hope!
sh when things difficult
sense of pride
way to get feelings under control
sh's in private home
heighten state of emotions not hopelessness
coping
cutting when too easy
feeling in control when cutting
creative
she's fine
sh resolved it
younger siblings arguments did not lead to sh
against her
family arguments lead to sh
inferior
partner
calm doesn't argue thinks same
partner no sh cause
see sh as suicide
partner same as her
see sh as part of depression suicide
could find it uncomfortable
difficult & horrible
confusing relationship
father the cause of arguments
father supportive
father they not that close
mother cause of sh
very close to mother
mother invalidates her
Light at the end of a tunnel
situation = solution
Self-harm because allows to cope
Suicide – no way out
emptiness
hopelessness to do with environmental issues
no solution leads to bad consequences
environmental issues
sh heightens emotions hopelessness is not
caution & considerate person
overbearing to others (siblings)
school – not popular attention seeking
school – bullied controlling & authoritarian (siblings)
self lies & the world & events as TRUTH
'rebel'
when young would agree to parents
disagree naked for attention
strong minded
strong sense of identity & self
self-destructive tendencies
older sister (siblings)
Do not tell stories
Sky
Controlled
identity taken away in arguments
causes anger resentment hopelessness
attacks on self trigger sh
evolving self & discovering new things



PART 2

PUBLISHABLE PAPER

"Scars tell my story":

Narrative Analysis of Self-injury Stories

Prefix

Presented in this section paper has been prepared for submission to the *Social Science & Medicine* journal. The criteria for submission has been lifted from the journal website and can be found in the Appendix to this part of the thesis.

Cover Page

Title: *"Scars tell my story"*: Narrative analysis of self-injury stories.

Author: Edyta Pazera, Jacqui Farrants

Correspondence: Edyta Pazera, with the complete address, telephone, fax number, and email address

Acknowledgements: The author would like to thank all those who agreed to take part in this research and share their stories.

Research Highlights

- Self-injury is a way in which a story of suffering and difficulties in a narrator's life is told.
- Scars can be perceived as a voice, and they resemble words and sentences; they are the embodied symbol of suffering.
- Body is seen as the witness of experiences, and a personal diary on which the story of suffering is written.
- The narrators constructed self-injury as a way in which a person attempts to look after himself/herself.
- Self-injuring replaces the process of telling stories, and therefore it serves the same functions as narratives.

Keywords

Self-injury, self-harm, story, narrative, narrative analysis

Abstract

Self-injury is considered as a major public health problem and a common reason for hospital admissions. It is seen by many as a dangerous, self-destructive behaviour and psychopathology. However, there is also a view, which is not as widely shared, that gives attention to the positive aspects of self-injurious behaviours. From this perspective, self-injury is seen as an attempt to survive. The aim of this research is to explore the narratives of those who self-injure in order to deepen the understanding of the behaviour. As this study was interested in exploring each individual's subjective experience, the qualitative method of inquiry was deemed to be most appropriate. Eight individuals took part in narrative interviews. The data was analysed using the narrative analysis method. The results showed that those who took part in this study constructed self-injury as a way to tell stories about underlying suffering and give some meaning to those experiences. Further, self-injury is understood by the narrators as a way to take care of themselves. The body of the narrators becomes a witness of this suffering, and scars are presented as the embodied symbol of painful experiences and a tangible 'proof' of what they had been through. Based on this, it can be concluded that promoting better communication may allow people to start telling their stories in other ways aside from self-harming (verbal, art, writing, etc.), which should help to reduce the reliance on self-injury.

Introduction

Studying self-injury has been a challenge due to the lack of clarity and consistency amongst clinicians and researchers in the field, who often adopt terms without giving explicit definitions. This makes it difficult to establish what forms of self-injury are being under investigation (Nock, 2010). Therefore, this research adopts a definition that has been found to be widely accepted, and is in line with the definition recently proposed by Glenn and Klonsky (2011) for non-suicidal self-injury. They described it as "a class of behaviours defined by deliberate, direct, and self-inflicted tissue damage, without suicidal intent and for purposes not socially sanctioned" (p. 751). This definition incudes behaviours such as cutting, hitting, biting, scratching, banging, burning, scraping, and wound-picking. Excluded in this definition are behaviours such as piercing or tattooing, overdosing and self-poisoning, substance abuse, eating disorders, and any harm to the self with a suicidal intention in mind. Some researchers and writers conceptualise self-injury and suicide as the same, and use one term to describe them both. However, research has shown that self-injury and suicide are very different concepts, with the former not intended to end one's life (Gollust, Eisenberg, & Golberstein, 2008). As argued by Korner (1970), suicide indicates a person's total acceptance of unavoidable, feared, and threatening results, whereas self-injury signifies something exactly the opposite. This can be well illustrated with the quotation: "It is easy to forget that dripping blood may accompany birth as well as death. The scars […] signify an on-going battle and that all is not lost…" (Favazza, 1996, p. 322).

Even though there has been an increase in research in the area of self-injury, the behaviour is still not well understood (Skegg, 2005). Self-injury is seen

by many as a dangerous (Hawton, 2004) and self-destructive behaviour (Linehan, 1993) or psychopathology (Nock, 2010), and a major public health problem (Kapur, 2009). This is reinforced by negative associations between self-injury and mental illness. Very often people who receive a diagnosis of post-traumatic stress disorders, personality disorder, dissociative identity disorder, bipolar disorder, and schizophrenia self-injure themselves (McAllister, 2003). Further, self-injury is a common reason for hospital admissions (Kapur, 2006; Kapur, 2009). There is a fairly common view that those who self-harm contravene the basic human drive for self-preservation (McAllister, 2003; Nock, 2010). These negative views of self-injury, coupled with lack of knowledge and little understanding of self-injury, contribute to the negative attitude amongst society and even those who care for people who self-injure (McHale & Felton, 2010).

Much research within the field of self-injury has focused on the functions of the behaviour, prevalence, and attitude of clinical or adolescent samples. Therefore, those reviewing literature in the field of self-injury have called for more attention to be given to the "natural history of self-injury in the general population and beyond adolescence" (Chandler, Myers, & Platt, 2011, p. 102). Long, Manktelow, and Tracey (2012) appealed for qualitative research that aims at presenting perspectives of those who self-injure in order to "deepen understanding of the issue, enabling people to share their experiences and advancing practice in a meaningful way" (p. 7).

Long et al. (2012) pointed out that those generalisations have been developed as a result of the majority of research on the subject of self-harm being conducted within a hospital population. They argued that the community sample might differ significantly. Additionally, it has been estimated that the majority of

those who self-injure do not get in touch with mental health services (Boynton & Auerbach, 2004). Therefore, more research based on a community sample is needed.

There is also a view, which is not as widely shared, that gives attention to the positive aspects of self-injury. Babiker and Arnold (1997) postulated that self-injury is an attempt to survive and has a role of sustaining life (Sutton, 2007). The behaviour has been confirmed by a study to be a form of self-care, where a person attempts to end suffering and free himself/herself from a psychic pain (Schoppmann, Schröck, Schnepp, & Büscher, 2007). Moreover, Motz (2009) argued that self-harm is a silent language, which has a function of communicating a person's emotional state to others and oneself. The memories of trauma and suffering are being 'written' on the body of a person who self-harms (Straker, 2006). This view is in line with those insights promoted by Self-Harm Survivors' Movement literature and writing. They claim that self-harm is a reasonable response to an unbearable distress, rather than an attempt at suicide or an attention-seeking behaviour (Pembroke, 1994). They also argue that self-harm releases tension and has a calming effect (Cameron, 2007). Moreover, they postulated that self-injury should be placed outside of the pathology of mental illness, and instead be classified as human experience searching for meaning in different contexts, which produces different responses (with self-injury being one of them) (Cresswell, 2005).

With these in mind, the main aim of this study is to explore the narratives of those who injure themselves in order to shed light on the concept of self-injury and deepen the understanding of this behaviour.

