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“It’s how you cope”: Surviving childhood trauma and the range of maladaptive coping mechanisms in which this may manifest, within the context of mental health difficulties.

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This Portfolio has been submitted in fulfilment of the requirements for the Professional Doctorate in Counselling Psychology (DPsych).

City, University of London
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This portfolio is dedicated to you.

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Preface

This section aims to present the three parts comprising this portfolio whilst simultaneously reflecting my process and journey towards becoming a qualified counselling psychologist. The first part of this portfolio refers to my doctoral research study, which explores the experience of genital self-injury in adult women. Moving forward, the second part of this portfolio presents a piece of clinical work that took place during my counselling psychology doctoral training. This piece demonstrates my clinical skills and efforts in working with a client using the modality of Schema Therapy. Finally, the third part of this portfolio ends with a publishable journal article which illustrates the findings of my doctoral research study. The underlying theme that brings these sections together is the experience of surviving childhood trauma and the manners and range of maladaptive coping mechanisms in which this may manifest within the context of mental health difficulties (Spalletta, Janiri, Piras & Sani, 2020; Smith, Kouros & Meuret., 2014)

My own experience of working with survivors of childhood trauma has undoubtedly shaped me not only as a professional but also as a person. These close encounters have enabled me to witness the myriad of ways in which individuals have tried to grapple with their past experiences. I have come to understand that many of the presentations we mental health professionals encounter such as addiction, self-injury or interpersonal difficulties, which are often viewed and labelled as maladaptive, are merely reflections of an individual's inner world and the strategies which they might have had to employ, in order to survive often unimaginable pain or loss. I have been fortunate to witness profound courage, resilience and spirit and have been privileged to walk alongside survivors and their efforts towards healing and post-traumatic growth. These experiences have left me with a sense of profound admiration, compassion and hope and form my source of inspiration and drive in my efforts to contribute towards alleviating suffering.

In the words of Elisabeth Kübler-Ross,

"The most beautiful people we have known are those who have known defeat, known suffering, known struggle, known loss, and have found their way out of the depths. These persons have an appreciation, a sensitivity, and an understanding of life that fills them with compassion, gentleness, and a deep loving concern. Beautiful people do not just happen."

It is therefore my wish that my clinical and research interest can be conveyed through the various parts of this portfolio and that my efforts as demonstrated through these sections, contribute to the field of counselling psychology.

Section A: Doctoral Research

My motivation in exploring the topic of genital self-injury stemmed in part from my clinical experience in working with individuals that engage in a variety of self-harming behaviours as well as through my previous engagement with research around the area of self-harm through my master's thesis, titled 'Complex PTSD Features as a Mediating Factor in Emotion Dysregulation Manifesting in Self-injurious and Suicidal Behaviour'. It is however through encountering individuals that engaged in this particular type of self-injury both in clinical settings as well as through my knowing someone that has engaged in genital self-injury in my personal life, that ultimately served as the factors that led to my decision to research this topic.

This doctoral research study aimed to examine how adult women experienced their engagement with genital self-injury, using data collected via semi-structured interviews with two participants and analysed utilizing the qualitative method of Interpretative Phenomenological Analysis (Smith, Flowers & Larkin, 2009).
The Introduction and Literature section offer an overview of the available body of research on the area of genital self-injury as well as an outline of the existing literature on a range of aspects relevant to this study and topic.
Analysis of the findings revealed 4 Master Themes titled 'Making Sense of Self-Harm', 'Perceived Defectiveness', 'The Struggle of Practicing Self-Care' and 'Targeted Harm'. The themes are presented and explored in depth in the Analysis chapter in the first section of this portfolio and findings are discussed in the context of existing literature in Section A's Discussion chapter. This concludes by also highlighting the strengths and limitations of this study as well as identifying opportunities for future research. In addition, the clinical implications of these findings for training and practice for counselling psychologists and other professionals are also presented.

Section B: Extended Case Study

The second section of this portfolio offers an example of my clinical work during my third year of the counselling psychology training and my clinical placement within a specialist NHS

service. It presents my therapeutic work with a client who presented with longstanding difficulties around relating to themselves and others in the context of experiencing complex trauma as a child as well as being diagnosed with a chronic skin condition.
These difficulties included a chronic difficulty regulating emotions especially, pervasive feelings of worthlessness, shame and self-hatred, interpersonal difficulties, chronic suicidal ideation and a range of maladaptive strategies which included substance abuse and self-injurious behaviour.
The approach utilized in this therapeutic work is Schema Therapy which is an integrative psychotherapeutic modality combining elements from object relation and attachment theories, Gestalt therapy and cognitive-behavioural therapy (Young et al., 2006).
Schema therapy although initially developed for the treatment of personality disorders, is commonly used for a range of chronic and entrenched mental health difficulties that are thought to have originated in one's childhood and is a particularly useful modality for difficulties that have not responded to other treatment approaches. It emphasizes and utilizes the therapeutic relationship as means for change by offering to the client an emotionally corrective experience (Young et al., 2006; Arntz and van Genderen, 2009; Giesen-Bloo et al., 2006; Rafaeli et al 2011, Arntz et al, 2005, Rafaeli et al., 2011).

A crucial aspect of my work with this client was to develop a strong therapeutic alliance despite the relational challenges that were often present. These mainly manifested in the client expressing a range of overcompensating and avoidant strategies which were understood as this client's efforts to avoid vulnerability and closeness due to previous experiences of developmental, interpersonal traumatization.
This case study offers an overview of our work with this client and their journey towards developing healthier and more adaptive ways of relating to themselves and others.
Schema therapy is an approach that often requires conveying to clients, great levels of engagement and emotional involvement and it requires from the practitioner to demonstrate an increased capacity for reflection, introspection, and resilience as well as capacity to express warmth, compassion and congruent care. Utilizing this approach in my work with this client, required me to confront and honestly reflect on my own apprehensions as a practitioner in my attempt to support them in their process and journey and in order to facilitate change. I have found working within this modality professionally and personally transformative and inspired by this, I have since pursued further training in this.

Section C: Journal Article

The concluding section of this portfolio includes a publishable journal article which I aim to submit to the journal of the International Society for the Study of Trauma and Dissociation, the Journal of Trauma and Dissociation. This journal was selected due to its exploration of topics pertaining to trauma-based concerns and presentations.

This article presents an overview of my research study's findings and the associations between these and further research and clinical opportunities.

In the context of the poverty in existing literature exploring the issue of genital self-injury, it is hoped that this article will offer and explore valuable insights and contribute to the body of literature, which may serve as inspiration for additional research in this topic.

Section A:
Doctoral Research

The Experience of Genital Self-injury in Adult Women

Supervised by Professor Carla Willig and Dr Jacqui Farrants

Abstract

Genital self-injury refers to the deliberate action of harming one's own body tissue with the aim of modifying this area or in the context of wishing to alleviate oneself from overwhelming feelings relating to their genital area.
Despite self-harming behaviours being considerably investigated in the available literature, genital self-injury is a presentation that has been rarely discussed despite its severity and the serious medical complications it is associated with.
Existing research supports the notion that there are variations between sexes with regards to the functions and motivations which underlie their genital self-injury.
This study aims to contribute to body of knowledge by exploring the experience of genital self-injury in adult women. For the purposes of this study, two participants were included. Collection of data using semi-structured interviews were further analysed through the method of Interpretative Phenomenological Analysis. Findings that emerged from the data were presented through four master themes: 'Making Sense of Self-Harm', 'Perceived Defectiveness', 'The Struggle of Practicing Self-Care' and 'Targeted Harm'.
The insights that emerged from these findings illustrated the participant's sense-making of their behaviour as well as underlying factors and motivations that were associated with their engagement in genital self-injury. All themes speak to the complex interplay between the participants' self-perception in the context of various aspects and experiences such as shame, trauma or dissociation and the way in which they manage their emotional distress through the targeted and specific nature of genital self-injury.
Relevance of these findings in the context of existing literature is discussed and clinical implications for training and practice are examined. These include the importance of professionals demonstrating awareness and openness in discussing genital self-injury, exploring and addressing its underlying function as well as considering suggesting harm-minimisation strategies where cessation of genital self-injury may not be possible.
Suggestions for future research are also further explored.

Introduction and Literature Review

1.1 Chapter Overview

The following chapter will provide a rationale for conducting a study exploring the experience of genital self-injury in adult women. An overview of the conceptualization of self-harming behaviour is first provided alongside variations in terminology, their subsequent definitions, and the challenges these nomenclature differences pose.

This section is followed by a literature review on perceptions, attitudes, and stigma in the context of self-injury and the implications these have for those who engage in this behaviour which also serves as a partial explanation for not disclosing or seeking support and which in turn impacts known prevalence rates and associated literature.

Subsequently, an overview of the current literature with regards to self-injurious behaviour in the context of various psychiatric presentations and relevant concepts, will be explored. These include the discussion of self-injury in the context of trauma as well as the role that dissociation and shame play in individuals engaging in this particular behaviour. Thereafter, existing literature on genital self-injury will be presented, initially distinguishing this from other practices that might erroneously be associated with this such as female genital-mutilation and aspects pertaining to BDSM/Kink practice.

A brief overview of research on genital self-mutilation in men vs women will be explored before existing literature on the latter will be discussed in more depth. This includes examining the literature in relation to this type of self-injury and experiencing child sexual abuse, in the context of a personality disorder presentation as well as in the context of concerns around pregnancy and childbirth and a psychotic disorder diagnosis.

Towards the end of this chapter, two recent areas of research will be explored. These include firstly a recent, independent and original research on breast and genital self-harm, which sheds light into the various factors that may influence the lack of awareness and poverty of research in this particular area. The second area of research includes recent studies examining the phenomenon of the use of sex and sexual behaviours as a form of self-injury. The latter highlight important themes that are relevant to and may underlie genital self-injury and further facilitate the understanding of the behaviour explored in this study.

Finally, this chapter concludes with the description of the rationale for this present study, the research aims and question as well as the relevance and implications it poses in the context of the counselling psychology field.

1.2 Literature Search

A thorough and comprehensive literature search was conducted and focused on literature published from 1900 to August 2023. Due to the particular topic researched and expecting poverty in the literature around genital self-injury in women, I decided to broaden my date range in order to obtain as much as data as possible. Databases utilised for the basis of this were PubMed (868 results) , CityLibrary Search (2019 results), PsycNET (106 results), Wiley Online Library (3718 results) and Google Scholar (1180 results). In addition, a range of journals were also utilised for this purpose, examples of which included the databases of SAGE Journals (1128 results) and Taylor & Francis Online. (1567 results). Examples of terms searched in various combinations included 'genital self-injury', 'genital self-mutilation', 'genital self-harm', 'genital self-injurious behaviour', 'genital non-suicidal self-injury', 'female', 'women'. The results were systematically reviewed prior to either being included or excluded in my literature search. Examples of what results that were discarded, were articles that focused solely on general self-harm with no mention of the genital area as well as articles that were irrelevant with the scope of my search such as articles that focused on female genital mutilation versus female genital self-mutilation.

1.3 The Conceptualisation of Self-harming Behaviour

Although self-harming behaviour has gained significant research attention during the past few decades, it has existed for thousands of years and is seen in various cultures and locations around the world (Favazza AR, 1998; Favazza AR & Favazza B, 1987). Accounts of self-harming behaviour can be found in the Bible where it is conceptualized in a multitude of ways including as a sign of insanity, a way towards redemption as well as a symbol of the devil (The Holy Bible, 1994).
Although it is very challenging to establish accurate rates with regards to the prevalence of self-injury across populations for a variety of reasons, lifetime prevalence of non-suicidal self-injury is 18% for adolescents in the general population and 60% in clinical populations (Brown & Plener, 2017; Fredlund et al, 2020) Furthermore, 6% of adults report engaging in self-injury however it is difficult to conclude whether these prevalence rates are accurate (Briere & Gil, 1998; Klonsky, 2011)
Conceptualizing self-harm, takes into consideration the variations in motivation in engaging in this behaviour as well as its intent and there is considerable division between the experts who understand self-harm to be an expression of a continuum of self-injurious behaviours regardless of intent and those that support a categorization of self-harm in relation to the existence or lack of suicidal intent (Ougrin et al, 2009).

There is a plethora of terms used to describe self-harming behaviours including ‘self-injury’, ‘self-inflicted violence’, ‘self-destructive behaviour’, ‘self-mutilation’, ‘para-suicide’, ‘deliberate self-harm’, and ‘non-suicidal self-injury’ among others (Inckle, 2017). Variations in terminology used, pose considerable challenges not only in conceptualizing self-harming behaviours but also has further implications with regards to research, assessment, as well as treatment. Furthermore, many of these terms may be associated with negative judgments and pathologizing or invalidating attitudes towards those that engage in such behaviours (Cresswell & Karimova, 2010; Inckle, 2017).

Inckle (2017) defines self-harm as ‘*any action that causes pain or damage to the body, but this may not be immediate or its primary purpose’* and discusses how there are socially acceptable and socially unacceptable forms of self-harm such as over-exercising or engaging in a number of beauty practices as opposed to for example disordered eating or harmful use of substances.
Self-mutilation as a term, was first used by Emerson in 1913 (Emerson, 1913). This refers to a ‘*voluntary, intentional injury focused on the person’s own body, without suicidal intent’* (Lupu et al., 2021). Non-suicidal self-injury (NSSI) was defined in the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders as the ‘*self-inflicted damage to the surface of the body without suicidal intention and with motives such as relieving negative feelings, resolving interpersonal difficulties, or inducing positive feelings’* (APA, 2013; Fredlund, Wadsby & Jonsson, 2020). Whereas self-injury is defined by Babiker and Arnold (1997) as ‘inflicting pain and/or injury to one’s own body, but without suicidal intent’.
Inckle (2017) contended that distinguishing self-injury from suicide is paramount as the former represents a coping strategy which contrasts with the notion of damaging the self and rather represents a motive of self-preservation. This simultaneously offers the individual that self-injures a sense of control, release and comfort that may not exist in their daily life.

Although a variety of terms have been used to describe self-harming behaviours, the use of term ‘genital-self-injury’ will be used to describe the phenomenon explored in this thesis, except in cases where this is described differently in existing literature.

1.4 Perception, Attitudes and Stigma in the context of Self-Injury

Although significant developments have taken place with regards to conceptualizing self-injury, this often remains misconstrued and carries considerable stigma (Staniland, Hasking, Boyes & Lewis, 2021). Adler & Adler (2007) contended, that self-injury due to its self-inflicted

nature which challenges society's idea around the notion of self-preservation, may be perceived as socially "deviant" behaviour (Staniland et al, 2021).
Furthermore, a plethora of misapprehensions around self-injurious behaviour, involve it being seen as a temporary and superficial behaviour, one that primarily involves adolescents and specifically females more than males, as an attempt to manipulate and seek attention from others or as a manifestation of suicidality (Borrill, Lorenz, Abbasnejad, 2012; Kumar, Pepe & Steer, 2004; Lewis, Mahdy, Michal & Arbuthott, 2014; Scourfield, Roen, & McDermott, 2011; Sandy, 2013; Lloyd, Blazely, & Philips, 2018
Mitten, Preyde, Lewis, Vanderkooy & Heintzman, 2016; Oldershaw, Richards, Simic, & Schmidt, 2008; Hughes et al, 2017)
The erroneous conceptualizations around self-injury, often result in associated stereotypes, which in turn are reflected in discriminatory and prejudicial attitudes towards those that engage in such behaviours .These attitudes are widely documented in the literature and especially in the context of medical and nursing staff as well as mental health professionals who may experience individuals who self-injure as "wasting their time" and as being less deserving of care compared to other patients (Staniland et al., 2021). Moreover, stigmatising attitudes by professionals, such as via the use of demeaning remarks towards service users that engage in self-injury, reinforces patients' low self-esteem and feelings of shame ultimately, impacting their willingness to disclose this (Uddin et al., 2023)
In addition, parents of individuals who engage in self-injury may also share negative views towards their children's behaviour, experiencing this as horrifying and devastating or as a temporary behaviour and as a form of manipulation (Oldershaw et al., 2008, Hughes et al., 2017)
Finally, unhelpful perceptions towards self-injury are also often shared by peers of individuals that self-injure who experience them as engaging in this for attention and as wasting professionals' time (Klineberg, Kelly, Stansfeld, & Bhui, 2013; Staniland et al., 2021).

Lloyd et al (2018), in their study exploring stigmatising attitudes towards individuals that self-injure, found that the greater the belief that a person is responsible for their self-injury, the greater the levels of anger that were reported by the participants. This, consequently, influenced their behavioural responses such as their unwillingness to support those that self-injure. In addition, in the Lloyd et al study (2018) participants perceived those individuals that disclosed their self-injury as more manipulative compared to those who did not, and experienced higher levels of sympathy for those who hid their behaviour. Another interesting finding was with regards to the participants' gender influencing stigmatising attitudes with

males, disclosing higher levels of anger and fear, as well as exhibiting more discriminatory behaviours towards those that self-injure, compared to female participants (Lloyd et al, 2018)

Often, these negative attitudes, are internalized by those that self-injure, and impact the way they relate to and view themselves as well as their willingness to seek help for their difficulties due to perceived stigma (Long., 2018; Staniland et al., 2021; Cleary, 2017; Rowe et al., 2014).
It is common, for individuals that engage in self-injury, to see themselves as anomalous or repulsive and to experience high levels of shame and guilt and as undeserving of support (Long, Manktelow & Tracey, 2015; Chandler, 2014; Lesniak, 2010; Long, 2018; Staniland et al., 2021).

Moreover, the propensity to conceal both the self-injurious behaviour as well as their subsequent wounds from others, can be understood in the context of the stigma that is associated with the interpersonal function of self-harm, such as it reflecting a wish to receive attention or avoid being reprimanded, despite these motivations not representing the majority of those who self-injure (Nock and Prinstein, 2004; Levenkron, 2006).
In the context of this, the individual who self-injures, is presented with a dilemma of knowing that on the one hand reaching out for support is fundamental in their recovery process yet on the other hand recognizing that their self-injury might elicit negative behaviours from others due to being perceived as manipulation (Hasking et al., 2015; Rowe et al., 2014; Lloyd, Blazely & Philips, 2018)

1.5 Self-Injury in Psychiatric Presentations

1.5.1 Overview

The occurrence of self-injurious behaviour in psychiatric presentations has been extensively researched and documented, with clinical psychiatric population prevalence estimated between 40% and 80% (Kerr, Muehlenkamp & Turner, 2010).
The most common psychiatric disorders that show comorbidity with self-harming behaviours in adolescence are borderline personality disorder (BPD) and major depressive disorder (MDD) with between 11-50% of individuals that engage in self-harm, having a BPD diagnosis and 40-50% of individuals being diagnosed with MDD (Haw, Hawton, Houston & Townsend, 2001; Chanen et al 2004; 2008; Boylan, Chahal, Courtney, Sharp & Bennett, 2019; Nock, Joiner, Gordon, Lloyd-Richardson& Prinstein, 2006 ;Jacobson, Muehlenkamp, Miller & Turner, 2008)

Goodman et al, (2017) reported the prevalence rates of non-suicidal self-injury in those diagnosed with BPD, at 95% for adolescents and 90% for adults. This can be understood in context when taking into consideration that self-harm presents a core aspect of the BPD symptomatology and presents a manifestation of a complex interaction with other features of the disorder such as those in the domains of interpersonal challenges, identity disturbance and emotional instability (Reichl & Kaess, 2021).