Methodology

As this research was interested in the individuals' subjective experience, a qualitative method of enquiry was deemed to be most appropriate. Furthermore, at the moment of writing this paper, there had been no research found in published databases that employed narrative analysis with adults who self-injure; therefore, this method was chosen to analyse the data.

The term 'narrative analysis' is an umbrella term for methods of analysing a story from texts (Riessman, 2008). Stephenson and Kippax (2008) stated that even though there are many forms of narrative analysis, they all share a common belief in stories as a way of making meaning in people's lives. Therefore, narrative analysis is interested in looking at how people make sense of experiences, especially experiences that they struggle to tell (Parker, 2004). A narrative analysis researcher is interested in how an interviewee "assembles and sequences events, and uses language and/or visual images to communicate meaning" (Riessman, 2008, p. 11). Narrative analysis investigates how and why events are storied, rather than just the content of stories. Therefore, this method allows a researcher "to think beyond the surface" (Riessman, 2008, p. 13).

Methods

As the majority of research in the field of self-injury has been conducted with a clinical population, this study was interested to obtain data from a non-clinical, community adult sample. In order to ensure the homogeneity of the sample and access to a non-clinical population, the inclusion criteria were as follows:

- twenty years of age or above;
- working at least part-time;
- no suicidal ideations;
- self-injure in a way that is in line with the definition of self-injury presented in the ‘Introduction’ section;
- not in therapy or counselling for their self-injury; and
- relying on self-injury at least from time to time.

This study followed Erikson's (1994) model of psychosocial development, which defined adulthood as starting at the age of 20. This is also in line with Moran et al. (2012), who conducted a cohort study and separated adolescents (up to the age of 19) from young adults (starting at the age of 20). They observed a significant drop in rates of self-harm between these two groups. Based on this, they concluded that self-harm is resolved naturally for many adolescents. This finding suggests that there may be a difference in the phenomenon of self-injury at the transition into early adulthood.

The above-mentioned criteria allowed the researcher to assume that people who took part in the study should not have been acutely distressed and they constituted a non-clinical population. Throughout the interviews there were steps undertaken to monitor the participants’ distress levels, and an action plan was prepared for a situation of anyone becoming distressed as a result of taking part in the present research.

Study sample

A total of eight participants were interviewed, which comprised of seven females and one male. Five of them were of British origin (including one living

outside of the UK), two were Americans, and one was Canadian. They were all aged between 20 and 29. Four participants responded to the researcher's call for participants after seeing the advertisement via user-led support websites (this included Facebook). Two participants said that they followed a national self-harm organisation on Twitter and saw the link to the research website, which they used to contact the researcher. One participant responded to the email sent by one of the organisations with distributed research leaflets, and another participant saw the research advertisement on a student-based forum.

Data collection

Participants had a choice of meeting the researcher in a location convenient for them, or conducting the interview over the Internet with the use of Skype. Three people agreed to meet in person and five chose to speak over Skype.

For this study, a narrative episodic interview method was chosen (Flick, 2009). This type of interview focuses on a particular event in a person's life, in this case, self-injury. The main goal of the narrative interview is to gather a detailed account of people's life stories, or some aspects of their lives (Riessman, 2008). The researcher asked participants to say in their own words about their self-injury. A number of probing questions were prepared, such as 'Could you tell me a bit more about…?', 'Could you expand on …?', and 'What do you mean by…?' The role of these questions was to gather the depth of individuals' accounts. The interviews ranged from 49 minutes to 87 minutes in length. Each interview was voice-recorded and transcribed.

Data analysis

There is no standard approach or list of procedures that is generally recognised as representing the narrative method of analysis. It is rather a multitude of different ways in which researchers can engage with the narrative properties of their data (Aarikka-Stenroos, 2010). Those within the field of narrative approaches have noted that “there is a need to open up the exploration of what we may learn from other approaches as we pursue our own particular one” (Mishler, 1995, p. 117).

Therefore, the present study did not employ any one method of narrative analysis. The method presented here is a result of an extensive literature search on what can be used and looked at when perusing narrative analysis, bearing in mind the research aim.

The present study’s analytic procedure can be broken down into a few analytical steps. These are individual narrative analysis, synthesis, and theoretical level stage, and, finally, writing up.

Individual narrative analysis stage

At this stage, the researcher worked with individual transcripts. First, each transcript was read a number of times. Then, the researcher looked for the beginnings, middles, and ends of the self-injury stories and identified sub-stories as proposed by Murray (2008). It was believed that this should help to elucidate and understand the phenomenon of self-injury stories. Additionally, a brief summary of each narrative was prepared, which helped to get a better feel of each interview and further assisted with analysis, as proposed by (Mishler, 1986).

Moreover, a reflective paragraph for each of the interviews was written (Langdridge, 2007). Reflexivity is considered to be an integral part of qualitative research that helps researchers to think about their own assumptions and knowledge, which influence their interpretations of the data (Parker, 2004).

Following Willig's (2008) recommendation, the researcher prepared a few questions in each of the four areas, namely: content, tone, themes, and functions of each narrative. These questions were taken mainly from Willig (2008), but also from Murray (2008) and Crossley (2000b). The transcripts were repeatedly read while bearing different sets of questions in mind.

After the individual level stage was completed for all of the transcripts, the researcher progressed to the synthesis and theoretical level stage.

Synthesis and theoretical level stage

The aim of this stage was to synthesise the findings and connect “the narrative[s] to a broader theoretical literature that [was] being used to interpret the story” (Murray, 2008, p. 120). During this stage, all the transcripts were read another three times to immerse with the data, and then a theoretical level reading was conducted. At this level, the researcher was looking at the common themes and the direction of the narratives, asking both the literature and the data ‘what those meant for the story that narrators told’. This process generated hypotheses and themes that were repeatedly put together and revised. Some of them were collapsed and merged together through the process of synthesis, reflection, the researcher’s own interpretation of the data, and literature searches. All those steps allowed the researcher to generate themes that were considered to be constructed across all the narratives as a self-injury story. This stage and process involved a

creative engagement with the data. The results of this process and the researcher's 'play' with the data led to the development of themes and explanation of self-injury presented in the 'Results' section.

Writing up

Last, in order to present the results of analysis, an effort was made to put all the findings into a coherent story (Crossley, 2000b). In order to present the findings, the researcher decided to follow some of Langdridge's (2007) recommendations of structuring them around the main narrative that emerged from the texts, and subdividing the description with the themes that were produced as a result of synthesis and the theoretical level stage.

For the write up, all of the narrators were randomly given names that are considered as popular names from where they came from, but which are also considered as popular English names.

Results

There were a number of themes found; however, in this article, only one of the themes with its four sub-themes that emerged from the analysis will be presented, that is, 'Self-injury – The Way to Tell a Story'. This theme was chosen to be presented here as it was the one that binds all the results together and it seemed most crucial for understanding people who self-injure and their struggle in the search for meaning.

Self-injury was constructed as something that allowed the narrators to express what could not be told, and, as such, became the way to tell a story about

their difficulties and a way to care for the self. As with any story, self-injury needs a witness; therefore, the body becomes the witness of suffering.

The narrators in the present study constructed themselves as experts of their own body, behaviour, and life. They spoke of awareness about the kind of things they needed to do in order to feel better or take care of themselves without involving other people. This gave an impression of self-injury giving them a sense of agency.

There were four sub-themes that emerged from the data: Difficulty Communicating and Expressing, Giving a Meaning to Experiences, The Body as a Witness of Suffering, and A Way to Look After Oneself. They are described below.

Difficulty Communicating and Expressing

The narrators referred to self-injury as something that allowed them to deal with experiences and emotions on a daily basis. It seemed that self-injury provided a way to express and communicate all the painful experiences.

The narrators reflected their difficulty to communicate and express all that they hold inside in any other way, other than through self-injury. Some openly attributed this to themselves and their perceived lack of skills. Often, this was presented as a part of a personal make-up and how the narrators saw themselves.

> ***David:*** *"I look at all my friends and they have, you know, healthy coping mechanisms, like they can just sit down and talk to somebody, and it's all ok for them. I don't think I have those communication skills, or I'm not sure what as.. [cutting] it's just sometimes the only thing that give me back to where I need to be."*

David seemed to make sense out of the fact that he did not deal with his life in a 'healthy way' by stating that he lacked communication skills. However, the narrators also expressed a difficulty in reaching out for help and admitted to leaving things to the point where they became unbearable.

The inability to talk about difficulties was also a result of people around the narrators who found it difficult to hear their stories and tolerate their self-injury. This theme is evident in Lily's story about how her parents approached her self-injury.

> ***Lily:*** *"My mum and dad, they don't, we didn't talk about it [self-injury] in first place. My mum's a nurse umm when she first found out she said: 'People like you we used to just bandage them up so they couldn't move and they couldn't do anything to themselves, so (.) that's what will happened to you if you keep doing this'. So (.) then she never spoke about it again, and I could think that I just hid it better, or she didn't notice, because it was an awful long time, ummm but I don't think that's possible because we lived in the same house. They just decided not to enquire."*

It was interesting that even though Lily's mother was a nurse, she was not able to approach this topic and hear Lily's voice. Instead, she put Lily in 'a box' with others who self-injure, thereby alienating her even further. In the narrator's view, the fact that other people are unable to hear and notice the suffering possibly reinforces the idea that self-injury needs to be hidden as/so that other people were not able to cope with the narrator's behaviour.

It seemed that even people who were the closest to the narrators were finding it difficult to engage and start a conversation about self-injury.

The narrators justified keeping their behaviour secret by presenting their worries with regard to consequences that they might encounter if they were to reveal their engagement with self-injury.

> ***Olivia:*** *"It's like everybody it's just looking at you differently, you know. They think you're this fragile person that, you know, needs constant, you know (.) […] I don't like people thinking that they that I'm, yeah, crazy or that I have some-something that's not fixable or that I'm going to go crazy in a moment. That they have to be on a guard or something."*

Olivia seemed to be concerned about the stigma that surrounds the behaviour and the fact that people may react to her differently. This was common across all of the narrators. The narrators often referred to self-injury being misunderstood and leading to other people's concern about them. They worried about what others might think of them if they were to find out about their engagement in self-harm, which further blocked the possibility of communication.

Giving a Meaning to Experiences

Due to the difficulty in communicating and expressing themselves, the narrators appeared to see the process of self-injury as a way to give meaning to their experiences. The narrators told stories in which chaos in their lives and different experiences were translated into something that was *"real"* (Sophie) and tangible for them. This allowed them to make sense out of the suffering and overcome it.

Lily: *"I was just sitting and my mum was arguing about something [with her dad] and I just scratched until it really hurt and then I realised, like I woke up and 'Yehhh?! this hurts! Ok'. And then I was not thinking about how I was feeling, was a kind of release from all the other stuff. So I kind of understood it. (.) I remember after that happened I wrote something like 'I figured it out, I figured out what can make things better. Now I know that there is something that I can do'."*

Lily's description of her 'discovery' of self-injury provides an insight into how meaning was given to chaos. It seemed that self-injury provided the answers for people to overcome painful experiences and feel that there was finally something that could be done, which helped to end the suffering.

This process of giving meaning to chaos and making sense out of events had also been described as a way to take charge over physical body reactions. The need for control transpired across all of the narrators' accounts. Lack of control is borne out of experiences of chaos where things happen to the narrators. Through the process of developing meaning, control is gained over the events. Therefore, all of the narrators spoke about a sense of control that self-injury gave them, which is explicitly verbalised in the excerpt below.

David: *"Yeah, it definitely gives me control. It lets me take all that emotional pain that I can't deal with and turn to physical pain, which I know that I can deal with."*

The importance of control is also illustrated in a choice of alternative methods of self-injury, such as replacing cutting with control over food and

exercise, which, essentially, are other forms of self-harm. Three narrators made reference to this.

Lily spoke about her very first experience with injurious behaviours when she was about seven years old and was hiding in a spiky bush from bullies.

> ***Lily:*** *"I felt in control of what was happening because it was me who went into the bush. Umm, and then it was my fault that hurt, it wasn't the fault of whoever was been mean that I couldn't control."*

The idea of the need for control and transforming experiences (and all that is done to the person) into something that makes sense and is done by the person transpires in the above excerpt of Lily's account. This was a common theme across the interviews.

The Body as a Witness of Suffering

As self-injury was constructed as a way to tell a story, this story needed a witness. The only witness for all narrators of their stories expressed via self-injury was their bodies. Therefore, it appeared that wounds and scars had a great significance for the narrators to the extent that some of them took photographs of the wounds.

The narrators spoke about their scars and wounds as though these told the story of the narrators' suffering, which are important, significant, and very often painful events and emotions in their lives.

> ***Sophie:*** *"With it [scar] comes a story, I guess, because all of them is triggered by an event that is, I guess, is more complicated than just one sentence. […] I guess they're [scars] like landmarks or milestones in my*

progression. […] I remember pretty much most of the situations, and even though the scars here have faded I remember it's there."

Sophie gave meaning to her scars as something that allowed her to mark the important moments. They represented the different stages and events in her life. It seemed that marks on the body persisted even though the 'physical' scar has faded. This was the meaning that she confidently held.

The narrators spoke about their relationship with their scars. Scars are being constructed as 'something' that one can have a relationship with and relate to. They appear to have a symbolic meaning for the narrators.

David: *"Nine out of ten times I can relate the scar to what caused it, what was stressing me out at that time, and while I hate the scars I also do love them.* {Researcher: Can you tell me a bit more about that?} *I don't know it's it's kind of like a record of my past. There are bad experiences that I've gotten through. And I wouldn't give up the scars that I have now but I really don't want anymore."*

For David, the scars were the evidence of his past 'written' on the body. They were his story of suffering. Even though the scars reminded David of the pain, they were also important to him. His wish for no more new scars reflects a desire to stop the suffering and pain.

The narrators also spoke about the idea of the scars being a reminder of the past events that caused them suffering and led to self-injury. The fact that most of the narrators were able to associate and remember the events or feelings with the scars indicates the importance of the experiences that lead people to self-injury.

Not all of the narrators had such positive and sentimental relationships with their scars. Some spoke about feelings of dislike they have for their scars due to the memory that these scars brought to mind, like in the case of Emily presented in the excerpt below.

> ***Emily:*** *"They* [scars] *are associated with a feeling, but they are not associated with specifics, and I think that's partly why I don't like them. I don't really like to be reminded that actually I spent quite a long time feeling like crap (laughter). erm, but I'm also used to them, I don't see them anymore, in a way."*

The narrators also spoke about scars as being a way to connect with other people due to the message that they hold.

For the majority of the narrators, the body was fulfilling the role of a witness of their suffering. However, for some, this was not enough and they also took photographs of their scars and wounds. These photographs were not shown to anyone, but rather were kept safe and hidden.

> ***Olivia:*** *"But I don't know why I take the picture why I like to have them, it's just maybe it's because I know that nobody's going to see them, you know, and I'm like at least to have some evidence of what I did, so it's not just going to go away and you forgot about like all the other once, right? Because that bothers me sometimes. […] (becomes emotional) I think it mostly bothers me just that that I've done it and that it's going to go away and it's like nobody will knew, sorry. […] Because I know that I'm the only one that knows how bad it was, so nobody really gets to see all that and they don't really know how bad I feel. That bothers me."*

Olivia became emotional when she spoke here. The desperate need for someone to know and to witness her suffering seemed to be in conflict with her saying that she did not want to talk to others about her self-injury or other problems expressed in other sections of her interview. She was worried that there would be no witness of her suffering. The above excerpt indicates that it is not the self-injury that she wishes to talk about, but rather the underlying difficulties that lead to it, yet again confirming the expressional and communicative function of self-injury. It seemed that even though she did not share her experience of self-injury with anyone, there was still a wish for others to know.

A Way to Look After Oneself

The narrators stressed the fact that self-injury allowed them to look after themselves. They all pointed at self-injury as a way to care for oneself, usually without anyone else's help. The narrators spoke about this function of self-care as having a soothing element.