Although self-mutilating behaviour, has often been reported in the context of BPD and abnormal personality traits, it is also significantly associated with bipolar disorder and particularly in individuals with bipolar I disorder (Joyce, Light, Rowe, Cloninger & Kennedy, 2010).
Another co-occurrence with self-harm, is in the case of eating disorders, where up to 68% of those diagnosed with an eating disorder (ED) disclose engagement with self-harm and up to 61% of those that self-harm, have an ED diagnosis (Svirko & Hawton, 2007).
In a metanalysis by Cucchi et al., (2016) 32.7% of patients with a bulimia nervosa diagnosis and 21.8 % of patients with an anorexia nervosa diagnosis, presented with a history of self-harm which may be understood as a manifestation of the known risk factors underlying these such as impulsivity and emotional lability (Warne et al., 2021)

Finally, the association between self-injury and those presenting with schizophrenia has also been documented, with a recent systematic review and meta-analysis by Lorentzen et al., reporting a lifetime prevalence of self-injury in 31.0% in those diagnosed with a schizophrenia spectrum disorder and 39.7 %, in those presenting with a clinical high risk for psychosis (Challis, Nielssen & Harris & Large, 2013; Taylor, Hutton & Wood, 2015; Lorentzen, Mors & Norgaard Kjaer, 2022).

1.5.2 Self-Injury in the context of Trauma

Survivors of trauma, and particularly those that have experienced complex trauma, present with higher rates of self-injurious behaviour in comparison to those who have experienced single-event traumas and compared to those that had not been exposed to trauma at all (Ford & Courtois, 2009). Complex trauma is understood as a manifestation of a series of repetitive, severe, persistent, and prolonged traumatic incidents that usually takes place at a delicate, with regards to the brain, developmental phase (Ford & Courtois, 2009). Of these individuals, the highest levels of difficulty and challenge are noted in survivors of child sexual abuse. The relationship between this presentation and self-injurious behaviour is mediated

by all-encompassing feelings of self-loathing and shame in the context of their traumatic experiences (Dyer et al. 2009)
Dissociation and somatisation are identified as the symptoms that function as the primary predictor of self-injury in this sub-group. Dissociation can be formulated as a fault in the process of the integration of experiences. Although being a common experience and can hold an adaptive function in the context of attempting to manage stressful and traumatic experiences, it may become problematic when used habitually by the person in their daily life which is a familiar occurrence for survivors of trauma and particularly for those that have experienced childhood sexual abuse. This is since self-injury seems to be particularly successful practice for these individuals to move in and out of dissociative states (Boon, Steele & Van Der Hart, 2011; Sanderson; 2013)
Furthermore, emotion dysregulation, which presents as significant challenge for survivors of trauma, also holds a crucial role in the manifestation of self-injurious behaviour. The notion of emotion dysregulation refers to the individual's difficulty to regulate emotions sufficiently, that is to incorporate external and internal processes in order to determine, evaluate and ultimately select and engage in appropriate responses when encountering a range of emotions, particularly when these are characterized by significant intensity (Thompson, 1994). Consequently, and in the context of encountering difficult experiences, emotion dysregulation may lead to severe lability in mood such as those encountered by individuals with a personality disorder diagnosis, most notably borderline personality disorder/ emotionally unstable personality disorder (Southam-Gerow, 2013).
When faced with such circumstances, trauma survivors may reach out to problematic behaviours instead of adaptive coping strategies, in an attempt to reduce overbearing emotions and experiences. An example of this, which is often observed in mental health services, is suicidal behaviour and self-injury (Dyer et al 2009; Boone et al, 2011; Geddes et al, 2013). Self-injury, in this case, functions as an avoidant in nature coping mechanism, and a way to soothe oneself and cope with distress (Sanderson, 2013; Ougrin et al., 2010)

1.5.3 The role of Dissociation in Self-injurious Behaviour

There are various mechanisms that are involved in causing and maintaining self-injurious behaviour, one of which is that of dissociation (Cernis, Chan & Cooper, 2019; Sommer et al, 2021; Hoyos et al, 2019; Nester, Brand, Schielke & Kumar, 2022)

The term dissociation refers to a mental state that is characterized by perceived fragmentation in the processing of experiences with notable dissociative aspects including,

the states of derealization and depersonalization (Boon, Steele & Van Der Hart, 2011; Sommer et al, 2021)

> The Diagnostic and Statistical Manual of Mental Disorders, defines dissociation as a "*disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control and behaviour*" (APA, 2013, p. 291)

The term derealization, refers to subjective feelings of unreality with regards to the external world, highlighted by a sense of distorted perception around one's environment and surroundings. Depersonalization in contrast, refers to a sense of unreality and disconnection in relation to oneself, one's own body and one's sense of agency (Carlson, Dalenberg, et al., 2012; Sommer et al, 2021).

Dissociative experiences occur both within and in the absence of an established psychiatric disorder and reflect transdiagnostic processes. Dissociation is a common mechanism in disorders that are associated with exposure to traumatic experiences such as post-traumatic stress disorder and borderline personality disorder (Barnow et al., 2012; Carlson et al., 2012) and serves as a mediating factor increasing the risk of and engagement in self-injurious behaviour in those that have experienced childhood maltreatment, and especially sexual abuse (Low et al. 2000; Yates et al, 2008)
In the context of childhood abuse, it is theorized that dissociation reflects a defence mechanism showcased in the form of helplessness or mental avoidance in the presence of inescapable danger or threat (Noll et al., 2003; Krause-Utz et al., 2017; Hoyos et al., 2019)

In a systematic review evaluating the association between dissociation and self-harming behaviour in adolescent participants, Cernis et al (2019), identified a positive correlation between severity and frequency of self-harm and severity of dissociative experience. In addition, Hoyos et al (2019) also established that experiencing abuse considerably increased the risk of engaging in self-harming behaviour; with dissociation being a mediating factor to this association. Dissociation was also associated to self-injurious behaviour in the context of PTSD and BPD with the latter being established as particularly vulnerable to the impact of dissociative experiences (Sommer et al. 2021)
Finally, in a study exploring the relationship between self-injury, emotion dysregulation and dissociation in those presenting with a dissociative disorder, it was concluded that emotion dysregulation was associated with increased dissociative symptomatology and greater engagement in self-injurious behaviour with those that have a history of self-injury in the last 6 months, disclosing higher rates of both dissociation and emotion dysregulation compared to those without recent experience of self-injury (Nester et al, 2022)

Associations between dissociation and self-injurious behaviour may be explained through two different mechanisms, both used to adjust the individual's level of dissociative experience- either through activating or evading this (Cernis et al., 2019). One mechanism hypothesizes that self-injury can facilitate the avoidance of emotions deemed unbearable via the activation of an autonomic response through the dissociative experience. Another model in contrast, proposes that self-injury is used as mechanism to elicit feelings and decrease the dissociative experience which the individual may experience as distressing (Schauer & Elbert, 2010; Klonsky, 2007). Therefore self-injurious behaviour in the context of dissociation, can serve as a maladaptive approach to regulating emotions via either facilitating a disconnection and 'escape' from intolerable feelings and inner experiences or with a function of generating emotion and 'grounding' the individual in to the present moment.

1.5.4 The Association between Shame and Self-Injury

The relationship between engaging in self-injurious behaviour as an attempt to manage challenging emotions and associated states, has already been documented in the literature (Edmondson, Brennan, & House, 2016; Sheehy et al., 2019).
Two emotions that are frequently described in association to one another although referring to separate emotional experiences, are shame and guilt (Tangney, Stuewig, & Mashek, 2007). Shame and guilt are understood as emotions pertaining to an individual's sense of morality and self-awareness in the context of self-evaluation and appraisal (Tangney et al. 2007; Tangney & Dearing, 2002)
The crucial role of shame in relation to self-injury has been previously reported, and a propensity towards experiencing shame has been linked to a greater frequency in the occurrence of self-injurious behaviour with the latter also contributing to the reduction of shame (Schoenleber, Berenbaum and Motl, 2014)

Shame, that has been labelled by C.G Jung as a 'soul eating emotion', can be defined as a ''threat to the self and to the social bond or to self-other relationship" (Jung, 1957; Gunnarsson, 2021). It refers to a cognitive and affective framework which includes negative appraisals of oneself and involves judgments around a sense of inherent defectiveness and undesirability (Chou et al., 2018; Gilbert & Procter, 2006; Sheehy et al., 2019) Shame can be understood as a constellation of emotions often observed in a continuum extending from 'mild embarrassment' to 'penetrating shame' , the latter being more prominent in those that experience mental illness (Scheff and Retzinger, 2000; Gunnarsson, 2021). Moreover,

chronic and long-standing experiences of shame may become embedded in the form of a shame-ridden state of self for the individual, which subsequently contributes into a cycle of shame and self-injury and in turn might result to the formation of a sense of identity around their self-injurious behaviour (Favazza, 2011; Adler and Adler, 2011).

Additionally, shame relates to the border between the self and others and consequently to what is kept private and what is shared (Retzinger, 2002). As a result, shame can be conceptualized as concerning a potential threat to a social connection due to how others might perceive us either in reality, or in our own mind and it is also activated when one might experience a sense of failure to meet cultural standards and morals (Gunnarsson, 2021). Leeming and Boyle (2013) contended that shame may be “understood as a sense of an inferior position in relation to a critical, powerful other whether this is related to an actual experience of being shamed by another person or to a more general sense of an internalised, critical other”.

In the context of the intricacies of relating to the self, whilst also honouring the underlying need to belong and to feel connected to others and the world, self-injury becomes an almost mediating factor ensuring a bridge between both. As Gunnarsson contended,

> *“When experiencing the self, as deeply failed (i.e., living with a shame-ridden self), the act of cutting one’s body becomes a way to try to uphold the social order and maintain (or mend) social bonds with others. Self-injury makes it possible for the individual to get control over the self, and one’s painful emotions and experiences of disconnections, and as one restores the bond to the self, one can again function in everyday life, just like any other individual and to continue to meet social and cultural expectations and obligations.”* (Gunnarsson, 2021)

In their systematic review and meta-analysis exploring the association between shame, guilt and self-harming behaviour, Sheehy et al (2019), highlighted a link between shame and self-injury. Specifically, they mentioned that those that have engaged in self-injury, reported higher rates of shame in comparison to the individuals that did not self-injure with a positive correlation between shame and frequency in the occurrence of self-injury (Sheehy et al, 2019).

Shame however can also be a precursor and outcome of self-injurious behaviour such as in the context of shame around subsequent scarring (Bachtelle & Pepper, 2015; Curtis, 2016)

Furthermore, in a study by Xavier, Gouveia and Cunha (2016), the relationship between the manifestation of self-criticism in persecutory and hateful attacks towards the self and the association with self-injurious behaviour in adolescents, was also established.
Finally, shame has additionally, played a significant role in the context of Lesbian, Gay, Bisexual and Trans (LGBT) individuals engaging in self-injury and suicidal behaviour and is conceptualized as a mechanism to avoid shameful emotions (McDermott, Roen and Scourfield, 2008)

1.6 The case of Genital Self-mutilation

Genital self-mutilation is a presentation that has rarely been discussed in medical and especially psychiatric literature, despite it posing a medical emergency that is accompanied by serious and tremendously challenging complications (Lupu et al., 2021). From a medical standpoint, these complications can be explained in the context of the microbial flora and the marked vascular area in this particular body part. Due to the majority of literature available, consisting of the publication of single case studies, drawing accurate conclusions around this type of self-injurious behaviour, is highly challenging (Boyer & Tucker, 2020; Lupu et al., 2021). This is also combined with the fact that actual prevalence rates are difficult to establish since genital self-mutilation, is significantly under-reported ((Lupu et al., 2021).

The term genital self-mutilation refers to the deliberate act of damaging one's body tissue aimed at modifying this, or with intention to ease oneself from overwhelming thoughts and emotions relating to this particular area of their body. Similar to other types of self-injury, genital self-mutilation does not usually involve suicidal intent. While men participate in genital self-mutilation, through acts varying from surface level cuts on their genital area, to partial or total removal of the penis or testes, in women, this behaviour is exhibited in the form of inserting objects in their vagina as well as performing self-genital excision or damaging their genitalia via burning, scratching, cutting etc or performing acts of self-clitoridectomy and often present as vaginal bleeding without a known origin (Reich & Wehr, 1973; Alao, Yolles & Huslander, 1999; Sanderson, 2006; Conde et al. 2017; Veeder & Leo, 2017).

With self-injury occurring in a continuum, and the most common presentations referring to superficial or moderate acts of self-harm, cases that present in the most severe end of this, are uncommon and the majority of them occur, according to existing literature, in patients presenting with psychotic disorders and are predominantly reported and discussed from a surgical point and medical point of view (Conde et al., 2017).

With regards to male genital self-mutilation, research has identified three subgroups; firstly, individuals who self-harm in such a way in relation to being in a psychotic state and following command hallucinations, individuals identifying as trans, intending to perform sexual self-reassignment, and finally, individuals who present with severe depression who self-injure in the context of a suicidal manifestation (Conde et al., 2017).
Whether suicidal intent is an underlying factor in genital self-mutilation or if this behaviour constitutes non-suicidal self-injury is subject to controversy with some viewing this as a manifestation of suicidal intent or it being a manifestation of 'focal suicide' which can be understood as destroying a part of the self in replacement of the whole (Meninger, 1938; Veeder & Leo, 2017). In a systematic review by Veeder and Leo (2017) it was found that suicidal ideation and intent was experienced by 15% of men that genitally self-mutilated (26 of 173 cases) and the association between these and psychotic symptoms such as hallucinations and delusions were found in 31% of cases (8 of 26). In addition, in 9 of 26 cases (35%), these men had ended their lives. Of these 9 cases, 6 had diagnoses of schizophrenia spectrum disorders, 2 had an unspecified diagnosis and 1 individual had a diagnosis of major depression whereas gender dysphoria was not present in any of the suicidal individuals (Veeder & Leo, 2017). In the above systematic review, the majority of individuals engaging in GSM and in the context of also presenting with suicidal ideation/intent, their ideation was manifesting in the context of pathological preoccupation with feelings of guilt, hallucinations and delusions (Veeder & Leo, 2017).
This demonstrates that in some cases, suicidal intent plays a role in men engaging in genital self-mutilation.

Female genital self-mutilation on the other hand, is captured in the following three subgroups: in an effort to conduct self-induced abortion, in women presenting with personality disorders and particularly with those diagnosed with borderline personality disorder and those that present with psychosis. With regards to the BPD subgroup, and subsequent genital self-mutilation, this may function as an attempt to regulate overwhelming emotions and to convey distress with the aim of eliciting support from others (Conde et al., 2017).

Although ultimately a rare phenomenon, genital self-mutilation in men seems to be much more acknowledged and researched in the literature. In contrast, female genital self-mutilation, based on the existing literature, appears to be extremely rare and research around this, is scarce.

1.6.1 Distinguishing Female Genital Mutilation from Genital Self-Mutilation

Through discussing this research project with colleagues and other professionals, an issue I often encountered, was the confusion between female genital mutilation and genital self-mutilation. This can in part be explained by the similarities in the words used to describe these two practices although these are and refer to entirely distinct phenomena, as will be clarified below.

Female genital mutilation (FGM) refers to a cultural practice, usually performed by specific practitioners within a given community and entails injury or partial or total removal of the external female genitalia and genital organs, in the absence of a medical rationale (World Health Organization, 2008; Litorp, Franck & Almroth, 2008).
The term ‘mutilation’ within the context of FGM, which was originally used to highlight the significant harm in this practice, is now often seen as problematic as it is perceived to carry a negative and pejorative undertone and it is not uncommon for terms such as female cutting or female circumcision to also be used to describe this (Elamin & Jones, 2020)

With regards to the prevalence of the FGM practice worldwide, more than 200 million girls and women have been impacted, with an estimated 3 million girls being at risk of undergoing FGM every year, mostly in countries of South Asia, Africa and the Middle East (United Nations Children’s Fund 2016; Elamin & Jones, 2020)
Although the practice of FGM has overall declined through the years, this decline has not been uniform across all countries (Todkari, 2018; Elamin & Jones, 2020)

According to the World Health Organization (2008), there are four different FGM subtypes which include a partial or total clitoridectomy (Type I), the partial and total removal of the clitoris and labia minora (Type II), the removal of external genitalia and sealing via the use of sutures the vaginal opening (Type III) and a final subtype (Type IV) which includes all other forms of genital mutilation such as use of corrosives and piercing of the genitalia (Elamin & Jones, 2020).

FGM practice which unfortunately persists despite the suffering it causes, results in a plethora of physical and mental health challenges. These include but are not limited to experiencing tremendous pain in the context of the procedure often taking place without anaesthesia, clinical complications such as infection due to it often taking place in settings that cannot ensure high levels of hygiene among others all of which have profound

implications for women's sexual, reproductive, and mental health. (Berg, Underland, Odgaard-Jensen, Freitheim & Vist, 2014; Elamin & Jones, 2020)
Furthermore, and in spite of significant awareness and attempts to prohibit this practice, positive attitudes towards FGM, still persist across many countries worldwide which may be a reflection of deeply embedded cultural, social and religious beliefs (Jahangiry, Pashaei and Ponnet, 2021)

In the context of what has been discussed above, one can distinguish FGM from self-injurious behaviour as the first refers to a type of sexual and physical abuse under the façade of cultural and religious practices whereas the latter refers to the deliberate harm of the self which is often in the context of attempting to manage overwhelming feelings and experiences.
Finally, an important distinction between FGM and genital self-mutilation revolves around the notions of consent, autonomy and agency. Female genital mutilation refers to a culturally sanctioned practice, often performed on children and young women who are unable to provide informed consent and whose autonomy is overridden by external individuals in their social environment imposing and performing this practice. Genital self-mutilation on the other hand, although a harmful and maladaptive psychological practice, even in the context of mental health concerns that may compromise the individual's decision-making capacity, remains a volitional act, involving the individual's consent and exercise of their agency and autonomy.