> ***Anna:*** *"It was a relief in that umm (.) […] I almost felt like I could take care of myself now that the pain was only outside and I can see it and I knew what to do about it. It wasn't this inward hurt that I (.) just would be in agony over but didn't know what to do for. It was something on the outside. 'Ok, I put a bandage on it. I'm good'."*

Anna spoke about transforming unbearable pain into something that she could take care of, into practical ways of coping with her difficulties and pain. This seems to be the main goal of self-injury. Internal suffering and emotional pain is not tangible, but rather it is abstract. Therefore, the narrators converted this into

something that was visible and tangible. This way, they could look after themselves.

Interestingly, this function of self-care is extended beyond just immediately after the act of self-injury. The effect of being soothed can last even days after the injury was inflicted.

> ***Chloe:*** *"The immediate after effect, the day after, and the day after that, the immediate few days afterwards, it's for me to, if I'm still feeling bad, I can touch it (touching the top of her leg). […] I'm walking around and nobody knows it's there, apart from me."*

Chloe described here how the effects of self-injury and the wounds are extended beyond the actual act of self-injury. She stressed the actual touching of the place where the cut was done as something that reminded her of the act, especially if things were still difficult. Whilst other people who do not self-injure generate meaning through communication and relationships with others, those who self-injure create meaning in the relationship with their self-injury. This also resembles a parent-child relationship, where the narrators take over the parental role of caring and they also become those who are being cared for.

All of the narrators said that most of the time, they were able to take care of their wounds themselves without involving other people. Only a few mentioned a few occasions that required them to seek medical help (these were mostly incidents usually occurring in the earlier stages of engagement in self-injury). A few narrators even mentioned that they had first-aid training.

Discussion

From a narrative perspective, it is argued that self-injury replaces the process of telling a story. Crossley (2000a) drew attention to the fact that stories "are used to restore a sense of order and connection, and thus to re-establish a semblance of meaning in the life of the individual" (p. 542). This is precisely what self-injury does for the narrators in the present research. From this perspective, self-injury can be explained via the narrative framework.

In thinking about self-injury as a way of telling a story, it is helpful to think about the 'what' (that is the things that are being said), 'how' (which is the way in which the story is being told), and, finally, the 'why' (understood as the reasons for people to say this type of story) elements.

The 'what' of self-injury stories represents the content of these stories. In the present research, self-injury stories are about the struggle and suffering of an individual. Through self-injury, the narrators 'said' that they suffered a great deal and that this was unbearable. Therefore, the behaviour is constructed as something that allows the narrators to try and end the suffering in a hope of reducing the psychic pain. This is reflected in the theme of self-care, which was also found in other studies (Schoppmann et al., 2007). Self-injury is a story about suffering and experiences that have a great significance for the person.

Similar to the way people tell stories through the use of language, self-injury stories represent not only the 'what' of stories, but also they present a very powerful way in which those stories are being told, which is the 'how' of stories. The narrators spoke about experiencing and expressing different forms of events by the acts of self-harm. The stories were 'told' by wounds, cuts, and bruises on the bodies of the narrators, very often with blood accompanying them. A story that

was told this way differed from each person and for each experience. Some people chose different tools and parts of the body to harm each time; others used the same tool and body part each time. This also referred to the way people self-injured, whether these were structured and controlled cuts, or done under impulse. This is parallel to the way stories can be verbally expressed. Some are constructed 'on the spot', rushed, and others are thought through before being spoken.

The 'why' of the self-injury story represents functions and the role that this story plays. There are a few assumptions about the role that stories play in our lives, which can be mapped onto the functions of self-injury. They give a meaning and order to events, construct one's identity, establish connections, and social and cultural functions of telling a story.

The narrators in the present study, however, positioned themselves as unable to utilise narratives and tell stories about their experiences through the verbal ways of communication, attributing this to their inability to communicate, and others not being able to hear their stories. This also emerged in a study by Hill and Dallos (2012), who interviewed self-injuring adolescents, and examined their stories using narrative analysis. They recognised the difficulty that young people have in generating coherent stories and talking about what caused and led to self-injury. Further, Klonsky (2011) found in his study with adults that self-injury was serving as a way to communicate with others, suggesting the difficulties of people who self-injure to find other ways of expressing and communicating.

For narrators in the present research, through self-injury the story about difficulties is being told. Other studies have claimed that after self-injury, the need for communication decreases (Leibenluft, Gardner, & Cowdry, 1987). This is also

supported by others who claimed that self-injury is used when words cannot be found (Conterio, Lader, & Bloom, 1998; Favazza, 1996; Strong, 2005; Sutton, 2007). Therefore, self-injury takes over the functions of narratives.

Narratives that people construct about themselves become “secure fixed points of certainty in a world where the present seems to be dissolving ever more rapidly into an uncertain future” (Parker, 2004, p. 71). Crossley (2000a) characterised that constructing narratives helps to experience our lives as meaningful and connected, and one of the most important features of our perception of the world is our experience of time as being a continuum. He then went on to say that when we experience trauma, such as illness, this perception is shaken. This has been shown in research and literatures concerning, for example, chronic pain (Good, 1994), HIV positive diagnoses (Davies, 1997), and cancer (DelVecchio-Good, Munakata, Kobayashi, Mattingly, & Good, 1994). In the case of self-injury, the disruption that people experience did not constitute some sudden events, but rather many everyday things that had significance for the individual. Those disruptions brought in a sense of discontinuity. Through self-injury, the narrators tried to restore a sense of continuity and connection to their own lives, similar to how other people would try to achieve through the use of verbal stories. Hence, both self-injury and scars became those secure, fixed points of certainty.

From a narrative perspective, self-injury is a way to try and give meaning, define those difficulties and bring some order to experiences. In other words, it allows people to gain some sense of control. Theoretical literature also suggests that self-injury can be seen as a way of resolving the lack of power (Brown & Bryan, 2007), which is the central premise of the ‘Giving a Meaning to Experiences’ sub-theme of the present study.

As for any story, self-injury needs a witness, and it seems that based on the present analysis, the body becomes a witness, a witness of suffering. This is in line with Straker's view (2006), who also suggested that self-injury is a way to 'write' the memories of trauma on the body of a person. The theme of the narrators' wish for a witness is also supported in a research by Sternudd (2012). He interviewed those who were posting and looking at photographs of self-injury on the Internet. He found that these were related to the idea of remembering and the need for proof of experience. Furthermore, posting photographs was understood "as a way of sharing experiences with others and giving and/or receiving help" (p. 421), which seems to also provide some confirmation of the next theme discussed below - 'A Way to Look After Oneself'.

Following this, the scars on the body have the same role as a written story. Those marks become words and sentences, and they constitute a personal diary of painful experiences and suffering 'written' on the body. They are the accounts of these experiences and a constant reminder of them.

Previous literature and research consistently points at self-injury as a way in which an individual looks after himself/herself. As an example, feminist theory suggests that one of the main functions of self-injury is for the person to take care of his/her own emotional states, which is to do with the ability of a person to self-sooth and self-care (Brown & Bryan, 2007). Schoppmann et al. (2007) conducted a qualitative research and found self-harm to be a form of self-care by which an individual ends his/her suffering. This view is also in line with the Self-Harm Survivors' movement literature (Cameron, 2007; Pembroke, 1994; Spandler & Batsleer, 2000).

Moreover, a way of coping with difficulties through engagement in self-injury seems to be in line with the dominant medical discourse that reinforces the idea of coping, cure, and recovery. This influences the way stories are being told. In medicine, there is a strong emphasis on medication as a way to overcome illness. Research into illness narratives showed that narratives often seemed to be testimonials about medical healthcare professionals or medications, rather than about the individuals themselves (Ezzy, 2000). It seemed that the narrators in the present study constructed self-injury in the same way. The stories are testimonials of how self-injury helps to deal with difficulties, rather than about the narrators themselves.

It has to be noted here that narrative research assumes that the data obtained via the interview process is co-constructed by the researcher and the narrator (Riessman, 2008). Even though in the present research an effort was made to represent participants' stories to reflect their experiences, it is important to acknowledge that the final data constitutes the researcher's own interpretive process, and so someone else analysing it may have come up with a different set of themes. However, it is hoped that through the process of checks and thorough documentation of all stages, the reader can conclude the research and its findings as believable.

Conclusions

The proposed way of thinking about self-injury in this study can be of help to professionals, families, and clients alike in overcoming the lack of understanding of the behaviour, as reported by studies into attitudes (Best, 2005; O'Donovan,

2007; Short et al., 2009; Simm, Roen, & Daiches, 2008). This way of conceptualising self-injury moves away from seeing the behaviour as pathology and may provide a shared language for all. In the present study, self-injury is seen as a way to tell a story about suffering, and it is a result of an inability to communicate and express through other means. Therefore, promoting better communication can allow people who self-injure to start telling their stories in alterative ways (verbal, art, writing, etc.), which should help to reduce the reliance on self-injury.

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Appendix

Below is a direct quote, shortened for the purpose of this portfolio, from the 'author information pack' of the Social Science and Medicine Journal (Elsevier, 2012).

Social Science and Medicine publishes the following types of contribution: Peer-reviewed original research articles and critical or analytical reviews in any area of social science research relevant to health. These papers may be up to 8,000 words including abstract, tables, and references as well as the main text. Papers below this limit are preferred.

We accept most word processing formats, but MSWord files are preferred. All author-identifying text such as title pages and references must be removed. Submissions should be double-spaced and use between 10 and 12pt font, and any track changes must be removed.
The text should be in single-column format. Keep the layout of the text as simple as possible. However, do use bold face, italics, subscripts, superscripts etc.

Cover Page should only include the following information:

- ***Title.*** Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible and make clear the article's aim and health relevance.
- ***Author names and affiliations in the correct order.*** Where the family name may be ambiguous (e.g., a double name), please indicate this clearly. Present the authors' affiliation addresses (where the actual work was done) below the names. Indicate all affiliations with a lower-case superscript letter immediately after the author's name and in front of the appropriate address. Provide the full postal address of each affiliation, including the country name and, if available, the e-mail address of each author.
- ***Corresponding author.*** Clearly indicate who will handle correspondence at all stages of refereeing and publication, also post-publication. Ensure that telephone and fax numbers (with country and area code) are provided in addition to the e-mail address and the complete postal address. Contact details must be kept up to date by the corresponding author.
- ***Present/permanent address.*** If an author has moved since the work described in the article was done, or was visiting at the time, a 'Present address' (or 'Permanent address') may be indicated as a footnote to that author's name. The address at which the author actually did the work must be retained as the main, affiliation address. Superscript Arabic numerals are used for such footnotes.
- ***Any acknowledgements*** Include if appropriate. These should be as brief as possible and not appear anywhere else in the paper.

Abstract
An abstract of up to 300 words must be included in the submitted manuscript. An abstract is often presented separately from the article, so it must be able to stand alone. It should state briefly and clearly the purpose and setting of the research,

the principal findings and major conclusions, and the paper's contribution to knowledge.

Research highlights
Research highlights are a short collection of 3 to 5 bullet points that convey an article's **unique contribution to knowledge** and are placed online with the final article. We allow 125 characters per bullet point including spaces. They should be supplied as a separate file in the online submission system.

Keywords
Up to **8** keywords are entered separately into the online editorial system during submission, and should accurately reflect the content of the article.

Methods
Authors of empirical papers are expected to provide full details of the research methods used, including study location(s), sampling procedures, the date(s) when data were collected, research instruments, and techniques of data analysis. Specific guidance on the reporting of qualitative studies are provided here.

Reference style
All publications cited in the text should be presented in a list of references following the text of the manuscript. In the text refer to the author's name (without initials) and year of publication e.g. "Since Peterson (1993) has shown that..." or "...as claimed elsewhere (Kramer, 1994)". For more than 2 authors the first author's name and "et al." should be used e.g. (Annandale et al., 1994).

Elsevier (2012)

Elsevier. (2012). Social Science and Medicine: Author information pack. www.elsevier.com/locate/socscimed.

PART 3

CLIENT STUDY

Meeting at Relational Depth:

A Person-centred Approach

1. Introduction and the Start of Therapy

This client study explores my work with Jo[1], an Afghanistan-born man, who came to therapy to look for help with managing his anger. The report presented here was based on twenty person-centred (PC) therapy sessions completed over a period of six months.

1.1. Rationale for the Choice of the Client

I have chosen to present this client because it illustrates the need to trust in a client's capacity to change in a direction towards self-actualisation. Moreover, this client study demonstrates that by following PC values, it was possible to meet with Jo at relational depth. It also draws on the importance of the use of supervision that was crucial in my work with this client.

1.2. Summary of the Theoretical Orientation

The PC therapy approach is based on the humanistic paradigm and its origin comes from the work of Carl Rogers, who has been recognised as the father of this approach (Mearns & Thorne, 2007). Originally, it was named as the 'non-directive therapy', later re-named as the 'client-centred therapy' and, eventually, 'person-centred therapy' (Eysenck, 2004).

The PC approach sees a client as the expert of his/her own experience and emotions and who has all the answers. A therapist's role is to facilitate the client making his/her own interpretations and deciding what he/she wants to talk about (Gillon, 2007; McLeod, 2003).

In the centre of the PC theory is an assumption that people have a general tendency to move towards 'healthy' directions, and they actively seek higher development, which is known as self-actualisation (Maslow, 1943). This concept is very often misunderstood and criticised, with many interpreting self-actualisation

[1] all the names and certain biographical/personal identifying details have been changed throughout in order to preserve confidentiality

as a process of growth in a ‘positive’ direction. However, within the PC approach, there are no positive or negative connotations associated with self-actualisation. Rather, in a most simplistic way, it means that a person does their best with their current circumstances (Mearns & Thorne, 2007). This is also understood as movement in a healthy direction, which is very different from the traditional way of understating the word ‘healthy’. A person’s ability to weigh up and value experiences necessary for growth is known as the organismic valuing process (Mearns & Thorne, 2007). The organismic valuing process represents a person’s ability to trust their own thoughts and feelings, and make decisions in accordance with his/her perception (Joseph & Linley, 2005).

The PC approach stresses that the relationship between the therapist and the client is of crucial importance to the therapy process and for therapeutic change to occur (Wilkins, 2003). Rogers (1957) named three core conditions necessary in order for a therapeutic relationship and change to take place. These are labelled as: empathy, congruence (genuineness), and unconditional positive regard (acceptance) (Gillon, 2007). With these concepts in mind, the aim of the therapy is to increase an acceptance of the client with him/herself and their circumstances, so that he/she can become congruent with whom he/she is as a person (Maltby, Day, & Macaskill, 2007).

The three core conditions facilitate the process of therapeutic change, which can be conceptualised as greater openness to experience (Rogers, 1961). The relationship between the client and the therapist and, also, the ability of the latter to get engaged in the world of the former are the conditions that will drive the client towards acceptance and change (Thorne, 2002). This involves a therapist and a client meeting and working at ‘relational depth’, which is understood as an environment of the therapist offering and client receiving a combination of the three core conditions. Working at relational depth is seen as a high level of psychological contact (Mearns, 1996). However, meeting at relational depth is a very difficult process, as even if a therapist offers this kind of relationship, it does not mean that a client would be able to respond to receive it or respond to it in the way intended (Mearns & Cooper, 2005). Relational depth requires a therapist to offer a highly empathetic relationship in which a client feels fully accepted.

Furthermore, a client needs to experience this empathy and acceptance from a therapist as true reflections of a therapist's feelings and values (genuineness) (Mearns & Thorne, 2007). Working at relational depth can refer to the quality of the overall relationship, as well as specific moments in the therapy (Mearns & Cooper, 2005).

1.3. The Context for the Work and the Referral

I worked at a community-based service situated in central London, where clients self-refer. The number of sessions offered initially within the service was twelve. However, this was rather flexible and there was a possibility of extending the sessions.

Jo self-referred to the service and he was allocated to me.