1.6.2 Distinguishing Genital Self-Injury from BDSM and Kink Practices

Although there are some BDSM/Kink practices that might resemble genital self-injury in the context of what was discussed earlier in this chapter, the phenomenon described in this thesis is distinct from these in ways that will be explored further below.
BDSM, is an abbreviation for a term that encompasses a range of concepts, expressions as well as consensual behaviours and activities that take place within a particular relationship structure (Magliano, 2015).
BDSM practices may occur within consensual relationship structures as well as occur within practices that a single individual engages in on their own. In this case, they are commonly and informally described within BDSM communities by the terms "solo play", "solo kink" and "solo BDSM".
'Kink', is a broad, informal term that describes sexual behaviours that are considered non-normative and is included within the BDSM context (Shahbaz & Chirinos, 2021)

The letters B and D traditionally stand for 'bondage' and 'discipline' whereas the letters D and S stand for 'dominance' and 'submission'. Finally, letters S and M stand for 'sadism' and 'masochism' respectively and also refer to terms 'master' and 'slave' which describes a specific relationship dynamic between two consenting adults in the context of which one assumes responsibility and authority over their willing partner (Shahbaz & Chirinos, 2021)

BDSM practices are part of a continuum and include activities relating but not limited to restraining, inflicting pain or extreme sensations in the context of punishment as well as involving psychological aspects of control (Shahbaz & Chirinos, 2021) It is important to distinguish however that not all aspects relating to BDSM are embedded in sex as BDSM also offers a way of achieving altered states of consciousness, with some individuals describing them as spiritual in nature and eliciting positive feelings such as gratitude or love (Beckmann, 2008; Harrington, 2011; Shahbaz & Chirinos, 2021)
An example of a particular activity designed to elicit a heightened sensory response in the receiving individual, is that of 'knife play'. Knife play is a term that describes the use of knives, razors and other sharp instruments and may or may not include the breaking of skin. This practice is part of a number of activities that are described broadly as 'edge play' due to their high-risk nature (Goerlich, 2021)

Differentiating genital self-injury from particular BDSM practices such as knife-play can be illustrated taking into consideration a number of values underlying BDSM practice and community. According to Goerlich (2021), these include *connection* and its use via the use of sensory play and power exchange to achieve a sense of bonding; *transparency*, which is deemed an essential component in fostering trust and intimacy; a sense of *mutual regard* which is rooted in concepts of respect, trust and care and includes aftercare following any BDSM related activity; *consent*, *inclusion* and certainly, *safety*.

Although harm may occur in the context of BDSM/Kink practice, the underlying desire for intense sensation and even pain is different to the pathology that underlies engagement in self-injury (Goerlich, 2021). Whether self-injury is in the context of pathology depends on a plethora of factors, seen in context, which include the manner of self-injury, its frequency, any precipitating factors, and the feelings that follow this (Shahbaz & Chirinos, 2021)
The difference in motivation is illustrated in the words of R.F. Baumeister (1988): *"It appears that masochists persistently seek pain but carefully avoid injury…masochism does not involve seeking harm to self. Pain is often sought, but injury is widely and carefully avoided".*

In the context of masochism and those that might engage in BDSM related activities, ‘good pain’ is not associated with shaming oneself for enjoying a sensation or practice rather than consciously searching for a particular kind of pain. In contrast, ‘bad pain’ emerges when pain is ego dystonic in nature, is undesired and compulsively inflicted. There is also often, limited insight on the psychological and emotional internal processes that take place in the context of their behaviour (Shahbaz & Chirinos, 2021)

Furthermore, Goerlich (2021) contends that when an individual is in a state of self-loathing such as seen often in individuals engaging in self-injury, any activity involving pain cannot be undertaken in a risk-aware and safe manner as the focus of self-injury is to externalize the pain or suffering, they experience within themselves.
A defining point around differentiating genital self-injury from BDSM/Kink practice might lie on the mere fact of how the individuals themselves formulate, and ultimately label their own experience. BDSM is conceptualised as a leisure and nonpathological sexual practice that is not inherently maladaptive or harmful (Brown et al., 2020; Mellin & Young, 2022).

1.6.3 Distinguishing Genital Self-Injury from Sex Addiction and Compulsive Sexual Behaviour

An important distinction that is worthy of exploration is that of genital self-injury from behaviours categorised as sex addiction or compulsive sexual behaviours. That is due to all three concepts, including engagement in maladaptive behaviours that are related to, or in the case of genital self-injury may be perceived as relating to, sex/sexual activity and are manifesting in functioning impairment and/or high levels of distress for the individual.

A range of terms have been used to define a psychological disorder describing and individual’s inability to resist their sexual behaviour. These include terms such as sexual compulsivity, sexual addiction, hypersexuality or sexual impulsivity among others. However, the extent to which these behaviours should be conceptualised as a compulsion, an addiction or an issue that concerns impulse control can be argued especially in the context of each description implying a different model of aetiology and treatment (Sahithya & Kashyap, 2022).
What differentiates these presentations from other sexual, behavioural patterns can be summarised in the individual’s inability to control their behaviour and to stop engaging in this, despite its harmful consequences (Sahithya & Kashyap, 2022).

According to Carnes and Adams (2020), there are some common patterns seen in sex addiction, as described in the literature. These include an engagement and preoccupation with impulses, sexual urges, and behaviours or preparatory behaviours, often during time reserved for other duties or activities, alongside a persistent wish yet failure to stop these. Moreover, these behaviours serve as a coping mechanism to avoid emotional or physical distress (Carnes & Adams, 2020).

Finally, these behaviours have also been associated to adverse childhood experiences such as emotional, physical and sexual abuse and also present alongside other comorbidities with personality disorders being reported as the most common comorbid condition (Sahithya & Kashyap, 2022)

Although one may argue that there is an overlap between some of the themes underlying genital self-injury and compulsive/addictive sexual behaviours and there may be a degree of persistence and compulsion pertaining to both, these are distinct with regards to their underlying mechanism and manifestation.
Genital self-injury refers to a non-sexual coping mechanism of regulating emotional distress via inflicting pain or damage that area of the body whereas compulsive sexual behaviours are sexual in nature and are not characterised by the intention of causing physical pain or harm, although this may be an unintended consequence. Therefore, in genital self-injury, the primary intent is to self-injure whereas in compulsive sexual behaviours the primary concern is to alleviate a sense of distress via sexual means and sexual gratification.

1.6.4 Male Genital Self-mutilation

The first article relating to male genital self-mutilation was published in 1901 and over 173 cases have been reported in the literature (Stroch, 1901; Veeder & Leo, 2017). In the context of a systematic review by Veeder & Leo (2017), the following subtypes of male genital self-mutilation became apparent: 62 cases involved penile amputation, 21 involved mutilations of their genitalia, 34 included combined amputation and castration and 56 involved castration alone. In the same study, and with respect to psychiatric diagnoses, the largest proportion of the individuals, were diagnosed with schizophrenia spectrum disorders (49%), followed by substance use disorder (18.5%), personality disorders (15.9%) and gender dysphoria (15.3%). One important aspect to consider with regards to personality disorder and substance use diagnoses is that these may frequently be underestimated as reports often rely on primary diagnoses. With regards to self-amputation, this has been observed considerably more frequently in schizophrenia spectrum disorders. In parallel, self-

castration, occurred more often in cases of gender dysphoria, compared to any other group. With regards to the mediating factors that may lead men to engage in these behaviours, the following aspects all seem to play a role and include somatic concerns and feelings of shame in the context of transsexualism, delusions of a religious nature and psychosis as well suicidal intent (Veeder & Leo, 2017; Eke, 2000).

Male genital self-injury has also been linked to experiencing sexual abuse. The following short extract showcases how a survivor, who was sexually abused by his mother and sister as a child, engaged in genital self-injury in the context of trying to manage the impact of his traumatic experience:

> *"[When I was dealing with the sexual abuse, there were times] when I was really considering cutting my dick off. Really hurting myself. I went through a stage when hurting myself was really appealing and I didn't want to have a penis. I didn't want to be sexual…"* (Denov, 2004, 151)

1.6.5 Female Genital Self-mutilation

1.6.5.1 Female Genital Self-injury and Child Sexual Abuse

Articles regarding cases of female genital self-mutilation in the literature remain a rarity, with the exception of a number of anecdotal reports, online forums discussions and psychotherapy related books, alluding to this topic. Furthermore, as and when these cases do present, the connections between this behaviour and having experienced child sexual abuse has not been extensively explored even though this is heavily suggested.

Sanderson (2006) has discussed the link between genital self-mutilation and a history of sexual trauma in the case of 'Linda', who is a 38year old child sexual abuse survivor, and as a result also experience significant dissociation. Linda, when feeling emotionally overwhelmed, would *'slash the outer labia of her vagina, in the hope of slicing it off completely. During these episodes of self-mutilation, she felt compelled to completely remove her external genitalia, including her clitoris'* (Sanderson, 2006).

In Hyman's book, *'Living with Self-Injury'* (2010), two other cases with a similar history, are mentioned. The following case of 'Jane', who is a survivor of child sexual abuse perpetrated by her father, also presents with genital self-mutilation:

> *'There have been times, when instead of cutting my arm… I've cut inside my vagina or done other things to cause pain: inserting a stiff brush into my*

vagina…sometimes I would leave it there so that I felt pain through most of the day.' (Hyman, 2010)

Hyman (2010) also mentions the case of 'Karen' who is also a survivor of father-daughter incest and engages in genital self-injury by cutting her vaginal area in the context of feeling that her father had destroyed a part of her sexuality.

'I don't like that part. I want to hurt it.' (Hyman, 2010)

Finally, in a study by Denov (2004), exploring the experience of sexual abuse by females, 33% of the participants engaged in self-injury which included a range of behaviours such as burning, cutting themselves as well as self-harming behaviours of a sexual nature. One female participant who had been sexually abused by her mother as a child, shared the following:

"When I talk about the sexual abuse by my mother…I'm so embarrassed…I feel so bad…I often want to turn on myself…I harm myself sexually. When I was being sexual with myself, I would be very rough and hurtful. I used to stick things up inside me… My mother used to stick things in me. I'm sure it's related to that." (Denov, 2004, 151)

1.6.5.2 Female genital self-injury in Personality Disorders

Conde et al (2017), described a case of a 20year old female, attending the emergency department having self-amputated her clitoris via surgical scissors. The patient demonstrated critical awareness throughout all stages of the self-mutilation process and presented with substantial concerns around her sexuality. Her case was formulated as a personality disorder disturbance.

'I am a thing now; I don't want to have a clitoris. I am not like others; I am not a prostitute… I do not want to be a man or a woman. I want to be a thing' (Conde et al., 2017)

Taking into consideration that it is difficult to draw conclusions, this article seeks to explore a connection between disrupted sexuality and genital self-mutilation. It also highlights

significant factors that may partially explain the scarcity of literature around female genital self-injury.
Conde et al (2017) provides an important justification for the variation between reported numbers of cases of male vs female genital self-mutilation suggesting the significant contribution of stigma and shame around the nature of this particular type of self-injury. Furthermore, they contend that male genital self-injury cases surface more frequently due to the likely life-threatening nature and consequences of male genital self-mutilation which often requires urgent surgical and/or urological medical care. In contrast, and due to the nature of female genital self-injury and female physiology, this may be hidden more easily, leading to many cases remaining undetected and underreported. Their final conclusion concerns the notion that psychiatrists tend to get involved in cases where clients are overtly psychotic and that these are published more easily in comparison.

In addition, and drawing similar conclusions, Alao, Yolles and Huslander (1999), indicated that the notion of genital self-injury is recognized more in males compared to females due to the nature of male genital self-injury being more severe and therefore leading to higher rates of reporting compared to that of females. Alao et al, introduce a case of a 23-year-old female with diagnoses of borderline personality disorder, polysubstance abuse and post-traumatic stress disorder who has self-injured on a number of occasions via the insertion of a razor blade into her vagina. The patient denied any psychotic symptoms and was consciously aware of her self-injury. This client's history highlighted a 'chaotic early upbringing' compounded by experiencing child sexual abuse and physical abuse by her stepfather and uncle, between the ages of 7 and 10 years and also exposed to similar experiences between the ages of 11 to 15 years, by her foster parents (Alao et al, 1999).

1.6.5.3 Female genital self-mutilation and perception around pregnancy and childbirth

A number of past studies have proposed that female genital self-mutilation could be recognized as an effort by the patient to conduct a self-induced abortion, as well as to attempt dealing with overbearing feelings around childbirth and pregnancy (Gerstle, Guttmacher & Brown, 1957; Goldfield & Glick, 1970; Simpson, 1973).
Goldfield & Glick have illustrated the case of a 19-year-old female patient, who has scratched and gorged her internal genitalia with her fingernails, in the context of wishing to receive a hysterectomy following the birth of her illegitimate child. Another case, presented by Gerstle, Guttmacher & Brown (1957), referred to a patient who repeatedly injured her vagina using a knitting needle and a hatpin during her last pregnancy, as a result of fearing this in the context of a traumatic delivery during her previous pregnancy. It is important to

note however, that it is not certain whether these explanations would still occur today or are merely reflective of a different time.

1.6.5.4 Female genital self-mutilation in Psychotic Disorders

The most recent study presenting a case of female self-mutilation case related to psychotic disorders have been published by Vohra in 2010. The patient in this case was a 29-year-old female, who has mutilated her nipples and genitalia with the usage of a knife while facing delusions around her family being harmed unless she self-injured in this precise manner. The following cases show similar patterns. Standage, Moore & Cole (1974), report a 20-year-old female patient injuring her own cervix and vaginal vault via inserting sharp items, following command hallucinations which were dictating her to do so. This patient has disclosed a history of child sexual abuse, carried out by an elderly neighbor. Wise, Dietrich & Segall (1989), wrote about a 33-year-old female patient who self-mutilated by amputating her labia majora, being convinced that her employer believed that she had genital warts. A more up-to-date study reports the case of a 29-year-old female patient who had a diagnosis of schizophrenia, that carried out lacerations on her labia majora due to having delusions around having a perceived engorged clitoris, which she felt was a result of excessive masturbation (Krasucki, 1995).

1.6.6 A recent, independent, research on Genital and Breast Self-Harm

An original, independent research exploring the lived experience of genital and breast self-harm was conducted by W. Aves (2023) and published in their blog, “Psychiatry is Driving me Mad”. This study, aimed to explore individual’s experience of genital and breast self-harm especially with regards to underlying motivations and functions of the behaviour as well as individuals’ experience of disclosure and seeking treatment vs non-disclosure/ not seeking treatment for this.

This study utilized an online questionnaire which was shared on social media and included a number of open and closed questions and responses were collected anonymously. Respondents included 137 adults with direct experience of genital and/or breast self-harm as well as thoughts or urges to engage in this particular behaviour. As 32 submissions were deemed incomplete, responses from 105 individuals were deemed valid. The sample included of 62% cis gendered women, 11% non-binary individuals, 7% trans men and 7% genderqueer individuals. Only a small group of individuals identified as cis men (3%) and

trans women (1%), which contradicts findings in historical literature indicating a higher prevalence of genital self-injury in trans women and cis men. (Aves, 2023)

With regards to findings, 31% of the sample reported engaging in self-injury in their breast area with 23% reporting engaging in both genital and breast self-injury and 20% engaging in genital self-injury alone. With regards to reporting thoughts and urges to harm either or both of these areas, 24% responded affirmatively and 2% preferred not to say.
Only 21% of the sample that engaged in this type of self-injury sought medical care around this, the majority of which attended an Accident and Emergency department (71%) and only some reported having discussed medical aspects pertaining to their self-injury with mental health professionals (Aves, 2023).
With regards to their experience of healthcare professionals' responses around their disclosures, 67% shared they had not disclosed this, and from those that did (32%), the majority (56%) shared their experience was negative and 18% reported this as neither positive, nor negative. Many individuals shared comments they had received reporting staff unwillingness to acknowledge and explore their disclosure with examples such as staff changing the topic, appearing embarrassed and sharing assumptions with regards to the motivation underlying their self-injury. Furthermore, comments with regards to treatment received in A&E by medical staff, deemed their responses as 'cruel' with staff reportedly 'mocking', 'laughing', 'degrading' and 'insulting' the individuals presenting with this type of self-injury (Aves, 2023).

The most significant reason reported as a barrier to disclosing their self-injury was shame (64%), which respondents identified it relating to several reasons including their overall engagement in self-harm, the topography of their self-injury and the association between this and past traumatic experiences as well as overall feelings reflecting a negative way of relating to themselves. Furthermore, feelings of shame were aggravated by professionals' negative responses among others such as concern around being sectioned, having to undergo physical examination or treatment without their consent as well as details around their self-injury being included in their medical notes (Aves, 2023).

With regards to reported motivations underlying their genital/breast self-injury, respondents offered a number of reasons. These included, responding to feeling ashamed and hating themselves as well as the perception that this area of their body 'did not belong to them 'and in managing painful feelings. These were in the general context of gender dysphoria as well as in response to the physical sensations experienced such as in the context of trauma-related flashbacks, menstruation, sexual arousal, and the physical urge to engage in

masturbation. Only a small minority of motives related to genital self-injury being in the context of psychotic experiences and in the context of communicating their distress to others, which is once again in contrast to motivations reported previously in the literature. Further comments, also reflected motivations relating to feelings stemming from experiences of sexual abuse such as those of disgust towards the self, anger towards their body and wishing to hurt this, a wish to negate their abuse by hurting this particular area of their body or in the context of having experienced body shaming via being bullied among others. A few respondents mentioned motivations pertaining to practicality, examples of which include self-injury in this area being hidden more easily or deemed to be less dangerous. Finally, the vast majority of respondents (77%) related their self-injury to having experienced trauma such as childhood abuse and sexual violence whilst others reported this was unrelated. (Aves, 2023).

Some comments by respondents reflecting overall their experience with self-injury as well as the findings of this study included the following:

> *"It is a quiet type of private violence. Of all the ways I have self-harmed, this type has felt the most intimate and personal."*
>
> *"I don't speak of it. I don't even really see other trans people speak of it so it makes me feel kind of gross and awful, like I can't even be trans correctly…"*
>
> *"That what was done to me doesn't come close to what I do to myself…"*
>
> *"I had no idea that there were other people who experience this. I have felt like a freak and so alone…"*
> (Aves, 2023)

The relationship between shame and secrecy around this type of self-harm is poignantly noted in the following comment by the author, W. Aves (2023), who also reported having lived experience of both genital and breast self-injury:

> *"The shame which often accompanies such a stigmatised from of self-harm, can act like a barrier between us, holding us apart, maintaining our silence and solitude."*

Differences in reported underlying motivations of genital self-injury in recent literature, such as in the context of trauma or gender dysphoria, differ from motivations identified in earlier research for example in the context of psychotic experiences. These differences may reflect

cultural and sociopolitical changes over time such as the awareness and acceptance of diverse gender expression, advancements in the understanding of mental health and in diagnostic classifications as well as increased awareness and reporting of mental health concerns. Finally, developments in research methodology may also play a role in recent findings.