1.4. Convening the First Session and the Presenting Problem

When I first saw Jo, he appeared as very gentle and polite. He had grey hair and was quite tall, walked slowly whilst bending slightly forward, which he later explained was due to pain in his legs. Jo spoke in a low voice and did not wait for prompts, but at his own pace told me what he wanted to share. This is in line with the ethos of PC therapy that assumes that the process should be client-led (Rennie, 1998). Jo said that he wanted to see a psychologist to help him with managing his anger. During our first session, he told me some of his background, and how he got in touch with the service. He said that he became addicted to painkillers taken for the pain in his legs. Initially, he took a couple of regular over-the-counter painkillers, but as time passed, he increased the dosage, taking up to twenty tablets a day. However, when we first met, Jo said that he had just completed a detoxification and he was not taking any medications. He reported that he was extremely angry at all times but rarely showed how he really felt to other people.

1.5. Biographical Details of the Client

Jo was sixty years old when he started therapy with me. He was born in Afghanistan. He had one sister. He said that his mother was a housewife and his father had a background in the police force. Jo told me that he was very well educated and worked as a chemist for years in his home country. Shortly after he got married, his daughter was born, who was later diagnosed with a serious heart condition. Jo and his wife relocated to England so that their daughter could receive a treatment. They had been living in the UK ever since, which he said was almost twenty years. He said that he had worked as a construction worker for a number of years until five years ago. He mentioned that he and his wife were not living together for a few years.

1.6. Initial Formulation of the Problem

Based on Jo's and my initial meeting, I developed a provisional formulation of his difficulties. Within the PC approach, some argue that a therapist should not formulate or generate a hypothesis as these are static and do not promote growth and change. However, it is important that a therapist engages reflexively with a client's material, and for this he/she needs to show their own understanding of a client's difficulties. This is precisely what is understood here by formulation.

Jo explained that in his culture, a man had to be strong and was not allowed to show any emotions. Therefore, in his family home, no one was allowed to cry, be sad, or get angry. He said that as a child, his father would get very angry with him for any signs of weakness. Jo described his father as very strict and domineering. I hypothesised that Jo's experiences of constantly trying and being unable to stand up to his father's expectations and also social constraints led him to develop a very poor sense of personal worth, which appeared to be conditional. Mearns and Thorne (2007) called this as having negative conditions of worth. As a result, Jo very rarely expressed the way he felt. He introjected those conditions, which then became a part of his personality – a process named as internalisation (Thorne, 2002). As a result of this, Jo developed a negative self-concept. He experienced anxiety that came from the discrepancy between his real self and his ideal self. Cloninger (2004) described the ideal self as the way in which a person would like

to be, whereas the real self as the way a person actually is. Jo told me that the person that he appeared on the ‘outside’ was not the same person as he really was on the ‘inside’. He felt angry ‘inside’ and felt that he needed to pretend in front of other people. The discrepancy between the ways he perceived himself was also evident in other areas of his life, such as work and fatherhood. He said that he was not a good father. He told me that he felt a lot of guilt and shame with regard to raising his daughter. Jo also mentioned that he did not mind working below his qualifications, but added that he missed the gratification of the job he used to do in his own country. Jo seemed to have an external locus of evaluation; therefore, every negative comment made by other people was perceived as an attack on his own self (Gillon, 2007). Therefore, he was striving to gain approval from other people by behaving in a way that he thought would be expected of him, such as being nice and not getting angry. This can also be seen as an example of Jo’s disconnection from the wisdom of his organismic valuing process.

1.7. Negotiating a Contract and Therapeutic Aims

The choice of the treatment method was influenced by Jo’s need to ‘just’ talk to someone about his life and difficulties. He was not able to clarify his goals for our sessions, apart from stating that he needed help with managing his anger. Taking into consideration Jo’s wishes and also my increasing awareness that there was more to Jo’s difficulties than what he described as an ‘anger management problem’, we decided to undertake the PC therapy. Moreover, I felt that Jo would benefit from an approach that would allow him to explore his difficulties at his own pace, which is one of the main assumptions of the PC approach (Rogers, 1951).

The length of the contract was influenced by the service standard procedure; therefore, twelve sessions were initially offered, with a review towards the end.

2. Development of the Therapy

2.1. The Pattern of Therapy and Therapeutic Process

Initially, following Tudor's (2008) suggestion, the main aim for our sessions with Jo was to build a trusting therapeutic relationship between us. I tried to encourage him to explore what he spoke about, whilst being very careful to stay within Jo's frame of reference, which Rogers (1951) defined as one's internal subjective world. I was trying to listen carefully and put myself into Jo's 'shoes', reflecting on what he spoke about.

The first couple of sessions were spent on exploring factual Jo's life events. He appeared to be open to talk about his experiences; however, he did not say much about his feelings, apart from mentioning his anger. This made me wonder whether Jo was avoiding something, or perhaps he was not able to express his emotions due to his conditions of worth.

Jo came to our third session and said that he came just to tell me that he was not feeling very well and that he wanted to go home. I was surprised by this, but agreed that we would meet the following week. I failed to notice that he was reaching out for someone to see his suffering. He also cancelled the following session, telling me on the phone that he felt very low in mood and did not want to leave his house. I wondered if the act of me letting him go was a message for him that I was not willing to stay with him in difficult moments and explore his feelings. Mearns and Thorne (2007) stated that it is crucial the therapist is not afraid to explore and accepts challenging feelings and experiences. I felt angry with myself and, on reflection, wondered if this could have been empathically experienced Jo's anger at the inability to be heard. With my supervisor's encouragement, I wrote Jo a letter in which I expressed my concern for him. He came back the next week for our session. Mearns (1996) postulated that the therapist's congruence and transparency would allow the therapist to engage with a client at relational depth. I therefore decided to tell Jo that I did not understand what he was going through, but was there for him and would be willing to listen to anything that he wanted to share. Afterwards, Jo just looked at me and he started to describe how difficult it was for him to sometimes even get up from the bed. He said that he suffered

physical and psychological pain and that, because of his earlier addiction, he was not even able to take any painkillers to relieve his pain. He said that he felt sad and hopeless. We spent this session exploring his feelings, and for the first time, I felt really connected with Jo and his pain. In line with the views of Mearns and Cooper (2005), it was hoped that Jo would start bringing significant material to the sessions if he felt that he could connect with me at relational depth. I feel that this session marked a beginning of this process. Mearns (1996) stated that the client will trust the therapist if he feels the expressions of the core conditions. During the session that followed, Jo revealed that he had a recurrent nightmare in which he was very badly tortured. He said that in the morning he had marks from beatings on his body that usually disappeared after a few hours. Jo admitted that his painkiller addiction was related to this nightmare, and that he was taking them to help him to sleep. This confirmed that Jo felt he could increasingly trust me and felt safe in our relationship.

In the following session, Jo told me that he had been seeing an ‘imaginary friend’ and that he had been in touch with the mental health team. As soon as he said that, I felt very anxious and started asking him questions. I thought that he might be ‘psychotic’ and I started trying to figure out where in the DSM-IV criteria he would fit. As a result, I completely lost my empathy and stopped listening, which was what Rogers (1961) warned about in his writing. With the help of my supervisor, I became aware of this and, afterwards, I was able to once again let Jo lead the process. In the sessions that followed, he was a bit reluctant to talk about his experiences at first but gradually started to open up again and told me how for years he felt like a prisoner in his own mind and body. At this point, I realised why he was so careful with regard to revealing his difficulties. No one believed him. ‘They’ told him that the chemicals in his brain were not in balance, but Jo thought that he was just being punished for everything that he had done in his life. He told me that he was taking 750 mg of Seroquel medication daily (the highest recommended dose for this antipsychotic drug), which was supposed to help with his ‘symptoms’, but he said that he did not see any difference. He said that he felt alienated and very confused. This was mirrored by my own confusion, which, at the time, I attributed to Jo’s presenting issues; however, on reflection I think it could have been what I empathetically sensed from Jo. He explained that his

nightmares started about five years prior to our meeting and this was at the same time that he started to see his imaginary friend. Jo described him as a man of a similar age to himself but with no name. He said that, usually, his friend would come and they would sit at the kitchen table talking for hours. Jo said that his imaginary friend advised him on different things with regard to his life and decisions. Jo told me that, at the beginning, he did not know that his friend was not real, and only after some time he realised that no one else could see him. Jo told me that he struggled to make sense out of these experiences but was certain that his imaginary friend helped him a lot. Jo said that if his experiences were just as they said, due to a chemical imbalance, the medication should have restored the balance, and symptoms should have subsided. This was not the case for him. Jo struggled to make sense out of all of this and so did I. I sensed that in order to further engage Jo in our relationship and meet him at relational depth, as recommended by Mearns (1996), it was important for me to be truly open and congruent at this movement and let Jo know that I, like him, did not actually know and understand. Therefore, I told him that I also did not have answers, but was willing to join him on this journey.
During this session, I also realised that Jo did not perceive me as one of 'them', which again confirmed a high quality of our relationship and truly moved me.

It seemed that from this session onwards, Jo started to more frequently tell me how he felt and tried to explore those confusing experiences and emotions. I felt that this marked another important moment in therapy. One of Jo's conditions of worth, as described in the formulation section, has been that people should not show their emotions, as these were not 'man-like'. Therefore, his willingness to open up in this way allowed me to think that he was starting to slowly reconnect with his organismic valuing process (Rogers, 1961). Further, Jo eventually admitted that sometimes when he woke up in the morning from one of his nightmares, he would cry. This, he said, made him despise himself. Jo described himself as weak and not worthy of anything. In those moments, I tried to be empathetic and let him know that I completely accepted him, hoping that with time Jo would be able to accept himself in the same way, as postulated by Rogers (1957).

Jo continued to frequently ask my opinion and sought guidance. It seemed important to him to know what I thought about the topics he wanted to discuss and his feelings. He also regularly asked me what I thought he should do. He did not seem to be able to trust himself and his own judgements. This indicated that even though Jo began to share some very personal experiences, which showed some movement towards his organismic valuing process, he was still very much disconnected from this process (Boeree, 2006). Further, it also illustrated that his locus of evaluation was mainly external (Mearns, 2003). There was an additional confirmation of this as Jo admitted regularly consulting his imaginary friend, who was the only person, up until very recently, that Jo could speak openly with. I felt that this was the main function of Jo's imaginary friend. In exploring Jo's fear of disclosing his problems to other people, he admitted worrying not only that no one would believe him, but also that he would 'lose face' in front of his daughter. Jo was concerned that she would not have respected him if she knew what he was going through. This made me think that perhaps there was another condition of worth that Jo had learnt, which is the belief that he needed to cope, and was worthy only when he was fully physically and mentally functioning. Jo's explanation allowed me to understand how lonely and isolated he felt most of the time, hiding himself from the world in his flat and avoiding people all together in a fear that 'they' may deem him, as he described, as 'mad' and not 'worthy'.

These also allowed both of us to realise how stuck Jo felt in his present situation; unable to move in neither direction, and make any decision; unable to accept his recent position, and unable to move from it. This was further evidence of his disconnection from his organismic valuing process.

In subsequent sessions, further exploration revealed that Jo experienced strong feelings of shame and guilt. Shame he attributed mainly to his experiences of having an imaginary friend and nightmares at night that left marks on his body the following day. Jo told me that he knew that they were unusual and even said that 'normal' people did not have those types of experiences. At this moment, I could empathically feel Jo's suffering stronger than ever. As he described, he was a prisoner in his body and mind.

Exploration of feelings of guilt allowed us to understand that they were connected to his role as a father. He kept telling me that he was not a ‘good’ father. He told me about his deep love for his daughter, and his wish to give her everything she deserved but not being able to do it. He felt that she deserved the ‘normal’ father, the one who could support her when she needed support and not a father that was unable to even support himself. I knew that Jo suffered and I could sense his deep sadness. When he spoke I could feel tears welling up in my eyes. My ‘felt sense’ of those feelings allowed me to further explore Jo’s edge of awareness, other words, feelings, and thoughts that a client is not aware of but may be alluding to (Gendlin, 1984). We both came to understand that behind those feelings of guilt and shame was a deep sadness, feelings of hopelessness, and disappointment with himself as a person.
I also started to wonder whether Jo’s feelings of guilt and shame could have been so great that the dream became a way of punishment for not fulfilling his conditions of worth.

When working with Jo, I had to trust the process of therapy and our relationship that Jo would recognise how to move towards growth by allowing him exploration of his difficulties whilst simultaneously trying to show him my empathy and acceptance of him and his difficulties, as suggested by Rogers (1957). I also started to increasingly trust in our relationship. It appeared to me that as the time passed, Jo felt increasingly free to open up within the sessions and talk about his puzzling feelings and experiences, which is predicted by Rennie (1998). Jo also started to use metaphors to explain how he felt in moments where he felt that words were not enough. As an example, to allow me understanding of his anxiety and anger, he said that he sometimes felt like people were pushing him to the corner of the room. In those moments, he told me that the walls of the room were getting closer and tighter on him to the point where he was not able to move, leaving him no other option than to attack and get angry in order to defend himself. During the sessions, I tried to listen and reflect Jo’s emotions, thoughts, and experiences back to him. It felt that we were together on a journey for meaning, understanding, and connection with the world.

At times during our sessions, I still caught myself trying to ‘figure out’ what Jo suffered from. However, I realised that this did not really matter after reading a chapter by Van Werde (1998), who compared a person to a tree, where the top part (i.e. branches and leaves) represents thoughts, dreams, hallucinations, delusions, etc., and the roots represent everything that grounds the person, such as sense of self, support of others, etc. Therefore, the stronger the roots, the easier it is to carry the weight of the branches and leaves. Moreover, Biermann-Ratjen (1998) said that the PC approach aims at integrating (rather than changing or getting rid of) a person’s experiences into their self-concept. This is also in line with the concept of recovery from mental health difficulties, which is understood as a process of regaining different aspects of one’s life so that the ‘difficulty’ constitutes one of the aspects of a person’s sense of self and does not define a person as a whole (Anthony, 1993). In other words, very often, when people become unwell (whether this is a mental or physical illness), being unwell suddenly constitutes their whole life and everything revolves around this. Through the process of recovery, a person learns to make space for other things in their life that temporally were taken over by illness, such as hobbies, friends, family, etc. The illness starts to be just one of many areas in a person’s life, and not the only area.

Based on all that has been discussed here, I understood that Jo needed strong roots; that is, a strong sense of self that would allow him to carry and balance his difficulties – nightmares, thoughts, hallucinations, emotions.

2.2. Making Use of Supervision and Difficulties in the Work

One of the most fundamental questions asked by my supervisor at the early stage of my work with Jo was whether I believed him. This question helped me to understand what my thoughts were, and I realised that I indeed believed that all the symptoms described by Jo were very real to him and I truly believed that this was greatly distressing him. This allowed me to be more congruent in the sessions and more accepting towards all of Jo’s difficulties. I could be transparent and I believe that this helped both Jo and I to meet at relational depth and relate to one another on a level that at times did not require any words to be said and I still understood how Jo felt, which Mearns and Cooper (2005) described as mutuality.

Further, my supervisor encouraged me to explore things that Jo was bringing to the sessions, which Mearns and Cooper (2007) called ‘unpacking’. This allowed me to understand how terrified Jo was when he went to bed each evening and how much he needed his imaginary friend to deal with life’s difficulties.

Supervision was extremely important when working with Jo as it allowed me a space to reflect on my sessions and presented material, which novelty posed a significant challenge to me. What, however, had the biggest impact on me was how open and honest my supervisor was: she also did not understand Jo’s difficulties, but she was not afraid to ‘stay with this’. Unlike me, she did not desperately try to find the answer, but rather believed that things would ‘unravel’ and get revealed in the process of therapy. This felt very empowering, and as a result, I was able to be more fully present in the sessions with Jo, which, in return, allowed Jo to be more open.