1.6.7 The Use of Sex as Self- Injury

A phenomenon that has gained research attention the past few years and shares some similarities and underlying themes with genital self-injury is that of the use of sex as self-injury (Fredlund & Jonsson, 2023).
It is widely understood that self-harming behaviours include both acts of direct self-injury towards one's body such as encompassed in the term, non-suicidal self-injury (NSSI), as well as acts of indirect self-harm examples of which include eating disorder difficulties, harmful use of substances and engaging in high risk sexual activities (St.Germain & Hooley, 2012; Mellin & Young, 2022)
SASI (Sex As Self-Injury) was originally defined as "*when a person has a pattern of seeking sexual situations involving mental or physical self-harm to themselves. The behaviour causes significant distress or impairment…*" (Jonsson et al., 2019). Behaviours related to SASI have their onset in adolescence with a US based, 2012 study reporting that 12% of college students engaged in sexual activity with the aim to cause physical and emotional harm to themselves (Fredlund et al., 2020; Mellin & Young., 2022)
Examples of behaviours that constitute SASI include but are not limited to selling sex as a way to manage emotions, sexual activity that includes significant levels of risk such as a wilful exposure to sexually transmitted diseases, activities that involve pain and or bodily harm, masturbating to the point of pain, recreating experiences of child sexual abuse via injuring their own genital area as well as wilful exposure to abuse by a partner (Zetterquist et al., 2018; Fredlund et al., 2020; Mellin & Joung, 2022)
Furthermore, SASI includes activities causing both emotional and bodily harm in the context of both partnered activities as well as ones that the individual engages on their own and are different to engaging in BDSM activity, as explored in a previous section of this chapter. (Mellin & Joung, 2022).
One of the core components identified as underpinning SASI was experiencing feelings deemed intolerable and specifically those of significant anxiety, depression, emptiness, self-loathing as well as dissociative states and states relating to previous trauma-related experiences that the individual is trying to regulate through their self-injury (Zetterquist et al., 2018)

SASI has been associated with experiences of victimization and specifically sexual abuse with those that had suffered earlier and penetrating sexual abuse engaging in SASI compared to those that engaged in NSSI alone and report greater levels of trauma-related symptomatology (Zetterqvist, 2018). The unique association between this type of abuse and engagement in SASI, may be formulated under the notion of a trauma-related re-enactment, via sex being utilised as a way of managing the impact of penetrative sexual abuse and subsequent symptoms and in the context of SASI offering either a sense of control, a manner in which the survivor emotionally regulates themselves or as a way to punish the self in response to feelings of self-loathing following the abuse (Fredlund et al., 2017; 2020; Fredlund & Jonsson, 2023; Zetterqvist, 2018)
This association is unsurprising as literature has previously demonstrated a relationship between experiencing child sexual abuse and a number of maladaptive coping behaviours of sexual nature such as compulsive, impulsive and problematic sexual behaviours, hypersexuality as well as sexual addiction and out-of-control sexual behaviour (Slavin et al., 2020; Fredlund & Jonsson, 2023)

The above can be understood taking into consideration the Traumagenic Dynamics Model developed by Finkelhor and Browne in 1985, which discusses the aftermath of sexual violence via four distinct dynamics that represent the impact of child sexual abuse with regards to the way the survivor conceptualizes themselves, their emotional states as well as the way they sexually relate to others. These dynamics include *betrayal*, which refers to a need for reclaiming safety and trust and often leads the survivor to develop erroneous judgments around the trustworthiness of others, *powerlessness*, which relates to a wish to reclaim a sense of control such as re-enactments of the abuse, *stigmatization* which is associated with feelings of guilt and shame resulting in a range of problematic and harmful behaviours as ways of coping with these and *traumatic sexualization* which relates to manifestations of compulsive sexual behaviour and preoccupation as well as negative attitudes towards sexuality and sex (Finkelhor and Browne, 1985; Fredlund et al., 2020; Fredlund & Jonsson, 2023).

1.7 Rationale for the Present Study

Although self-injury has been considerably investigated in the literature, the domain of genital self-injury has been marginally explored. Genital self-injury is defined as the intentional action of mutilating or injuring one's own genital tissue with the aim of easing oneself from overpowering emotions and attitudes they may hold around this particular area of the body (Sanderson, 2006). This type of self-injurious behaviour has been briefly

explored in males with the majority of relevant research showcasing that this is primarily explored from a medical standpoint yet has been rarely researched in females (Conde, Santos, Leite, Vicente & Figueiredo, 2017).

Current research supports the notion that there are variations between sexes with regards to the motivation underlying their engagement in genital self-injury which subsequently influences how professionals explore and implement treatment and care plan options (Stroch, 1901; Conde et al., 2017; Veeder, 2017; Eke, 2000; Sanderson, 2006; Hyman, 2010; Gerstle, Guttmacher & Brown, 1957; Goldfield & Glick, 1970; Simpson, 1973; Vohra, 2010; Standage, 1974; Wise et al., 1989; Krasucki, 1995).

The purpose of this current study is to explore the experience of adult women's engagement in genital self-injury which will consequently compliment the formulation of this behaviour, foster understanding and reduce negative perceptions around this. Attending to the gaps of the current literature will not merely influence treatment options yet would furthermore inform good practice which will be relevant for professionals of various disciplines. Additionally, this is especially applicable to the counselling psychologists, for which conceptualizing genital self-injury is crucial as they encounter a plethora of mental health presentations where self-harming behaviours transpire.

Taking into consideration, the tentative associations drawn from the existing literature, and in the context of its location, genital self-injury appears to be trauma-specific in part (Hyman, 2010; Sanderson, 2006). Paucity in current literature and lack of awareness around this type of self-harm, might be additionally explained by the stigma that is associated with trauma of a sexual nature. Therefore, counselling psychologists and other professionals that encounter and support those that engage in self-injurious behaviours in addition to individuals that present with trauma-related conditions such as personality, dissociative and post-traumatic stress disorders may apply knowledge obtained from this research, to guide their own practice and to influence overall clinical recommendations.

Finally, the main objective of this study is to answer the research question: 'How do women that engage in genital self-injury, make sense of their experience?' via utilizing a phenomenological standpoint and whilst also navigating the existing literature. Ultimately this research study hopes to give voice to a group of individuals that have been largely ignored or misrepresented in the current literature and bring attention to this profound and multi-faceted behaviour that holds such intricate implications.

Methodology

2.1 Overview

The aim of this chapter is to demonstrate the theoretical, methodological, and procedural aspects of the current study. I initially present my research aims, rationale and research design and proceed to introduce the reader to the theoretical components of the research which include my epistemological position as is underpinned by my own philosophical principles. The chapter further demonstrates my basis for adopting a qualitative approach to explore my research question and the rationale for selecting Interpretative Phenomenological Analysis as a suitable methodology to address the aims and research questions of this study. In addition, procedural aspects of the study are clearly outlined. These are followed by a detailed description of the ethical considerations in order to showcase adherence to relevant ethical guidelines. The final section of this chapter focuses on the area of methodological and personal reflexivity and examines the impact that my own perceptions, prior knowledge, preconceived notions, and overall value system might have had on the research process.

2.2 Research Design

For the purpose of this study, a qualitative method employing face to face as well as remote semi-structured interviews was used. Participants included adult women who currently engage in genital self-injury or have done so, in the past and who were also receiving professional mental health support. Interpretative Phenomenological Analysis, a qualitative approach with an idiographic focus was chosen to explore the research question, "How do women that engage in genital self-injury, make sense of their experience." The particular methodology of IPA investigates how individuals may make sense of important experiences under specific circumstances (Smith, Flowers and Larkin, 2009). The ultimate purpose of this research is to give voice to a group of individuals that has been overlooked and not represented in the body of literature and to further encourage awareness around genital self-injury. This would further educate and illustrate multidisciplinary professional practice including in the context of counselling psychology that encounters this presentation (Smith, 2008).

2.3 Theoretical Components of the Research

2.3.1 Rationale for a qualitative approach

In comparison to quantitative research, qualitative research is primarily exploratory in nature and aims to depict and gain insight into the human experience via a process where participants are given a platform where they can provide accounts of their experience from their own perspective (Willig, 2012). A qualitative approach can offer rich perspectives on individuals' behaviours, feelings and motivations enabling a deeper understanding of a given phenomenon. It can be conceptualized as an investigative method that intends to analyse data via the medium of language and behaviour (Berkwits & Inui, 1998; Lincoln & Guba, 1985). In addition, given that participants are at liberty to use their own words to define their own experience this also contributes in reducing the power differential between participant and researcher. This distinguishes it from a deductive approach which is characterized by predictions stemming from assumptions based on existing theories therefore suggesting the presence of an objectively measured, generalized truth (Willig, 2012).

Since the aim and focus of my research study is to capture and understand how women make sense of their experience of genital self-injury and any meaning they assign to this, and not to quantify their account, the selection of qualitative methodology seemed most appropriate.
Since a plethora of qualitative methods are available, selection of the one deemed most suitable to guide a study's research design, is centred around the researcher's theoretical and philosophical positioning, and in the context of the aims of their research. This is of particular importance as obtaining valid information may not be possible should the methodological choice not align with the researcher's view of the world (McLeod, 2014; Smith & Osborn, 2015)

Interpretative Phenomenological Analysis is a particularly suitable and advantageous methodology in exploring intricate, complex, and under-researched areas as well as those that evoke powerful emotions (Smith & Osborn, 2015). Therefore, in the context of the reasons outlined briefly above and the discussion of various aspects throughout this chapter, that a qualitative approach and specifically IPA was selected for this study.

2.3.2 Theoretical Positioning in Research

Qualitative research examines the meaning that accompanies experience which may differ between individuals and is impacted by one's context (Braun & Clarke, 2013; Willig, 2013). Since the aim of research is to produce meaningful and substantial data, it also is valid to anticipate, that the nature of the research questions will be impacted by the researcher's own expectations and the way they conceptualize and make sense of the world around them. Moreover, being familiar with the researcher's theoretical positioning is of great importance as this ultimately comes across in and inevitably shapes and underlines the data (Willlig, 2012; 2013)

Ultimately, there may be as many assumptions and variations around the nature of truth as there are researchers, and taking this notion into consideration, allows researchers to make sense of the data that emerges.

Therefore, researcher transparency with regards to their attitudes and perceptions is paramount in enabling the reader to understand the implications these aspects have on the material. This will furthermore contribute to the appraisal of the research produced (Willig, 2013; Nightingale & Cromby, 1999).

Several aspects, namely ontological, epistemological, and axiological frameworks comprise the theoretical positioning of the research.

The notion of ontology in the context of research, refers to the nature of existence and explores the variety of ways that one can conceptualise reality and whether this is conceptualized as a subjective or objective construct (Willig, 2012).

The epistemological framework discusses the very nature of knowledge and whether this as well, can be perceived as objective, subjective or a combination of both. This framework will impact all domains of the research from the questions being asked to the actual methodological and analytical processes (Willig, 2012; Ponterotto, 2005)

Finally, an axiological framework refers to the value researchers place to different facets of their research and is considered of great significance as ones values are considered to inevitably shape the findings of qualitative research (Guba & Lincoln, 1994)

2.3.2.1 Ontological and Epistemological Framework

Philosophical realism refers to the notion that the existence of entities is separate from our own perception and theories around them (Phillips,1987).
According to Willig (2013), ontological stance exists in a continuum between realism and relativism whereas epistemological standpoints may be categorised among others in social constructionist, realist and phenomenological.
Ontological realism, refers to the assumption of the existence of a real world which includes a number of processes that exists independently of one's own constructions, perceptions and theories and the knowledge we hold around these (Denzin & Lincoln, 2011)
As a result, research that is produced in the context of this framework would create information that is deemed as a correct representation of a phenomenon. This is categorically antithetical to a relativist ontology according to which various realities that are created according to one's perspective can exist, resulting in research that investigates the various aspects that contribute to the formation of the stance on a given experience (Maxwell, 2012)
With regards to the dominant approach used in social sciences, realism and specifically critical realism has been the primary approach held (Baert, 1998; Hammersley, 1998; Suppe, 1977).
In scientific realism, reality is conceptualized and constructed via our senses in response to phenomena in the universe. Consequently, realist theories discuss and involve the real features of the world (Schwandt, 1997).

With regards to my research, I hold a critical realist position and hold integrative values that are shaped by my roles as both a researcher and a practitioner. Although the critical realist position does differentiate the existence of a real world, it also reflects on the categorization that individuals make when attempting to make sense of the world recognizing these as flexible and open to further exploration. Furthermore, in the context of critical realism, experiences are considered real to the individual and are beyond their social construction acknowledging nonetheless that this reality is not absolute or complete. Consequently, this may lead to various perspectives of the same experience or event (Bhaskar, 1975; Guba & Lincoln, 1994). Therefore, the classifications that arise in critical realism and the associations between them may be replaced by alternative ones (Scott, 2005).

I personally recognize that objective reality does exist, and that the external world is real yet also adhering to the notion that an individual can only make sense of the world in the context of their own perceptions of it (Howitt, 2010). It is not possible to describe experiences and events correctly, in the absence of consideration of a person's subjective experience in the

world and other aspects that contribute to this such as culture and language. This is irrespective of the recognition that these do certainty occur in reality (Pilgrim & Roger, 1997). I therefore understand that my unique sensemaking and interpretation of events will be directly influenced by my own experiences (Eatough & Smith, 2008). Considerable efforts to bracket these from my research were made, however it is crucial to note that despite these it is still not possible to offer a purely distinct account of a participant's experience. This also results from the notion that individuals cannot ever experience the world in the same way irrespective of all their efforts to grasp someone else's unique experience (Smith, Flowers & Larkin, 2009).

My decision to select IPA for the methodology of my research was influenced by my critical realist position which in addition enables me to take into consideration the nature of knowledge I aim to create, whilst simultaneously recognizing the assumptions I hold around this (Willig, 2013). Consequently, I hold an interpretative stance and do not accept an experience merely at face value my aim being to explore the subjective experiences of my research participants (Willig, 2012; 2013).
In addition, and despite not focusing on constructing generalizations or causal links with regards to themes in my analysis process, I acknowledge the reality of these inevitably taking place in the process of an overview being generated and with the aim of influencing clinical practice (Willig, 2013).

Finally, I further recognize that critical questioning during the interview process is crucial in the context of developing richer data whilst wishing that my interpretations remain as expressive of the participant's experience and empathic as possible (Shinebourne, 2011; Ricoeur, 1970; Willig, 2013).
An important point to note, is that critical questioning when acquiring information, may also be perceived as intrusive by participants. This is especially pertinent for participants who may find it challenging to reflect on and share their experiences. This is nevertheless necessary in the context of this process (Eatough & Smith, 2008; Smith et al 2009; Willig, 2013).

2.3.2.2 Axiology

Further to the ontological and epistemological classifications, the component of axiology additionally underpins research. The term axiology originates from the Greek word axios (Greek ἄξιος) and is defined as 'worthy', 'deserving' and 'of value' (Heron & Reason 1997;

Heron, 1996). Axiology refers to the understanding of one's own value system and emphasizes on capturing what is of paramount worth for a person (Heron & Reason, 1997).

Taking into consideration the underpinning philosophy of various research paradigms is crucial in making sense of this as different paradigms are characterized by distinctive sets of beliefs (Killam, 2013). Since axiology navigates the core of what is perceived as worthy, being aware of a researcher's axiological system is deemed fundamental. With regards to my own reflection process around my own axiological system and in the context of my research, I can identify my primary focus being the search for meaning in experiences. This is also underpinned by my strong sense of confidence in the intrinsic worth of all human beings, their fundamental right to dignity and their inclusion and representation in all of life's domains. I therefore hold the belief my own value system as described above, will become apparent throughout my research.

2.3.3 Theoretical Accounts of Methodology

2.3.3.1 Rationale for selecting Interpretative Phenomenological Analysis

In the context and process of selecting a suitable research methodology, various options were taken into consideration prior to reaching the decision that IPA would be used. Narrative Analysis was initially explored as a possibility but was then rejected. Narrative Analysis is a methodology that entails the systematic investigation of narratives with the aim of making sense of how individuals construct their experience through their shared narratives, yielding a plethora of themes and meanings. Furthermore, it examines this and the participant in a social and historical context (Josselson & Hammack, 2021). While both IPA and NA focus on navigating the subjective experience, they are different with regard to the way data is analysed as well as their focus. For NA, this centres around the content of stories and how these are structured, exploring these in context whereas IPA prioritizes the interpretative practice aiming to grasp nuance and capture the sense of depth and richness in someone's experience and subjective sense-making of this.

Discourse Analysis as a methodology, prioritizes the significance of language in the construction of an individual's sense of reality (Starks & Trinidad, 2007). In addition, it follows a social constructionist approach to research representing its core assumptions with regards to the possibilities for knowledge (Lyons & Coyle, 2007). According to the social constructionist paradigm, a critical stance is held towards the preconceived ways of

understanding ourselves and the world and the presumption that the classifications we utilize to interpret these, correspond to 'real' and 'objective' entities (Burr, 2003; Lyons & Coyle, 2007). With regards to this approach, conceptualizations of the world are a result of social processes and linguistic connections in cultural and historical contexts (Lyons & Coyle, 2007).

Discourse Analysis was rejected as a methodology for my research, as it did not align with my research aims and philosophical position. In addition, another factor behind my rationale for excluding this was due to the focus that Discourse Analysis holds on the use of language and text which meant reduced flexibility when examining and discussing the data (Murray, 2003; Willig, 2013).

Finally, the case of Grounded Theory, a common alternative to IPA, was also considered as an option. This methodology focuses on interpreting the construction of meaning whilst also creating theories that illustrate a range of social processes that underlie the phenomenon in question (Glaser & Strauss, 1967).

Consequently, Grounded Theory, was also excluded due to its focus on the elaboration of a theory to makes sense of the phenomenon researched and not emphasizing on exploring the experience itself (Howitt, 2010).

IPA was therefore deemed most appropriate as it aligned best with my aim to makes sense of the inner world and lived experience of women who engage in genital self-injury. Furthermore, and due to IPA allowing the in-depth exploration of an individual's inner world it was concluded that was most suitable to the development of an understanding around genital self-injury which would subsequently elucidate crucial clinical contributions.

2.3.3.2 Overview of Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis is a qualitative research methodology with a primary focus on observing and analysing how individuals make sense of their life experiences. Husserl discussed the need to 'go back to the things themselves' as the phenomenological nature of this approach signifies the importance of exploring experiences in their own terms (Husserl, 1927).

IPA is principally concerned with the journey of a lived experience regarding the acquirement of significance often encountered when something fundamental occurs in a person's life. As a research approach, it does not wish to fit experiences in predetermined classifications (Smith, Flowers & Larkin, 2009). In recognizing that experiencing an event of major

importance for the person, enables them to engage in a reflective process around this, IPA wishes to explore and be involved with its outcome (Smith, Flowers & Larkin, 2009).

In the context of IPA reflecting an interpretative effort, it is guided by the process of hermeneutics which in turn refers to an underlying theory of interpretation. Since IPA stipulates that individuals wish to make sense of their experiences, it recognizes that as a result of this, their statements and narrative will be a reflection of these efforts. However, and in acknowledging the researcher's need to interpret a participant's account, IPA accepts the notion that a shared account of an experience ultimately indicates what a participant has chosen to share with the researcher (Tuffour, 2017; Smith, Flowers & Larkin, 2009).
Double hermeneutics, refers to the process in which the researcher is trying to make sense of the participant's sense-making of their own experiences. This essentially involves the process of two layers of interpretation and of the researcher holding a dual role during this. This in turn, highlights the dynamic and interactive nature of this process as well as the dynamic and reciprocal interaction between participant and researcher (Smith, Flowers & Larkin, 2009).

The first aspect of the double-hermeneutics process involves the interpretation of meanings and perspectives of the participants' subjective experience and aims to make sense of their lived experience in the context of their own descriptive accounts. IPA does not impose existing theoretical frameworks during this process as it is more interested in the way the participants understand their own experience (Smith, Flowers & Larkin, 2009).
The second aspect of double-hermeneutics refers to the researcher's reflections on the interpretations offered by the participant. In the context of both researcher and participant sharing the essential nature of being human, it is acknowledged that they both hold similar capacities and skills which the researcher utilizes more deliberately. In this process, the researcher will inevitably convey their own theoretical background and conceptualizations which consequently colours their interpretation of the participant's interpretations (Smith, Flowers & Larkin, 2009).

Therefore, the dual role that the researcher holds in IPA refers to the researcher first engaging and immersing themselves deeply in their participants accounts of subjective experience whilst carefully bracketing any preconceived notions and frameworks. This is followed by the process of reflecting the impact that the researcher's own background has on the way they interpret the data.
In addition, the idiographic focus that IPA holds, encourages the robust investigation of an experience, what the individual makes of this and finally how it is for them to have had this.