However, there was one more form of supervision that I utilised: the internal one, with myself. The PC approach sees this type of supervision as an integral part of therapy (Rickard, 2011). I spent a lot of time thinking and writing down my reflections from the sessions with Jo, especially trying to consider those moments which allowed us to connect on a very deep, relational level. Reviewing my notes, I could see the pattern. Those movements happened whenever I allowed myself to be vulnerable and show Jo that I was there for him no matter what he said and that I was interested in him. In other words, Jo and I connected on the deepest level when I allowed myself to be guided by curiosity and by Jo, rather than techniques, as predicted by Mearns and Thorne (2007). Rogers (1977) wrote that if the therapist trusts in the client’s inherent potential, the client will be able to move towards growth and self-actualisation.

3. The Conclusion of the Therapy and the Review

3.1. The Therapeutic Ending and Evaluation of the Work

When the therapy was getting to its final, twelfth session and Jo and I started to evaluate our work together, Jo expressed his wish to carry on with his therapy. He said that this was the first time in five years that he had had someone to talk to so openly and that he was looking forward to our sessions. He said that he noticed that he did not have the nightmare for a few days after we met and that he felt more peaceful after our sessions. This indicated that Jo started to connect with his organismic valuing process. Based on this, I also hypothesised that the nightmare could have been a form of punishment for not adhering to the conditions of worth, for being 'weak' and feeling emotions. Through our relationship, he was slowly internalising that this was acceptable, which then led to a temporary lack of nightmare. Therefore, we decided to carry on with our sessions until Jo decided he did not need them anymore. This is in line with the PC ethos, which advocates that a client should decide about the end of the treatment and that therapy should take place at the client's own pace (Bozarth, 2005). I also felt that it was important for me to support Jo in his progress. Further, Jo's wish to carry on with our sessions indicted that his journey of personal growth was at the early stage and his locus of evaluation was still mainly external, as he did not trust himself to carry on with his progress by himself at this stage.

A few weeks later, Jo started to wonder whether he should go travelling with his family back home and was asking me what I thought. This again confirmed that his locus of evaluation was still very much an external one. Jo's family had been inviting him for almost two years, but he said that he was not able to go and would not even consider it until recently. He used to tell me that he was not strong enough to 'face his family'. Instead of answering Jo's question about whether he should go, I repeated the question back to him, as suggested by Rogers (1961), and Jo immediately started to consider the pros and cons of such a decision, including what it would mean for our meetings.

After another few sessions of work together, Jo came to the session and said that he had decided to go and visit his relatives in Afghanistan and then to go travelling with them. He said that he wanted to continue with our sessions until his departure day. I felt that this was a very big step and that Jo was connecting with his organismic valuing process. I believed that Jo's decision to visit his family was a movement towards his inherent potential.

During our last session, Jo was able to recognise and acknowledge how much he had already achieved over the course of our meetings. He seemed to talk a lot and I felt that he was avoiding something. The PC approach assumes that the therapist is able to sense an edge of a client's awareness (Gendlin, 1984). I therefore asked Jo how he felt about therapy and what this meant for his future. Exploring his feelings and thoughts led us to uncover Jo's ambivalence with regard to his future and feelings of fear underlying this. We realised that he also felt slightly disappointed that therapy did not provide a 'magic solution' to all his difficulties. He felt that he continued to suffer and acknowledged that this might never end. However, he shared with me that he now knew that he would be able to carry on with his life. I was somewhat surprised at Jo's honesty and openness at that point. This moment felt very important as Jo allowed himself to fully show all his feelings, rather than just those that would be acceptable to me. This confirmed the strength of our relationship.

In summary, at the beginning of our meetings Jo told me that he wanted to manage his anger. During the course of our sessions, he started to say that he would like to accept things more and that he wanted to 'live' his life again. I felt that his decision to go travelling was exactly fulfilling this wish. This illustrates that, with time, Jo learnt to increasingly rely on his own opinion and he also stopped asking about what I thought as often. Instead, he was able to explore his own views, which indicated a move towards an internal locus of evaluation. I wondered if my trust in him allowed him to trust himself, as proposed by Rogers (1951).

3.2. Learning from the Case

Mearns and Cooper (2005) wrote that a therapist's preoccupation with techniques can get in the way of the relationship, because in order to meet with a client at relational depth, a therapist needs to let go of therapeutic techniques and expectations and to approach a client from "a place of naivety and un-knowing" (p. 117). This was mirrored with my experience of working with Jo. I have realised that the more I tried to fit Jo's difficulties into DSM diagnostic criteria, the more I struggled to work with him. The more I tried to understand where his 'symptoms' fit, the more confused I became. Only by allowing myself not to know and by acceptance of this I became open to Jo's experience and was able to join him in the exploration and discovery of what was going on for him. We could together try to make sense of the things that he spoke about. I experienced a high level of psychological connection with a client that was based on mutuality; being in-tune with another person to the extent that, at times, words were not necessary.

One of the most important lessons was my realisation that I have a tendency to want to 'hide' behind the profession of a psychologist. I have realised how easy it is to forget that a client is capable of growth and self-actualisation. In a moment of anxiety that came from not understanding Jo's difficulties I wanted to diagnose him. I am now mindful that this was for my own benefit in order to contain my emotions. I now understand what Mearns and Thorne (2007) meant by stating that diagnosis is a static process that is not helpful for the client as it may reject the growth. Only by allowing myself to be a person with Jo and show my vulnerability was I able to let him make his own interpretations and allow him to decide what he wanted to talk about. I realised that the more I felt myself in the relationship with Jo, the more open and accepting he became towards himself.

However, I am now also mindful that being able to let go of the techniques and diagnoses required me to believe in myself. This is rather a very difficult thing, especially given the status of trainee. During training, it seems that those techniques were a good way of containing my anxiety. They provided a certainty in a world where everything seemed to be so unpredictable. Every new client brought new challenges; every new placement and supervisor confronted my old ways.

Everything was constantly changing: the clients, placements, supervisors, personal therapists, even tutors and university assignments. It seemed important to have something to rely on, which is what techniques did. They allowed having something to hold on to in this world of uncertainty and an ever-changing future. Therefore, work with Jo challenged me on every level. I had to question and later forget all my assumptions, and just allow myself to be guided by curiosity. This was exciting but also very terrifying. Interestingly, on reflection, I think that this was also mirrored by Jo's experiences and his therapeutic journey. In order to let go of his 'symptoms' and preoccupation with whether or not people believed him, or whether or not he was 'mad', Jo needed to let go of the old way of seeing his world. Like me, he did not believe that without this 'frame' he would be able to carry on with his life. He also acknowledged how scary and terrifying not knowing was.

On reflection, there were still many areas that Jo and I did not have time to explore. I wondered how he felt about the relationship with his wife; he did not talk about her much during our sessions and even if he did, it was usually in a passing statement. Further, I also noted that except for the statement at the initial session about his mother, he did not speak about her at all. It seemed that the only female he did talk about was his daughter. I further wondered what this all meant to our relationship. Was it easier or more difficult for Jo to open up to me because I am a woman? However, I felt that it was important during the therapeutic process to follow Jo's lead and stay within his frame of reference (Rogers, 1957).

I have realised that sometimes I am so busy that I do things on an 'auto-pilot'. However, work with Jo allowed me to stop and make time to truly think about my assumptions and values. This reminded me why I decided to pursue psychology in the first place. Work with Jo truly moved me and I am sure it impacted on my developing identity as a therapist. It is a constant reminder that clients are the experts and they know what and how to move in a way that is 'just right for them'. I believe in my clients and I believe that they can change and they often do. However, even if they do not, that is also okay, because sometimes not moving/changing is the best that a person can do out of their circumstances.

Therapy with Jo was an adventure. I believe that we both learned a lot from each other. However, it has to be acknowledged that regardless of how hard I had tried, without Jo's receptiveness (openness to receive what is being offered) and his expressiveness (understood as willingness to be open) (Cooper, 2005), we could never have met at relational depth. I admired his openness, ability to take risks, and show his vulnerability. I was aware of how privileged I was to have met Jo and be able to watch him grow and move closer towards his organismic valuing process.

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