With regards to the small number of participants in IPA studies, this reflects an aim to detect differences and similarities in the participants accounts, allowing for the establishment of homogeneity of a sample group which in turn permits the consideration of convergence and divergence within this (Smith, Flowers & Larkin, 2009; Tuffour, 2017)

Data collection in IPA primarily relies on semi-structured interviews which is one of the most common methods utilized in qualitative research, as it allows flexibility in the interview process and schedule whilst maintaining the centrality of the participant in all aspects of the process. Other forms of data collection can also be used which might include written documents, diaries, visual and audio representations, or use of objects among others which can then be analysed to convey additional layers of meaning (Smith, Flowers & Larkin, 2009)

In the case of semi-structured interviews, the process includes the collection of data and development of transcripts that are then analysed on an individual basis using a systematic qualitative analytical method and are formed into a narrative account which includes verbatim participant quotes from their interview intertwined by interpretative comments by the researcher (Smith, Flowers & Larkin, 2009).

2.3.3.2.1 Phenomenology

Phenomenology refers to the philosophical stance held during the exploration of and study of the human experience and existence and encapsulates concepts around what a person might deem important, the experiences that comprise our lived world and ultimately the meaning assigned to being human (Larkin & Thompson, 2012; Smith, Flowers & Larkin, 2009).
The notion of phenomenology was developed by Edmund Husserl whose particular focus and interest lay in the examination of various phenomena and the way in which they manifested in the world (Willig, 2013).
This is of great significance for psychologists who utilize the framework that phenomenological philosophy offers in their attempts to explore and make sense of lived experiences.
Echoing Husserl's assertion with regards to 'going back to the things themselves, one can understand researchers' frequent requirement to form ideas into pre-existing systems as opposed to exploring them individually in their own right. This gradual and reflexive shift in

stance from the object itself to its perception, is precisely reflected in Husserl's phenomenological standpoint (Husserl, 1927; Smith, Flowers & Larkin, 2009).

Despite the influence and legacy that Husserl had on his student Heidegger, it is Heidegger that questioned whether knowledge can truly exist outside an interpretative stance. This is due to Heidegger understanding this, as set in the lived world (Drummond, 2007). Hence, Heidegger focused on the nature of existence itself and what constitutes this as meaningful which was in contrast with Husserl who was more interested in the individual's psychological processes. With regards to Heidegger's viewpoint, an individual was not to be seen in isolation but in context (Heidegger, 1927;1962).

French phenomenological philosopher Merleau-Ponty, expanded on Heidegger's concepts shifting however towards a different direction. His ideas incorporated an embodied understanding of one's relationship to the world whilst stipulating that human beings experience themselves differently to other beings (Merleau-Ponty, 1962).

Finally, Jean Paul Sartre, highlighting the significance that the developmental factor holds for human beings, points out that individuals are always becoming themselves. (Sartre, 1943; 1948;1956).
Throughout their work and ideas Husserl, Heidegger, Merleau-Ponty and Sartre, attempt to capture the intricacies of the human experience and the challenge to understand it in order to make sense of it (Smith, Flowers and Larkin, 2009)

2.3.3.2.2 Hermeneutics

The term 'hermeneutics', stemming from the Greek word *ερμηνεύω* and can be translated as '*to interpret'*, refers to the theory of interpretation (Finlay, 2009).
The primary aim of phenomenologists engaging in Hermeneutics is to address queries around the original interpretations and intentions of an author (Smith, Flowers and Larkin, 2009). According to Schleiermacher, interpretation has two layers; the first being that of grammatical interpretation which examines the objective meaning of text. The second layer of interpretation refers to the psychological interpretation which examines the distinctiveness of an author (Schleiermacher, 1998). Schleiermacher (1998), conceptualizes interpretation as an intuitive and artistic endeavour that sees interpretation in a holistic context and does not merely abide to technical parameters.

Heidegger's formulation of the hermeneutic phenomenology signifies the dual process of exploring latent or distinguished things in addition to the manifestations that appear into the surface. According to Heidegger appearances carry a dual quality which encompasses the obvious and hidden meaning that things hold for individuals (Heidegger, 1927; 1962).

Gadamer, prioritizes the historical importance and influence of tradition on the interpretative process (Gadamer, 1960; 1990). According to his views, the researcher does not automatically hold authority around the interpretation and meaning of a text (Smith, Flowers and Larkin, 2009). Furthermore, Gadamer suggests a distinction with regards to the understanding of the text versus the understanding of a person as he stipulates that the former ought to be prioritized (Gadamer, 1960; 1990).

Finally, I will end this subsection on hermeneutics by exploring the hermeneutic circle which is a crucial component of the hermeneutic theory. The hermeneutic circle is not identified by one writer in particular rather it is used and understood by the majority of hermeneutic writers. This cycle refers to the dynamic relationship between parts and whole and stipulates that in order to understand one part, one would have to examine the whole and vice versa (Smith, Flowers and Larkin, 2009) The way this manifests in IPA research is that the hermeneutic circle reflects a continuous movement between the global understanding of data and the detailed analysis of the individual experience. Iterating between these processes, allows researchers to identify emergent themes and patterns which in turn allows for a comprehensive interpretation of a given phenomenon (Smith, Flowers and Larkin, 2009). The hermeneutic circle presents an appealing way of understanding methodology in Interpretative Phenomenological Analysis.

2.3.3.2.3 Idiography

Idiography refers and is concerned with the particular and as a concept, it significantly impacts IPA as IPA, is idiographic in nature. IPA is considered as such due to its focus on understanding and interpreting individuals' subjective experiences and its attention on the divergences and convergences among participants experiences (Smith et al., 2009). This process occurs in two levels, the first being an in-depth systematic analysis that aims to make sense of the particular, and the second which aims to understand the way which phenomena are comprehended by particular individuals in a particular context (Smith, Flowers and Larkin, 2009).
As a result, IPA utilizes small samples which are purposefully selected for its method. It is also not uncommon for IPA to use analyses of single cases to produce assertions.

Consequently, though it may refrain from generalisations, it still examines the various ways these generalisations are established (Harre, 1979; Smith, Flowers and Larkin, 2009).
In addition, the idiographic focus that characterizes IPA, permits analyses of particular components of the lived experience. This is illustrated greatly in the example of single case studies that given a rigorous data analysis and a carefully led interview, may offer important insights on an area of interest that holds particular significance for the participant. This in turn enables further contribution to psychological research (Smith, Flowers and Larkin, 2009).

2.3.3.3 Limitations of Interpretative Phenomenological Analysis

Whilst IPA poses a valuable qualitative research methodology it does have certain conceptual and practical limitations. Being aware and mindful of the constrictions of a selected methodological approach is of great importance in the research context (Willig, 2013)
IPA is a methodology that has an interest in meanings and experiences, examining various phenomena in the context of the point of view of the individual that encountered them (Willig, 2013).
One of the limitations with IPA relates to the role of language. Willig (2013), contends that phenomenological analysis depends on the representational validity of this. However, the selection of words one uses to describe a given experience consequently creates a particular version of this. Therefore, one could claim that language creates reality, rather than defines it (Willig, 2013). As a result, a particular experience can be described in a plethora of ways. As such, language contributes to the sense of meaning and cannot merely refer to an expression of an experience. Consequently, data in IPA enable us to understand the ways that one might talk about a given experience which may shift away from the focus on this experience itself. Moreover, the way in which one chooses to talk about a particular concern, results in a categorization of an experience which in turn means that language forms experience and directs thoughts and feelings around this as opposed to language being means to express oneself (Willig, 2013)

As IPA focuses on gaining a better conceptualisation of how participants see and experience the world, it is further engrossed in the way the world appears to those that engage with it. From a phenomenological viewpoint the individual and the world are seen as a whole and not as distinguished from one another. Therefore, and taking into consideration the rich presentations of individuals' experiences in this case research cannot offer hypotheses of why these might take place, as well as the variations between the participants'

phenomenological conceptualisations. This in turn means that a phenomenological approach such a s IPA, although may offer an in-depth account of a lived experience, it is limited with regards to offering any explanations around it (Willig, 2013).

In addition, another valid question would be around participants ability to convey meaning to the researcher as well as communicate their experience in depth. This is due to the fact that it requires that a participant holds an ability to express through their use of language nuance with regards to their inner world (Willig, 2013)

Finally, another limitation is around the role that cognition holds in phenomenology. IPA, relates to a social cognition paradigm and as such it is concerned with the relationship between the physical state, cognition and verbal account (Smith et al, 1999) This in turn means that we can make sense of participants' experiences, when conceptualizing these in the context of their cognitive framework. Nevertheless, prioritizing cognition might be perceived as in contrast to certain facets of phenomenology as this contests, the division between subject and object. (Willig, 2013)

2.3.3.4 Interpretative Phenomenological Analysis in the context of Counselling Psychology

IPA's significance in the context of counselling psychology primarily relates to an in-depth yet nuanced exploration of an individual's lived experience which in turn allows to examine and appreciate the subjective layer of clients' experiences. Consequently, this provides valuable contributions to the conceptualization of the therapeutic process.

Since IPA is concerned with the meaning individuals give to their experiences and holds an idiographic focus, this methodology presents a strength in the context of counselling psychology. Taking into consideration that clients' responses to life experiences are shaped by their own histories, diverse backgrounds, and cultural influences, this means that IPA's focus into the subjective world of the individuals, aligns with the values of counselling psychology which emphasizes on making sense of the intricacies of the human experience (Rafalin, 2010). This also aligns with the core conditions of the person-centred approach which lies at the heart of counselling psychology and the values of which have shaped my own view and philosophy as a therapist and researcher. (Rogers, 1957)

I therefore recognize that my own professional, personal background and knowledge will have led to my own assumptions with regards to life experiences. Although I aim to hold an unknowing stance with both clients and participants, approaching them without preconceived assumptions around their experiences and remaining curious and open towards their accounts,I simultaneously recognize how these factors would have certainly, shaped the composition of this study.

2.4 Procedural Components

2.4.1 Sampling

Since IPA research focuses on examining the subjective standpoint and sense-making of a participant experience with regards to a particular phenomenon, it necessitates an in-depth analysis of rich data obtained via the participants' accounts. (Smith & Osborn, 2015)
IPA studies commonly involve quite a small and often homogeneous sample of participants with the sample size allowing an in-depth examination of the data and consequently observing the idiographic values of IPA (Smith et al. , 2009; Smith & Osborn, 2015)
According to Clarke (2010), three participants is considered a default sample size for IPA studies of an undergraduate or master's level, whereas for professional doctorates, this number is increased to between four and ten participants.
However, overall, and with regards to a suggested number of participants, there is no proposed sample in IPA. This is due to a larger number of participants being of less importance compared to the richness of the data analysis yielding more and greater insights with regards to an experience which is consequently of greater significance (Smith et al., 2009). Even a study using a single participant could be acceptable provided that they can produce a convincing and rich case (Smith, 2004; Noon, 2018).
Furthermore, IPA can also be used to analyse data from single case studies, and this is due to IPA being an idiographic in nature methodology that stresses the significance of 'the individual as a unit of analysis' (Smith, Harre´, & Van Langenhove, 1995; Eatough & Smith, 2006).
IPA is particularly appropriate for the idiographic method as it allows a close, detailed, and contextual analysis of a particular phenomenon taking into consideration how this is experienced and subsequently given meaning in the context of an individual's unique worldview and life circumstances (Eatough & Smith, 2006).

There is documented reluctance of participants to come forward and share their experiences around self-harm. This might be due to a plethora of reasons but mainly due to the

unfortunate stigma that self-harm carries, and the taboo with identifying oneself as someone who engages in this behaviour (Pembroke, 1996).
The above fact in combination with the significant sensitivity and privacy that characterize the locality and nature of genital self-injury led to anticipating a small number of participants to come forward.
For the purposes of this study, I aimed to recruit between 6 and 8 participants although eventually, and due to significant challenges in recruitment which I will further explain below, I obtained two participants conducting three interviews in total.

2.4.2 Participants

Inclusion criteria for this study determined that the participants must be female of at least 18 years of age in order to ensure informed consent. No maximum age was set with regards to participation. Moreover, individuals taking part in the study needed to be at present or in the past engaging in genital self-injury, that is self-injuring their genital area. Initially, it was decided to only include participants that were currently engaging in genital self-injury as it would allow us to gather real-time data that would offer a more precise understanding of their experience. It was later decided however to include those that have genitally self-injured in the past. This was partly due to this being a hard-to-reach population and ensuring an adequate sample size but also in part due to the wish to enhance generalisability of the study's findings and capture a broader picture of the phenomenon of genital self-injury.
In order to ensure safeguarding and in line with the ethical considerations of this research, participants needed to be receiving psychological support at the time of being interviewed, within mental health services such a private organizations and charities or receiving psychotherapeutic input to minimize potential harm if this were to occur, as a result of taking part in this study.
Participants presenting with active suicidality, as determined by the screening interview process which took place prior to conducting the interview, were excluded from the sample due to the reason stated above. Concerns with regards to risk were assessed via asking the participant questions pertaining to suicidal ideation, intent and plan as found in the CORE-OM (*Clinical Outcomes in Routine Evaluation – Outcome Measure* - Appendix A- which will be discussed further in a different section of the methodology chapter*).*
Adults participating in this study were to not be considered 'adults at risk' and do not fall under the Mental Health Capacity Act (2005) and were able to give informed consent as well as were able to make informed decisions on their own behalf.

Individuals who may have presented with a degree of learning disability or a mental health concern that meant they were unable to make an informed decision, on their own behalf, and in line with safeguarding, were not to partake in this study.

Assessing risk and exploring participants' mental state during the screening and interview process was also informed by my own personal and professional judgment as well as prior clinical knowledge around working with individuals presenting with high levels of risk; including self-injurious and suicidal behaviours. Due to the sensitive nature of the research topic of this study, it was crucial that I ensured the questions and further exploration around inclusion and exclusion criteria that would inform my decision with regards to their participation, was communicated to prospective participants in a highly respectful and compassionate manner.

2.4.3 Recruitment Strategy

Participants for this study were initially recruited from various private mental health services and charities in London and Greater London area. These organizations were initially approached via a number of methods which included telephone, email and in-person contact.

As existing literature suggested that genital self-injury occurs mainly in trauma-related disorders, services that specialize in these areas were contacted. These included services that specialize in the area of trauma and especially those that work with survivors of sexual assault/ sexual abuse as well as those that work with individuals presenting with but not limited to self-harm, personality disorders, dissociative disorders as well as psychosexual difficulties among others. Moreover, therapeutic communities that support individuals with personality disorders and other presentations relating to (complex) post-traumatic stress were also contacted with regards to recruiting participants from them. The rationale behind the choice of appropriate services was the likelihood of high occurrence of self-injurious behaviour within the presentations of their service users.

Furthermore, organizations that offer general non-specialised mental health support to individuals presenting with a wider range of concerns and difficulties were also contacted in order to maximize chances in participant recruitment. This is also due to the fact that genital self-injury, being largely hidden, might not be the primary concern that a service user presents with when engaging with services.

Finally, and due to challenges in recruitment discussed further, in the section below, we broadened the recruitment method to include online recruitment as well as for interviews to be conducted via phone, video call platform as well as face to face where appropriate or requested by the participant. The rationale behind online recruitment was due to it allowing access to a greater pool of potential participants such as found via social media platforms including self-harm awareness pages and groups. This was also deemed important as it allowed prospective participants a greater sense of autonomy and privacy in ultimately deciding whether they wish to take part in the study.

Finally, information around this study and a relevant recruitment flyer (Appendix B) was also circulated and shared amongst friends and colleagues who further advertised through their own professional and personal networks and social media accounts.

In total, thirteen organisations were approached for recruitment, five of which responded positively. Zero participants were excluded from taking part in this study.

2.4.3.1 Challenges in Recruitment

Although anticipating encountering challenges in the recruitment process and despite broadening the original study's recruitment criteria to include online recruitment as well as for interviews to be conducted via a variety of means, all avenues for reaching participants were not fruitful for a significant amount of time between original ethical approval and first interview. The majority of services I approached, and despite consistent efforts on my part, did not respond to my queries around recruiting from their service. It was also a very small number of organizations that agreed to advertise and promote this study. Interestingly, one organization shared that they could not help during that time due to the magnitude of similar requests but invited me to send relevant information once again at a later stage (almost a year later) with the aim to share this at an in-house event where this organization's therapists were to be present. Another organization that supported survivors of trauma agreed to circulate this among their therapists and advertise within the service however did not agree to advertise within their social media accounts as they deemed this out of the scope of the way they utilized these.
Finally, one of the organizations that had expressed interest and had a potential participant at the point of initial enquiry, had already discharged this service user, when approached again at a later stage.

Through the recruitment avenues described above, only one participant came forward who met inclusion criteria and subsequently took part in this study. The second participant had originally participated in a pilot study and was then included in this study- see section 'The Pilot Study' below, for further information around this.

2.4.4 Data Collection

For the purposes of this study, semi-structured interviews were conducted.
The use of semi-structured interviews is considered to be one of the most popular data collection methods in the use of IPA research (Smith and Osborn, 2003)
Although there are a number of ways one can utilize to obtain data, the use of one to one, semi-structured interviews was deemed appropriate and preferred due to the flexibility it offers for various aspects to be explored by the researcher as well as allowing for an encounter which could help produce rich participant descriptions and consequently bringing into light new perspectives and observations with regards to the topic studied. This is further illustrated, through the use of conducting more than one interview with an individual participant; an approach which was used in this study (Flowers, 2008). The rationale behind conducting two interviews, was in the context of the sensitivity of this topic, as a second interview which allowed me as the researcher to explore in more depth, issues that were raised by the participant in the first interview. In addition, this choice enabled the built of trust and rapport between myself and the participant during the first interview which later facilitated deeper exploration during the second interview.

2.4.5 The Interview Schedule

The interview schedule for the first interview consisted of 13 open-ended questions (Appendix C) around genital self-injury. The interview commenced with an opening question around the participant's feelings around taking part in this study and discussing their self-injury with the researcher. This was followed by questions with regards motivation in taking part in the study, their understanding around different types of self-injury as well as the meaning they assign to their own practice of self-injury.
The interview schedule further included questions around the participant's feelings and behaviours post self-harm, and questions pertaining to self-care in the context of this and further questions on the nature of their self-injury. The last few questions explored the sense that the individual makes of their self-injury and any feelings they held towards the interview process itself. Individuals were also given the opportunity to add further comments.

The second interview scheduled comprised of 9 additional, open-ended questions (Appendix D) and initially explored any questions, comments or reflections that came up as a result of partaking in the first interview. It then explored the participant's experience and sense-making with regards to areas around the development of their self-injury, and specifically their self-injury in their genital area, their experience of therapy and the impact this may have had on their self-injury as well as their understanding of it.

The questions included in the interview schedule were inspired in part through my experience as a trainee counselling psychologist and specifically through my clinical encounters with clients, patients and service users that engage in severe self-injurious behaviour and a small number of individuals that engaged in self-injury in their genital area. Questions in the second interview schedule were inspired in part by the themes observed in the narrative and account of the first interview as well as the comments they shared following their interview and their expressed interest to have explored them further during that process.

The questions included in the interview schedule deliberately avoid the explicit use of the term, 'genital self-injury' and utilise the general terms 'self-harm' and 'self-injury instead. The rationale for this decision was based on various considerations. First and foremost, this reflects being mindful of avoiding any potential preconceptions, biases or questions that may appear to be leading which further ensured that the responses were participant-driven and not researcher-led. In line with this, avoiding the use of specific terminology, aimed to allow participants the flexibility to express themselves and describe their experience using their own words, at their own terms and time. Finally, this decision also reflected prioritising the participants' experiencing a greater sense of comfort, safety and sensitivity during the interview process by creating a less intimidating environment facilitated by the use of less explicit language. This was in the context of wishing to encourage them to discuss their experiences openly whilst limiting possible feelings of distress.

2.4.6 The Pilot Study

A pilot study was conducted using convenience sampling to recruit one participant who was already known to me prior to the study taking place. The purpose of this was to familiarise myself with the process of arranging and conducting an interview and to further examine whether my interview schedule met criteria for an IPA study. These included developing questions that would allow for the feelings and thoughts that the participants' associate with their experience to be explored in depth, that would stimulate reflexivity and that would align

with and were relevant to my research question. Furthermore, it was important that these questions were open-ended in nature and that the language used in these was clear and easily understood by the participants. Overall, it was crucial that the interview schedule allowed for some flexibility in order to pursue the themes that emerged and that the questions were presented in such a manner that fostered an environment of safety, sensitivity, empathy and non-judgment (Smith et al. 2009)
Finally, the purpose of this was to also obtain any feedback that I could utilize in various aspects of the study.

Although initially, the pilot participant did not exclusively fit criteria due to the fact that they were not engaging in genital self-injury anymore, they met all inclusion criteria following broadening these to include individuals that engaged in genital self-injury both in the past as well as at present.

This interview was conducted in the same manner as the subsequent research interviews and observed the same protocol proposed with regards to arranging and taking part in the interview, as other participants in the study. Furthermore, the pilot participant was offered the same information sheet (Appendix E) and debrief sheet (Appendix F) as well as signed the same consent form (Appendix G) as other participants in the study.

Although this individual was originally planned to be part of the pilot study, since they met all inclusion criteria and had consented to take part in this study, they were later included in this. This decision was discussed and explored with my research supervisor and the participant's inclusion was decided in the context of the above information as well as the high relevance and richness reflected in the data provided in their interview.

2.4.7 Arranging and Conducting the Interviews

The procedure described below, was used in this study and significant focus was placed in ensuring that those who participated in the research did not experience any sense of pressure and coercion when consenting to take part to this.

Research was advertised and circulated within various services that participants were engaged with. Therapists within those services could also use their clinical judgment to provide information sheets/flyers to appropriate clients, reiterating that the service, rather than themselves were involved with this research and that the individual may or may not be

interested in taking part. It was also made clear to the participants that their therapist/practitioner had no involvement with this research study and would not be informed by myself on whether they had accepted or declined to take part in this.

All participants that expressed interest in participating in this study could also contact either my supervisor or myself via phone or email to request additional information and to discuss next steps. In the case that an individual confirmed wanting to take part in this study, a phone conversation was then arranged where I provided further information and explained to the participants briefly what to expect from the process as well as outlined confidentiality and its limitations, risk and benefits of taking part in this as well as reiterated their right to withdraw consent. Towards the end of this phone-call and having had the opportunity to ask further questions and request further information, the participant was informed that they would be offered a two-week period ('cooling off' period), in order to consider whether they wished to take part. During this phone-call they were asked whether they would prefer to be contacted again by either myself or if it would be preferable for them to initiate contact following these two weeks. The method via which contact was made was also decided by the participant at this stage.

Participants were informed, that should I had not heard from them at the end of this two-week period, I would have assumed that they did wish to take participate in this study and no further contact would be made.
For those that expressed wish to participate, at that point we discussed about arranging to meet face to face for the interview process and were also given the option for the interview to be conducted by via phone or via a video platform. A pseudonym was also chosen at this stage to ensure confidentiality. Appropriate risk management procedure was also followed prior to the interview- please see more information in 'Ethical Considerations' section of this chapter.

With regards to in person- interviews and out of sensitivity to the participants alongside being mindful that some individuals might have difficulty around travelling or coming to an unfamiliar location, two options with regards to the location that the interview were to take place, were offered. These included either City University or a space within the mental health service the participant was attending. At this stage it was made clear that any space used for interviews within the mental health service was separate from the one used for therapy. The choice with regards to the location of the interview was the participant's decision as it was deemed highly significant that they were able to choose a space they felt most comfortable.

Should anyone were to choose to attend the interview at City University and with regards to travel expenses, compensation would be provided.

Information and Debrief sheets were given and signed consent was obtained at the start of the interview meeting and a copy of this was given to the participant.
At the end of the interview, and during the debrief process, participants were asked whether they wished to obtain the results of the research following its completion and were informed that should they wished to do so, they can be contacted via their preferred method and so they can be sent a summary of the findings.

The research was also advertised at a later stage and following further ethical approval, online, via social media platforms including the social media accounts of a large UK charity that offers support to adult survivors of all types of childhood abuse and neglect. Finally, following a third approved amendment by the ethics committee and in the context of challenges in recruitment described above, the original advertisement was posted utilizing the same recruitment channels and avenues as before, whilst also stating that recruitment was ongoing and adding that should any previous participants wished to contact me again to provide further comments they could do so and we could arrange a second interview to explore this further.
Participants were to follow the same procedure described above if interested to take part in this study.

Two individuals formed the participants of this study which resulted in three interviews taking place. Screening phone-calls took place in a private and comfortable environment where confidentiality was observed. The rationale behind this and the significance of this was reiterated by the researcher.
The first participant's interview took place in person whereas their second interview was via a video-call. The second participant only took part in one interview which again took place via a video-call.
Interviews lasted between 60-90 minutes to allow ample time for the depth needed with regards to IPA interviews and every effort was made to ensure my participants were comfortable through this process.

2.4.8 Recording and Transcription

The interviews were recorded on two digital voice recorders simultaneously to prevent possibility of technical error or malfunction and to ensure these were audible. Following the participants being briefly reminded of the research aims and being reiterated that there were no right or wrong answers as well as their right to pause, not answer part of or a specific question as well as terminate the interview, recording started.

Interviews were transcribed verbatim (Appendix H) as per the IPA guidelines recommendation and transcripts also included comments on non-verbal cues, pauses and fragmentations in speech in order to capture the participant's account and experience as accurately as possible.

2.4.9 Data Storage

Any electronic data such as audio recordings and interview transcripts as well as the signed informed-consent forms were stored on password-protected computer files within encrypted hard drives. Any paper documents were shredded and securely disposed. Any personally identifiable information was anonymised, and participants' names were replaced with non-identifiable pseudonyms.
Recordings of the interviews were initially stored in a password protected folder and were deleted immediately following transcription.
In line with statutory requirements, any data relating to this research with the exception of the digital recordings will be archived for 10 years following which, the data will be securely destroyed.

2.4.10 Analytic Strategy

Although frequently, IPA studies involve a number of between 3 and 15 participants, these can also be conducted using fewer participants and sometimes only one, such as in the form of a case study (Reid et al, 2005)
In the context of this study's small number of participants (2), in addition to a focus and interest in the individual as a whole compared to a focus in the participants' shared experience, the analytic process treated each participant as a separate case study honouring further the crucial aspect of divergence in the IPA analytic process.
This allowed for the recognition and illustration of variation in the participants' accounts.

Through the number of emergent themes, consequent subthemes and superordinate themes for each interview and participant (Appendix I & Appendix J) presented later in the Analysis chapter, great care was shown to illuminate nuance and explore in greater depth the sense-making of their experience. This was particularly helpful taking into consideration that there were two interviews obtained for one of the participants compared to one interview for the other.

This idiographic, single-case focus process was followed by the development of 4 master themes illustrating any shared aspects in the participants' accounts.

The selection of these 4 master themes, which are presented in detail at the end of the analysis chapter, are a result of convergence during the analytic process. These themes reflect a shared understanding and a sense of commonality in how both participants make sense of their experience of genital self-injury.

A detailed and comprehensive analysis of the participants' interview transcripts at both an individual and collective level, yielded rich insights and meaningful themes. These powerfully demonstrate their experience and perception of the multiple facets that form this type of self-injury. With regards to the analytic strategy used, this followed the interviews being transcribed verbatim and analysed largely as per the Smith et al (2009) suggested 6 stage protocol. Each transcript was studied and analysed individually.

With regards to this study, this protocol included the initial engagement with the data via reading and re-reading the text and the initial noting of anything of interest. The coding process followed, which included comments divided into descriptive, linguistic, conceptual and decontextualizing categories, produced a set of notes, remarks and observations stemming from the data.

These notes served as a basis for the development of emerging themes, which were then closely examined for connecting motifs. These in turn, formed a number of subthemes and superordinate themes for each interview which were further explored for connecting subthemes and superordinate themes for each participant. Finally, any identified, overarching themes, patterns, or experiences across both cases, formed the basis for the development of a number of master themes that encapsulated the integration of any shared elements.

With regards to the master themes' presentation, contextual commentary- highlighting the significance of each theme in the context of both cases- as well as reflections in a more abstract level, were offered. In addition, findings from both cases were compared and contrasted to provide another layer to the analytic process, contributing further to the

broader understanding of genital self-injury via the in-depth exploration of each participant's account.

2.4.11 Quality and Validity

As discussed earlier in this chapter, phenomenological approaches in the context of qualitative research explore the concept that knowledge is enabled by various influencing factors including but not limited to language, cultural background, and an individual's view of the world. Therefore, and in an effort to ensure that this research is of high quality, this study should adhere to a number of different values described briefly below.

'Sensitivity to Context' refers to being mindful and paying attention to a number of aspects that comprise the context of a study. These include primarily immersion in relevant research and literature and in the theoretical accounts created by previous researchers who have analysed relevant topics or utilized similar methodologies (Yardley, 2000). In addition, taking into consideration the socio-cultural setting of the study and the impact that linguistic, ideological, and socioeconomic factors would have on the participant's as well as researcher's worldview, is considered crucial in making sense of the data obtained (Yardley, 2000). Ultimately, sensitivity to context refers to the sensitive exploration of the data and the careful consideration of the consequent interpretations made.

The values of 'Commitment, Rigour, Transparency and Coherence', refer to the expectations of diligence in the process of data collection, analysis and reporting of the research.
'Commitment' refers to the prolonged and detailed engagement with the subject studied, the immersion with the data in order to yield rich information and acquiring a level of competence in the chosen and relevant methodology.
'Rigour' involves the comprehensiveness of the data collection and analytical process as well as the interpretation of the data. These should take into consideration all the differences and intricacies present in the data material. It is important to note that although rigour refers to a sense of completeness and would be a result of the adequacy of a sample, this does not necessarily relate to the number of participants but to the possibility of obtaining adequate information in order to perform a thorough analysis (Yardley, 2000).

The notion of ‘transparency’ refers to the disclosure and the sense of clarity in the ‘’story’’ behind the research study whether any descriptions and justifications provided are clear to the reader. This can be accomplished by offering a detailed description of all stages of the research process and the clear relationship between the data obtained and the researcher’s interpretations of these (Yardley, 2000). The presence of excerpts of the data such as transcripts enable the readers themselves to highlight patterns that were recognised in the analytical process (Huberman and Miles, 1994; Perakyla, 1997; Yardley, 2000) Moreover, ‘coherence’, refers to the pairing of the philosophical framework that underpins the research and the research’s aim and research question (Yardley, 2000)

Finally, and as the ultimate measure with which research is evaluated is its ‘impact and importance’ and refers to the significance and worth of the research. This does not refer to a particular aspect of usefulness as this is to be examined and evaluated in relation to the analytical objectives, the purposes this was intended for as well as the relevance it holds for the community for which it was deemed of significance (Yarldley, 2000).

2.5 Ethical Considerations

As this study was of a highly sensitive nature, there were several ethical issues to consider in order to ensure that this research complies with City University and the British Psychological Society (BPS) ethical standards and Code of Human Research (BPS, 2014; Oates et al., 2021). Furthermore, my own role in this research was also impacted by my status as a trainee Counselling Psychologist and my own clinical experience of working with individuals that engage in high-risk behaviours such as self-injury.

These standards informed any measures that were put in place in order to address any potential ethical concerns and to ensure the minimization of adverse reactions by my participants. The recruitment process as well as the process involved in arranging and conducting the interviews- as described in detail in the sections above- was informed by the wish to ensure that the participants did not experience any sense of pressure and coercion with regards to taking part in this.

In the information sheet given to the participants, the rationale of the study as well as the risks and benefits of the research were outlined clearly, and they were given opportunities to discuss these and ask further questions should they wished to. Moreover, it was reiterated

that participants could withdraw at any point prior to the data analysis stage without being penalised or disadvantaged in any way.

Prior to the interview, participants were also informed that they could abstain from answering any or part of any questions they did not wish to or did not feel comfortable to do for example if they found these questions too personal or intrusive.

2.5.1 Risk and Safeguarding Considerations

In line with safeguarding considerations and in the context of assessing for any risk concerns, participants were asked questions with regards to suicidal ideation, intent or plan as informed by and found in the CORE-OM form prior to their interview. The Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM) is a 34-item questionnaire offering the same five level response choice in all questions, spanning the last seven days from the day of administration. This measure covers four domains including concerns around wellbeing, problems, functioning and risk (Evans et al. 2000). A selected number of questions pertaining risk concerns were used and not all 34 questions were administered.

In addition, and in order to safeguard my participants' emotional wellbeing, during the interview, I was also attentive to any verbal and non-verbal signs of distress or discomfort according to which participants would be invited to pause, take a break or withdraw from the study should they wish. My understanding and assessment of signs of distress was also informed by my own professional knowledge and clinical experience.

Following their participation in this, participants were also offered the opportunity to share any questions or concerns that came up for them during the interview process. They were in addition given a debrief sheet with further information on next steps should they wish to discuss questions or concerns further which included the option of contacting my research supervisor and myself as well as a list of services and contacts to utilize should they feel they needed additional support following partaking in this study.

Due to the sensitive and challenging nature of this study, and in order to safeguard myself during this research process, I engaged in a range of strategies to proactively support my wellbeing. These included having frequent supervision and peer support meetings that provided guidance, feedback as well as crucial space for debriefing emotional material that

arose during the various stages of the study. In addition, attending personal therapy regularly as well as continued professional development trainings helped me acquire specific knowledge and tools that allowed for the processing of the emotional impact that this study had on me. Finally, setting firm boundaries in the context of managing my workload and engaging in a frequent self-care routine enabled me to maintain an overall sense of balance during this process.

2.5.2 Ethical Approval

This study was granted ethical approval from the Psychology Department Ethics Committee of City, University of London in July 2019 (Appendix K). Further amendments with regards to broadening the study's recruitment criteria and recruitment method were approved in February 2020 (Appendix L). Final amendments with regards to arranging a second interview with participants was approved in January 2022 (Appendix M).

2.6 Reflexivity

The process of reflexivity refers to the researcher's reflective process with regards to the various personal aspects that can influence and shape their research and findings (Willig, 2013)

Aspects pertaining to methodological reflexivity were discussed earlier in this chapter under the section 'Theoretical Positioning in the Research.'
Personal reflexivity refers to the awareness of how our own assumptions, beliefs, stances and experiences influence the research process.
I primarily acknowledge that a number of experiences and encounters in my personal and clinical life have impacted the motivation to explore the topic of genital self-injury via conducting this research study.

I acknowledge my own pre-existing relationship to the topic studied via my background in working with a variety of presentations both in Greece and the UK which included those with severe and enduring mental health concerns, survivors of complex trauma, including those that present with personality disorders, severe self-injury, and chronic suicidality.
In addition, my MSc thesis titled 'Complex PTSD features as a mediating factor in emotion dysregulation manifesting in self-injurious and suicidal behaviour' contributed to my understanding of the area of self-injury and inspired me to explore specific issues pertaining to the area of self-harm at a later stage.

On a personal note, this research topic is also influenced through my prior relationship with an individual who in the context of surviving complex trauma as a child, engaged in this particular type of self-injury in an attempt to manage the impact of their traumatic experiences.

Although I take into consideration my pre-existing relationship to the topic in the context of the factors mentioned above, I simultaneously acknowledge that as I do not have a personal history of engaging in self-harming behaviours, my understanding of the topic remains at a theoretical level.

Further concerns and reflections around this are explored in greater length, in the Discussion section of this portfolio.

Analysis

3.1 Chapter Overview

The aim of this study is to understand how adult women make sense of their genital self-injury. Therefore, this chapter, is a reflection of my attempt to carefully highlight my participants' experience as described in their narratives.
Interpretative Phenomenological Analysis (IPA) was selected as a method of analysis in order to capture how my participants understood their lived experience of self-injury.
Holding a dual focus, IPA focuses on the unique experience of the individual, prioritizing this as well as searching for patterns of meaning across participants whilst carefully avoiding overgeneralizations.
Initially, through the emergence of idiographic themes in each account, I focused on the unique experience of the individual. Following this, I searched for overall patterns of meaning across accounts and identified a number of superordinate themes to illustrate these.

Following Smith et al. (2009) suggested practice around supporting transparency by integrating the analysis with the data, I used a selection of extracts and quotes from the participants' transcripts in this chapter. Furthermore, this practice ensures that as a researcher, I maintain integrity by staying grounded in the data and by focusing and safeguarding my participants' unique voice and experience.
In an effort to avoid redundancy, I largely omitted the use of quotes to illustrate these master themes, with only the occasional, select quote used to demonstrate any unique perspective or nuance.

Moreover, in the service of preserving confidentiality and anonymity, I did not offer participant demographic and biographical information. In addition, I removed or altered all identifying information and have given both participants a pseudonym.
Following each quote, I gave in parentheses, the participant's pseudonym, page number and line number as seen in their transcript (e.g., Isabelle, 3, 45). When a participant has been interviewed twice, I included an additional interview number following the participant's pseudonym (e.g., Kate, 1, 3, 45).
In addition, I did not alter the transcript text and depicted any extraction from previous or following text through the use of an ellipsis … . Any hesitations, pauses, non-verbal gestures and other observations are also reflected in brackets similarly to how they appear on the transcript.

As the analysis process is a co-construction of meaning between the participant's data and the researcher's interpretation, a process that Smith and Osborn (2003) refer to as 'double hermeneutics' in IPA research, I placed careful consideration, in preserving closeness and commitment to the participant's narrative. Furthermore, I made every effort for this attention to be reflected in the themes that emerged from the data. It is important however to highlight, that my own interpretations of the participants' accounts of their lived experience, might differ to other researchers. As a result of this, another researcher might have selected different quotes from the transcript, developing different coding and in turn, different themes.
Finally, I omitted reference to theoretical background and literature from this chapter in order to preserve the focus solely on the results of this study. The results are instead further discussed and explored in context in the Discussion chapter.

3.2 Overview of Themes

The themes developed aim to guide the reader through the multi-faceted experience of genital self-injury for the participants, Kate, and Isabelle. An overview of the superordinate themes and subthemes for each participant alongside the overarching master themes are illustrated in Table 1 below.

Table 1. Superordinate and Subordinate Themes

Superordinate and Subordinate Themes

Kate	Isabelle
1) Struggling to Make Sense - Does this Count? - Confusing Pleasure and Pain - Connecting the Dots	**1) It's in the Name** - Calling it What it Is - Self-harm is Something that's Bad for You
2) Something's Wrong with Me - Dr Jekyll, Mr Hyde - The Things I Couldn't Be - Trying to Catch-up	**2) Destructive Pleasure** - Relieving the Unbearable - Finding Pleasure in an Unpleasant Thing
3) With Self-Harm By My Side - Taking Control of the Hurt - My Protective Friend - An Inevitable Outlet	**3) The Function in the Harm** - It's How You Cope - Dealing With a Disconnected Self
4) Relating to Myself - Taking it Out on Me - The Quest for the Ultimate Harm - Struggling to Care	**4) Feeling Defective** - There's Something Wrong with Me - The Skin I live In - It's What You Deserve - What Have I Done?
5) The Healing Journey - The Importance of Supportive Others - Slow and Steady: Navigating the Therapeutic Process - In a Much Better Place	**5) The Challenge of Self-Care** - Self-Care isn't my Strong Point - It Starts when You're Young

Master Themes

- **Making Sense of Self-Harm**
- **Perceived Defectiveness**
- **The Struggle of Practicing Self-Care**
- **Targeted Harm**

For Kate, 5 superordinate themes were developed. The first theme, ***'Struggling to Make Sense'***, highlights Kate's efforts to grapple with and make sense of her experience in the

context of other behaviours as well as in the context of her assumptions and pre-conceived notions around what constitutes self-injury and how her experience fits in this.
The second superordinate theme, ***'Something's Wrong with Me'***, relates to Kate's perceived sense of defectiveness both with regards to her self-injury as well as in the broader sense of not feeling enough and feeling different to others around her.
The theme ***'With Self-Harm by My Side'***, is a powerful account of the sometimes supportive and protective function that self-injury holds for Kate whereas the theme ***'Relating to Myself'*** shows in contrast her self-injury as a representation of a punitive way of relating to herself.
Finally, the fifth superordinate theme ***'The Healing Journey'*** illustrates her passage to a life without self-injury and towards an overall more compassionate way of relating to herself and the aspects that contributed to this.

For Isabelle, 5 superordinate themes also emerged from the data. The first one, ***'It's in the Name'***, revolves around Isabelle's journey towards conceptualizing her experience as a form of self-injury.
The second theme, ***'Destructive Pleasure'***, showcases her perception of the at times contrasting aspects of her self-injury; a behaviour that although experienced as pleasurable and satisfying, proves to be ultimately destructive and harmful.
The third theme, ***'The Function in the Harm'***, illustrates Isabelle's attempt to explore any underlying function that her self-injury might serve for her whereas ***'Feeling Defective'*** is a theme that explores Isabelle's negative self-perception in the context of various aspects of her life. These include her feelings towards her underlying skin condition, her self-injury as well as the relationship between the two.
The fifth and final theme titled, '***The Challenge of Self-Care'*** is an expression of Isabelle's overall thoughts and feelings around the notion of self-care as well as her relationship with this in the context of her self-injury.

The final section of this chapter, follows the presentation of four master themes that attempt to integrate findings from both case studies, forming overarching patterns, and shared themes across their experiences.
'Making Sense of Self-Harm' focuses on exploring the way in which the participants make sense of their self-injury and the challenges they experienced in the context of this.
'Perceived Defectiveness' explores the way both participants relate to themselves and the impact this has in the development and maintenance of their self-harm. The third master theme titled '***The Struggle of Practicing Self- Care'*** relates to the difficulties both participants experience in this area and making sense of these in context. Finally, ***'Targeted***

Harm', sheds light into the conscious choice of self-injuring in this specific area of their body over another and expands on the rationale they hold around this and the importance this carries for them.

With regards to other methods of self-injury besides genital self-injury, one participant ('Kate') engaged in self-injury by pinching various areas of her body as a child and then during adolescence specifically self-injuring her breast area via inserting sewing needles shortly prior to starting to engage in GSI. This behaviour did not continue whilst engaging in GSI, although the participant did self-harm via scratching areas of her body and engaged in skin-picking and biting the inside of her lips for some time following cessation of GSI.
The other participant ('Isabelle') did not engage in any other methods of self-injury outside of GSI.

Kate

3.3 Superordinate Theme 1: Struggling to Make Sense

In this superordinate theme, I attempted to capture Kate's sense of effort to make sense of her experience, both on an intrapersonal level as well as in the context of general, common beliefs and perceptions around self-harm. This includes a layer of expressed frustration and disappointment in the lack of awareness around this type of self-injury and the impact that this has had in how Kate has ultimately formulated[1] her behaviour within her mind as well as in how she perceives herself as a result of engaging in this. This is illustrated within the at times powerful and evocative language she uses to describe this.
In addition, this theme also explores Kate's confusion, self-doubt and uncertainty around her self-injury and the sense of ambivalence she holds in the context of it potentially relating to her experience of masturbation.

3.3.1 Subtheme 1: Does this Count?

This subtheme tries to capture Kate's struggle to understand her behaviour and to formulate this in some form of way in her mind.

[1] The term 'formulated' here refers to how Kate made sense, structured and conceptualised her experience of self-injury.

‘No. I didn’t know it. I didn’t know what it was for a very long time so I thought that it’s important that people know what it is (pause) ’ (Kate, 1, 2, 19-20,)

This quote reflects Kate’s lack of understanding of her self-injury. There is a sense of adamant certainty in her use of word ‘No’ when expressing how she wasn’t aware whether genital self-injury was a known behaviour. In addition, there is also an acknowledgment of the importance that awareness of this topic holds for her. The antithesis showcased through her words around the absence of awareness for herself vs. the expressed importance in others being aware, illustrates the acknowledgement of the negative impact of a time lived in the absence of understanding and the wish that others have a different experience to her.

‘…I didn’t think that this was self-harming for a very long time but the other types of self-harm you know, cutting, burning whatever…I think it was the nature of it, you know, because it was more visible…I knew about these types (emphasis) of self-harm for a very long time but I really didn’t think that this particular way is you know (chuckles) a type of self-harm.’ (Kate, 1, 2, 22-29)

Here Kate expresses her sense of distinction on what constituted self-harm in her mind perhaps rooted in assumptions around what she had believed self-harm to be up to that point. She places an emphasis on being aware of different types and manifestations of self-injury that are visible to others which might reflect her perception of invisibility as an excluding factor, further impacting how she formulates her own experience.
There is also a sense of disbelief and perhaps shock in the realization that this is also a form of self-harm which is reflected in her use of the word ‘really’. This accompanied by her observed chuckle might reflect a sense of nervousness that perhaps follows this realization.

Kate’s sense of frustration and perhaps anger towards genital self-injury not being known and the impact that this lack of awareness has had on her is illustrated in the following quotes:

‘(increase in voice.vol) Well there is [ie. a difference between genital self-injury and other types of self-harm], because it is not known…that is the reason people don’t come out and you know talk about this…it is difficult for people because they don’t know most of the people who self-harm in that way…well I’m thinking of myself, I would not classify it as self-harm. If I knew that it was a type of self-harm it would

make things easier for me to speak out before I did because well, nobody talks about it… (Kate, 1, 3, 32-38)

In this extract, Kate's expressing her perceived certainty around the lack of awareness being a reason behind people perhaps not being aware that their behaviour constitutes self-harm which in turn creates an vicious cycle in the difficulty of being open and sharing their experience if they don't perceive this as a more common practice. There is an underlying sense of urgency and a wish for there to be awareness around this topic showcased in the volume of her voice, and in the felt sense of certainty in her words.
Kate further acknowledges the impact this personally had on her as she recognizes this would likely mean she would have spoken about her experience earlier with all that this would change for her.

In the following quote, she further goes on to describe another layer of the impact that this lack of awareness has had on her especially as in her view, professionals were unaware of this which further impacted how she viewed her experience.
The use of the word 'freak' creates a powerful image with an animalistic or subhuman quality perhaps reflecting a deep, felt sense of defectiveness and disconnection from others around her. This might link to and reflect an underlying sense of disappointment towards professionals who are regarded as holding knowledge and power to bring awareness, reduce stigma all of which can positively contribute in how one can make sense of their experience.

'…It is not acknowledged as self-harm by many psychologists as well and it makes you feel like a freak for doing this and if it was known it would make it easier for me to speak about it' (Kate, 1, 3, 38-40)

The link between awareness of self-injury and the ability to seek support, is further illustrated in the following quote:

'…I remember, around the age that I was doing this and I didn't even know it was self-harm, I had friends…that would…show me their marks…from cutting or from cigarette buts…it was known that this was self-harm. And I remember them…going to therapists and psychologists and…speaking about these things and I dunno how much it helped but I'm damn sure it helped that they could speak about it.' (Kate, 1, 18, 232-239)

Here, Kate grapples once again with the impact of the known vs unknown types of self-harm and the sense that self-injury has a homogenous presentation characterized by visible marks that elicit a sense of certainty and erase doubt as to what they represent. Kate also communicates her belief that due to a broader awareness of these types of self-injury, others could access professional support help perhaps alluding to others such as herself not being able to receive the same help. The use of the words 'I remember them' and 'damn sure' evokes a sense of sadness, of regret, even anger and of precious time being lost, that colours Kate's retrospection.

Finally, Kate's lack of understanding and conceptualization of her self-injury as such, is further illustrated in the following extract. This reflects Kate's pre-conceived idea of self-harm as an attention seeking behaviour, possibly stemming from the general stigmatizing narrative around self-injury. Therefore, the contrasting, concealed nature of her behaviour might have contributed to her difficulty making sense of this as self-harm. The use of the word 'cringe' likely express strong emotions of disgust and shame and allude to a wish for her to not be perceived as attention seeking. This in turn might indicate on how she might view the notion of one seeking attention overall and her contrasting preference for her self-harm to not be about communicating with others but instead for it to reflect something about herself.

> *'…People had all this idea that self-harm is a way of…you know how they label it and say 'attention seeking'? And the word itself, made me cringe…the idea of concealing it…does go well with this idea of mine that it was attention seeking to self-harm yet…I can only look back and say this now because I didn't realize it was self-harming at all…". (Kate 1, 18, 242-247).*

3.3.2 Subtheme 2: Confusing Pleasure and Pain

The subtheme 'Confusing Pleasure and Pain' explores Kate's attempt to navigate her sense of confusion between masturbation and self-injury in the context of her own experience and there is an expressed sense of her not being certain where one starts and where the other ends. Mediated by what she describes as compulsive, a word that alludes to the involuntary, and to her not having a choice and not being able to stop, she oscillates between pleasure and pain as well as in the space where these two experiences meet and where they separate. A sense of fragility and anxiety is palpable and is illustrated in her words, pauses and sighs which is accompanied by a sense of urgency to make sense of her experiences. This perhaps reflects a wish for her self-injury to be distinct to her sexuality and to acquire a

sense of clarity in her expressed confusion and contradiction. It is as if, she requires for it to be clearly defined before it is comprehended and finally acknowledged.

'…I think it was soo merged with compulsive masturbation for me (takes deep breath) I think (sighs)… Well it clearly wasn't (pause) masturbation (pause) now looking back. And I didn't even feel like it was. For it to be masturbation it needs to be uhm pleasurable, doesn't it? I don't think (short pause) much of a pleasure was in there but I think that was particularly you know, it was the problem.' (Kate, 1, 4, 46-51).

Her further expression that she would find difficult for anything sex-related to be pleasurable, illustrates her sense of struggle in this area. This perhaps holds a perception of shame, as reflected by her short pause before using the word 'difficult'. This admission offers another layer of understanding that aims to shed light on her self-injury in context and to explore her confusion between pleasure and pain.

'Anything sex related, being pleasurable (short pause) would be difficult". (Kate, 1, 5, 53).

"I think that was the thing that confused me in a way? …I mean now looking back I see that back then… I think that you know for you to be masturbating there needs to be some sort of pleasure involved. And it's not as if I would not ever masturbate, you know without self-harming, and it is not as if every time I would self-harm in that way, I would be masturbating. Uhm, but there was definitely some confusion and uhm (pause) yeah." (Kate, 1, 6, 55-66).

In the extract above, Kate expresses a sense of yearning to understand and perhaps be understood as seen in her efforts to explain herself in detail. There is possibly also an additional wish reflected through her words 'looking back' and 'back then' around her declaring albeit subtly, the difference between who she was in the past and what she knew about herself compared to a more enlightened, current self. This might allude to a further wish to distance herself from her past and to showcase a sense of growth and maturation. The repetitions of the words 'masturbation', 'pleasure' and 'self-harm' and the at times difficulty articulating her thoughts, serve as further acknowledgment of the confusion and difficulty to distinguish masturbation from self-injury and pleasure from pain.

In the following extract, there is a sense of this dissonance ever so slightly dissipating where both concepts of pleasure and pain seem to merge. There is a sense of Kate seeking a sensation through her self-injury, one that although not pleasurable, perhaps satisfying in its ability to hurt. Kate's sense of expressed certainty in her enjoyment of the painful aspect of her experience and her conclusion that she 'was after the pain', is in contrast with the sense of hesitation in defining this as self-harm.

> *'I liked the sensation. It was not a pleasurable one. I liked that it hurts. So it was self-harm I think. Because it was not pleasurable. But I was after the pain...' (Kate, 1, 28, 460-462)*

> *'…I dunno, you know maybe it was like reliving the trauma I dunno.' (Kate, 1, 28, 462)*

In this final quote, Kate seems to reach a realization around her experience of self-injury, formulating this as an attempt to relive and relieve her trauma of bullying and sexual abuse through seeking pain. This might reflect her possible sense of confusion in the acknowledgment of her wish to simulate this in order to make sense of it and its perhaps impact. In this context, self-injury serves a way of identifying with a symbolic, traumatizing aggressor.

3.3.3 Subtheme 3: Connecting the Dots

The final subtheme titled 'Connecting the Dots' follows Kate's journey from her naming and accepting her experience in the context of self-harm through her quest for answers around her self-injury and the various elements that have contributed to this.

The following extract illustrates the importance that Kate places on having an accurate label of her behaviour as self-injury and the sense of feeling understood and the inclusion that this provides. This perhaps reflects her finally being able to allow herself freedom from her self-judgments and to experience a newfound sense of hope in what these realizations may bring.

> *'… I think it comes back to this not being known as it being self-harm, isn't it. Because putting the label on and say 'this is self-harm, you are not just a freak, there*

are other people who do that' and it is not that different from cutting and burning your skin or whatever it is just in a place that people can't see it. It made things easier for me…' (Kate, 1, 17, 219-223)

Kate's evident sense of relief in her therapist knowledge on genital self-injury, alleviated her sense of shame, further contributing to her understanding of her behaviour in the context of self-harm and not as some form of rare and unique to her, defect. This in turn helps shift her self- perception of perhaps an outcast to a person sharing a shared sense of humanity.

' I'm glad that my therapist knew about it because it would make me even more ashamed if even my fucking therapist didn't know about this. I think that 'freak' bit comes from not knowing that this in fact did exist". (Kate, 1, 17, 227-230).

Having defined her experience as genital self-injury, Kate's focus shifts towards searching for answers and the reasons behind this.

'Why this type of self-harm, why…there, what caused it, because…we all go through things and there are…many people around who self-harm…and other you know ways…what made me in a way, to self-harm like this?... (Kate, 2, 2, 32-37)

In the above quote, the repetition of question words reflects the intensity in her need to understand, and to explain perhaps firstly to herself what led her to self-harm in this particular way. The choice of the word 'there' and the slight pause before saying this, illustrates a form of avoidance on naming her genital area which could be an expression of Kate's own feelings around her self-injury and her wish to create some distance from the location that this relates to perhaps due to her own associations around this.
In the use of phrases such as 'we all', 'many people around' and 'other ways', Kate seems to compare her experience to that of others reflecting possibly her own judgment of this and her sense that there are other perhaps 'more acceptable' or 'well known ways to self-injure. This creates a further layer of otherness and hierarchy as to what she perhaps considers as 'acceptable enough' as if there is a limit she has somehow crossed.

The following extract, highlights Kate's step by step process towards awareness and how this led to her further 'connecting the dots' by linking any contributing factors to the development of her behaviour.

'…For the most part of it I was not even aware this was self-harm. Which made it more confusing for me, in some level I knew that this was not ok…there was something abnormal about it…but this did not register as self-harm, so I think it made it a bit difficult for me to think of the reasons why, I don't think I've connected the dots for a very long time' (Kate, 2, 3, 48-54)

The use of words such as 'for the most part' and 'in some level' to illustrate her sense of partial awareness, highlights a sense of fragmentation within herself and an operating of the self in parts some of which hold greater understanding than others. The impact of a non-integrated self is then reflected in Kate's challenge to initially see her self-harm in context.

'… and yeah (pause), yeah I think for me to realise the (pause) bullying and the abuse I've been through would have had any part in any sort of self-harm. I don't think I've connected the dots…only you know after years of therapy and after our interviews I'm thinking more about it…' (Kate, 2, 3, 55-59)

There is a sense of hesitation and trepidation as she discusses her realization of a potential link between the adversity she has encountered and her self-harming. This is reflected in her pauses which might further showcase her feelings towards any association between the two. Kate's choice of words 'after years of therapy' showcases perhaps the necessary time needed to process some of these experiences and to reflect on the impact these might have had in the development of her self-injury. Her therapy experience and her partaking in our interviews allows her perhaps a space to make sense of her self-harm by exclusively focusing on this. This further permits her to 'connect the dots', and her use of this metaphor illustrates her a newfound ability to see her experience in context.
Kate's search for answers and the awareness and association of painful past experiences and her self-injury is further illustrated in the following quote:

'…going through my education when I started…to question things…I just wanna know what caused it…in a way I do know…it has to do with the trauma, it has to do with the nature of the trauma…' (Kate, 2, 5, 70-73)

Again, there is a sense of urgency in her wish to make sense of her experiences, almost in a clear cause and effect' manner. In addition, there is a sense of expressed desire reflected in the phrase 'what caused it', for the self-harm to be caused by an external factor. This might allude to her wanting to disconnect from her role in engaging in this.

'I'm trying to make sort of connection because the trauma I've been through was of, you know a sexual nature I think being a very introverted person and not you know sharing things very easily, or expressing things very easily, uh it was bound to…come back to me I think, any sort of expression… I think it started that way, yes self-harm if you think about that is very, very logical. And I think the trauma being in a very sexual nature…in a very automatic way made me…self-harm in that way.' (Kate, 2, 6, 81-89)

This final extract, illustrates Kate's efforts to further 'connect the dots' recognizing an association between the particular nature of her trauma and the locality and type of self-injury she engaged in. Her perception of her difficulty in expressing and communicating her inner world to others is described as an almost inevitable and unavoidable precursor to her turning the 'things' she struggled to share, inwards, in the form of self-injury. Her use of words 'logical' and 'automatic' offer another layer of understanding on the link between how she perceives herself and her engaging in self-injury, viewing this as a reasonable albeit somewhat instinctive and involuntary next step.

3.4 Superordinate Theme 2: Something's Wrong with Me

The following superordinate theme refers to Kate's perception of herself as someone who is defective and different to others and explores how this influences her understanding of her experience with genital-self-injury.

3.4.1 Subtheme 1: Dr Jekyl, Mr Hyde

In this subtheme, Kate grapples with the realizations of experiencing herself as a fragmented and how this comes across and influences her self-harm.

In the extracts below, she expresses what seems like a struggle to come to terms with how her self-injury makes her feel about herself. Her use of language reflected in her choice of word 'freak', expresses her palpable self-criticism and evokes a strong sense of alienation and isolation both from the world around her but possibly also from other aspects of herself. In describing herself as 'Dr Jekyll and Mr Hyde', Kate expresses her view of the striking difference of these two distinct sides of her, one that she allows others to see and one that remains hidden and perhaps unacknowledged. One that is perceived as good and one that is seen as evil.

'…I felt like a freak! After realising that this is self-harm this is not just masturbation…which I think I knew at a deeper level…It had to stop at some point. For me to be a functioning adult, not a Dr Jekyll and Mr Hyde kind situation.' (Kate, 1, 13, 170-174)

and

'…''who in their right mind would do this? Why would you want to hurt yourself so much?... For someone to be functioning at this level…being so lovely…and you know at night this (pauses) thing comes out… (Kate, 1, 15, 193-199)

Her use of the phrase 'functioning adult' and her expression of needing to stop self-harming, might represent an underlying wish for her to see herself as a benevolent, integrated whole. This also alludes to her view of self-injury and perhaps of those who self-injure, as dysfunctional. In wondering herself on 'who in their right mind' would self-harm in the way she does, she showcases a clear distinction between what she perceives as right and wrong.

Kate describes a vivid picture of her viewing herself as this 'thing' that comes out at night. This again elucidates the fragmented ways she experiences herself as illustrated in the quotes below.

'…Cause I always used to self-harm at night. And during the day I was this happy go lucky, all smiley person and I was just miserable. Although I didn't feel like I was miserable, being this structural thing, that was happening, like a crack behind closed doors…' (Kate, 1, 13, 175-178)

'…There has to be…I dunno a massive level of dissociation involved…like a dissociative identity disorder kind of thing…I was something else during the day and then at night, while I was self-harming… the night was like a cover…it was shameful.' (Kate, 1, 15, 200-206)

Her use of medical language in words such as 'dissociation' and 'dissociative identity disorder' reflects some sense of awareness in what her behaviour might illustrate and perhaps allows her to see this in context. Her description of dissociation further highlights a

sense of disconnection from herself and her surroundings and the time of self-injury is described as a cover serving perhaps as shield against her mentioned feelings of shame.

In describing the link between being unable to sleep and self-injuring as ‘classical conditioning’, she offers another layer on how she perceives her experience; one that has an automatic and involuntary associative quality.

> *‘…whenever I wouldn’t be able to sleep, I would self-harm and I feel it was almost like classical conditioning…’ (Kate, 1, 20, 279-281)*

This is also illustrated in her following description of her self-injury which further reflects a sense of disconnection from her awareness which might reflect a wish to disconnect from her actions and what these might bring up for her.

> *‘…It was a knife actually that I used…the memory is very hazy…because the only thing I remember was…the pattern of my duvet and stuff like that…and after that, I just washed the knife and put it in the dishwasher like nothing had happened…’ (Kate, 1, 27, 429-438)*

3.4.2 Subtheme 2: The Things I Couldn’t Be

This subtheme explores the expressed sense of defectiveness and otherness that accompanies and influence’s Kate’s experience of her self-injury.

> *‘…it would mostly be relating to me feeling ashamed for whatever I couldn’t do… or couldn’t say or couldn’t show to the other person. It could be anyone… it was mostly around me you know friends, family whatever could move on, yet I couldn’t’ (Kate, 1, 9, 116-121)*

In the above extract Kate explores some of the reasons behind her self-injury and what self-harm meant to her. She describes her feelings of shame linked to a perceived sense of not feeling enough and able with regards to managing different aspects of life, as illustrated by

her use of the word ‘whatever’. These feelings of shame and perceived defectiveness and failure seem to focus on a difficulty expressing herself and showing her emotions and are in the context of comparing herself to others around her, even those that might not hold some significance for her, as reflected in her use of the word ‘anyone’.

Kate links her sense of failure in not feeling able to show others positive emotions in feeling like a child that cannot grow up. It seems as if she links her emotional inhibition to being young and not ‘adult enough’. There is a palpable sense of sadness reflected in her sigh as she expresses this realization which perhaps represents her views around being able to show affection, care and love as a sign of maturation and personal development and growth.

> *‘I couldn’t grow up.’ (Kate, 1, 10, 124)*
>
> *and*
>
> *‘I couldn’t (pause) show, that I care, that I love…it linked to me feeling like a kid…it mostly related to me feeling like a child, me feeling like I couldn’t grow up enough, I can’t you know (sighs) adult enough… (Kate, 1, 10, 126-129)*

This is also illustrated further in the following extract where Kate describes the painful impact her friend’s critical words had on her. Kate feeling not enough is especially prominent in the context of her expressed difficulties in managing romantic feelings which for her, represent a sense of growth and of developing from childhood to womanhood. Her expressed shame quickly shifts into questioning herself and there is a self-critical tone present in her words as she asks herself why she finds expressing her feelings towards someone so difficult compared to others around her.

> *‘… She was basically blaming me…not taking a step further or expressing my feelings…my thoughts and…it was basically my fault that nothing happened between me and this crush. Well I didn’t express enough or showed that I wanted them enough…and yeah this thing that couldn’t happen or didn’t happen with the boy…it was the shame. Shame of feeling… not enough of a woman, not enough, not grown up enough… I felt like a kid… why is it so easy for everyone to get on with their lives and their relationships, to express that they like someone…but it’s such a big hassle when it comes to me?’ (Kate, 1, 26, 388-404)*

Below, Kate attempts to make sense of the nature of her self-harm by making links to adverse past experiences including her history of sexual trauma. She seems to question why

she didn't self-harm in another part of her body as if this was somehow a choice albeit unconscious, that links her past to her self-injury. Moreover, she tentatively explores this link further reflecting on the start of her self-harm and it relating to her feeling as less of a woman perhaps in the context of her experiences.

> *'what happened in my past…determined how I self-harmed…why not these things and vaginal self-harm? I think that it just comes back to my past and how self-harm started with me feeling …less of a woman.' (Kate, 1, 31, 524-529)*

> *'…it just comes back to me not feeling enough of a woman to be able to have healthy relationships…not being able to express myself, to voice my needs, instead I just did it myself.' (Kate, 1, 31, 532-534)*

This final quote elucidates how Kate associates having healthy relationships as a sign of being enough of woman. Her feelings of inadequacy are then reflected in her experience of self-injury. Self-harm becomes for Kate an expression, a voice of all that is unspoken, one that is turned inwards and reflects all that she feels she couldn't say and all she feels she couldn't be.

3.4.3 Subtheme 3: Trying to catch-up

This theme capture's Kate's feelings around what she perceives as a delay in her emotional development and is one that has its focus in comparison. There is a felt impression of her feeling somehow left behind compared to her peers, struggling to catch-up with them.

Kate expresses her feelings of sadness around being a child who was aware, perhaps reflecting on being cognizant and perceptive of her peers, comparing where they are with regards to their stages of growth to where she feels she lies. She paints a powerful image of a person who is on the outside looking in, hypervigilant of the changes in the world and those around her. Whatever she observes and concludes, ultimately forms an inner critic in her mind that finds her coming short, time and time again.
A sense of regret accompanies her awareness of what she perceives as developmental deficits. Her use of words 'things' seems to refer to specific milestones serving perhaps as rites of passage in the journey towards adolescence and finally, adulthood.

'…(sighs) sadly I was a very aware child, and I could see that all my peers have been through some things roughly around the same time whereas I was just not there…' (Kate, 2, 8, 109-111)

In the extract below Kate describes how her traumatic experiences left her wanting to hide herself perhaps from the world around her. There is a sense of her being preoccupied with and prioritizing concealment as means to protect herself from real and imagined dangers and a sense of urgency reflected in her use of language. Her words furthermore evoke an image of her hiding away, closed off within herself. Her awakening and emergence are only met by a felt disappointment as she feels far behind from everyone else.

'Because of the trauma… I was trying to hide myself so bad that I just forgot to open up. And when I did… I feel I was very far behind by then.' (Kate, 2, 9, 118-121)

Kate seems to experience being wanted as a source of danger and the language she uses alludes that she identifies being desired as a threat that she need to handle or fight off somehow. This threat becomes for her an infection that her body needs to battle, and self-injury develops from a need to catch-up somatically, to be ready for what the future holds and what she might feel is expected of her.

'I wouldn't know how to handle you know, if someone was into me, it would feel threatening, it would feel foreign really and I would fight it as, as if it's a microbe… I think in a way I wanted to, (pause)…probably catch my body up with it. In a very physical way as well.' (Kate, 2, 9, 123-129)'

'…Still I feel like I'm catching, catching up you know, with people my age…' (Kate, 2, 13, 202-203)

For Kate, her peers seem to have reached a destination, a stage in their development, perhaps effortlessly in her mind, whilst she struggles to meet them.

<u>3.5 Superordinate Theme 3: With Self-Harm By My Side</u>

The third superordinate theme explores Kate's experience of her self-injury as a supportive other, that allows her a sense of agency and control in a world she perceives as threatening and attacking.

3.5.1 Subtheme 1: Taking Control of the Hurt

This subtheme showcases a function of Kate's self-injury as a process that allows her to take back control of a hurt that seems inevitable and inescapable for her.

The end of a difficult day, with all the painful experiences and feelings that this brings, leaves Kate turning her pain inwards. Taking this out on herself seems to be an attempt for her to plan for what the next day would bring and get herself and her body ready for this. In this way, self-harm becomes not only a solution to an agonizing problem but also a way for her to look after herself.

> *'… At the end of a bad day, I would sort of take it out on myself… I think I would hurt myself enough and badly enough so that nothing else would hurt me more the next day' (Kate, 1, 10, 130-132)*

The following quote illustrates Kate's wish and ultimately need to make herself strong enough to withstand the pain she was facing in the outside world. Her words suggest an underlying concern of feeling weak or powerless, needing to prepare herself for the worst that awaits. In the face of the unavoidable, her only choice seems to be, to ensure she is the one that hurts herself first.

> *'…I was like you know making sure I would do it to myself… to make myself stronger as well…' (Kate, 1, 11, 140-143)*

Here, self-injury might be seen as a 'lesser of two evils', the less unpleasant option of two harmful choices. An action, that seemed necessary to help her cope and manage the pain that she felt life brings. For Kate, self-inflicted harm serves as a shield against external attack and the hope that she through this redirects its impact, as far away from her as possible. Her use of the word 'twisted' perhaps reflects her perception of her behaviour as disturbed or abnormal. It echoes a contradiction, the paradox of self-harm as an unconventional form of self-care hidden in the natural need of a person to have some control over their circumstances in order to feel safe in this world.

> *'…in a twisted way…preparing myself…for the pain of the world…making sure I was hurt enough by me so that nothing else hurt me…' (Kate, 1, 11, 146-148)*

In the context of others' behaviour towards her, that likely left Kate feeling helpless and defenceless, her engaging in self-injury becomes a voice of resistance and defiance against the senseless and unjustified hurt of those in control and power. In using the word 'crap', Kate denigrates others' attempts to hurt her, perhaps wishing to diminish the impact they have on her. In her swearing she expresses her anger, insolence and contempt- a form of uprising against those that torment her leaving her a fighter, that stands up for herself.

> *'…whatever crap people did, I could do more… it was a rebellious kinda thing. It was like 'fuck you'! ' (Kate, 1, 12, 154-155)*

If the act of taking control is considered in itself empowering, it makes sense that Kate would prioritize this, as seen in the quotes below. If hurt is inescapable, then
being able to control this somehow reduces the pain it causes, making this experience bearable.

> *'… I would do it so that it would stop hurting because if the source of the hurt was known or controlled in way…because me hurting myself was not as bad as others hurting me.' (Kate, 1, 30, 514-518)*

and

> *'… I am going to hurt myself now, so that…when others hurt me it doesn't hurt as much. To make sure that I hurt myself the most… it had a, you know, a sense of control in it.' (Kate 2, 21, 337-341)*

Ultimately, this theme confirms the importance that Kate, places in having agency over her own body and of cultivating and preserving a sense of ownership by any means necessary, including self-injury.

3.5.2 Subtheme 2: My Protective Friend

'My Protective Friend', explores the protective function that self-injury held for Kate. Here, self-harm seems to take a life of its own, becoming a friend for her in her hour of need. This seems to highlight her sense of underlying loneliness and the fear that this perhaps brings with it, when considering facing the world on her own.

In the extract below, Kate's sadness is visible and her sense of loss, visceral. She describes an existence that is marred with pain and there is a sense that in the absence of her self-

harm, she has been robbed of the only form of expression she had to communicate the hurt she has suffered.

> *'Because every day is hurt now (chuckles, tears up). And I am not hurting me and I don't know how to express when people hurt me' (Kate, 1, 12, 151-152)*

Life without self-injury is likened to feeling 'like a snail out of its shell'. This shell which is deemed necessary, resembles a home that offers safety and protection from external harm. With this lacking, Kate is now vulnerable and defenceless, exposed to nature's elements around her.

> *'And now I just feel like I don't have any shell. I feel like a snail out of its shell. (Kate, 1, 12, 157-158)*

Kate further describes the sense of ambivalence that accompanies her stopping to self-harm. On the one hand she feels a sense of pride, recognizing the significance that this achievement holds and perhaps the challenging journey she had to go through to get there. On the other hand, and with self-harm representing a protective shield against external threat, she is now facing the world alone, without the strength and power this gave her. This leaves her in a place of uncertainty, unprotected and susceptible.

> *'I am proud that I was able to stop… but I think, I feel, I am not as strong as I would like to feel.' (Kate, 1, 12, 161-163)*

This final quote encompasses the crucial role that self-injury played in Kate's life. Self-harm is personified, becoming an old friend that despite how dysfunctional they may be, protected her ultimately from herself. There is a sense of familiarity and loyalty reflected in the use of the word 'old', as if it someone who time and time again showed up for her. This friend not only defended her from the damage that others could and did cause, but eventually became a protective factor against Kate's potential for self-annihilation via helping her relieve some of the pressure that built inside of her.

> 'I feel like it's an old friend really. However dysfunctional, I felt that it did protect me. Maybe if I didn't do that I would do things that are worse…that protected me from not committing suicide…it was a way to let it out.' (Kate, 1, 29, 472-478)

3.5.3 Subtheme 3: An Inevitable Outlet

This subtheme navigates the function of an outlet that Kate's self-injury held for her. There is a sense of inevitability and urgency in her words as she realizes that whatever she was holding in, needed to come out. Genital self-injury then becomes an outlet for this and although Kate attempted to find alternatives that were perhaps healthier or less destructive, she concludes that it was likely that any sort of outlet she engaged in, would be in the form of self-harm.

> '…automatically I think ''It had to come out of somewhere?'' I was trying to think of any alternative…outlet but I am not sure If I can come up wh- I think I would still self-harm if not in that way, in some other way or form…'' (Kate, 2, 12, 159-162)

Below, Kate explores her thinking process further, feeling that if she could not protect herself through introversion, or take in out on herself somehow, she was likely to hurt and punish others around her. Being faced with these two options, Kate chooses to sacrifice herself perhaps wishing to protect others from the force that her suppressed emotions possessed. This showcases another layer that might be of importance for Kate- that of ensuring she does not hurt others in any way, contrary to those that have hurt her.

> '…if I'm not gonna be…all you know introverted…and I'm not you know punishing myself, I would try and punish everything else probably…. Maybe other people or…being very uhm reckless in a way' (Kate, 2, 12, 167-172)

Her words reflect a sense of hierarchy, where others are prioritized and held at a greater value compared to herself, that lies further down her perceived ladder of importance. It then perhaps becomes an easier even automatic, choice to select herself as a target for her hurt.

Her view of herself as someone less deserving than others is illustrated further, below where Kate, feels she must look after herself and meet her needs so 'others don't need to'. As if she were a burden, she tries to alleviate others from herself.

There is a formality and a sense of distancing and minimization of the importance of her needs and wishes as reflected in her use of the word 'business'. There is an image of harshness coming to mind that is in stark contrast to the vulnerable nature of needs. One could also argue that Kate's use of the word 'business' may also refer to her sexual needs and in the context of this, may reflect her relationship to the notion of desire and how she wishes to manage this.

Self-injury becomes an outlet for all of Kate's feelings including those of anger. One might think of this as entirely understandable given her experiences and a feeling that it would make sense to communicate. It seems however that for Kate, perhaps feeling that anger equates aggression, the only outlet available, lies in self-injury.

> '…trying to take care of my, you know, needs my business, so that you know, others don't need to… I think in a way it also has to you know serve as an outlet for all that anger' (Kate, 2, 22, 343-347)

3.6 Superordinate Theme 4: Relating to Myself

The following theme explores Kate's self-injury in the context of how she relates to herself. In this, self-injury becomes a form of Kate punishing herself for whatever faults or defects she associated with herself, for whatever feelings she held and couldn't process in a more compassionate manner. The theme follows Kate's development of the ultimate self-harm, one she finds in the experience of genital self-injury and finally navigates her complicated relationship with self-care highlighting the challenges and struggles that relating to herself in a positive way, brings.

3.6.1 Subtheme 1: Taking it Out on Me

Here, Kate's self-injury reflects an urgent effort to escape the mental state she finds herself in. This is a state characterized by feelings of inadequacy that she wishes to punish herself for. Through her words, she paints a vivid picture of her self-attack, one motivated by wishing to chastise herself for her difficulty in feeling. This develops into a retaliatory way of becoming present and grounded and a vengeful antidote to her feelings of numbness and detachment.

> *'…for me to maybe to snap out of something. Out of a state that I am in. Me feeling like I am not enough…well it comes back to punishment doesn't it… it was more like you know 'Take that! Whatever! For me to feel something, anything… for me to show that I feel something…' (Kate, 1, 8, 98-104)*

Furthermore, Kate's self-injury serves as a multifaceted and symbolic punitive voice, at times expressing what she feels she couldn't in romantic contexts. Other times, this escalates,

becoming a weapon that harms her for her perceived flaws; for not being strong enough to withstand others' remarks and to weather their impact.

> *'…I think when it first started…it was a combination of me…expressing more in the sense that I didn't with the boy and to also punish myself for being so weak and so open to people's remarks.' (Kate, 1, 27, 417-419)*

Kate's self-injury, being fuelled by anger, quickly becomes deliberate and targeted aggression towards herself. She paints a graphic picture of her self-harming process, one fuelled and coloured by a sense of determination, describing her efforts to bleed, and hurt. Blood perhaps symbolizing that the hurt had achieved its purpose and could now pause. In Kate's wish to 'ensure' this, one might see a wish to succeed in contrast to all she might feel she has failed at. She speaks of this being her way of taking revenge, retaliating perhaps against the perpetrators and her abusers in the only way she sees possible.

> *'…it was anger driven.. it was more of a punishment.' (Kate 1, 31, 545*

and

> *'…I used to self-harm by…inserting things as well and making sure it bled and hurt…this was my way of just probably taking revenge in a way…' (Kate, 2, 10, 131-133)*

Her use of language illuminates her desire to inflict pain on herself and to hurt a body she felt had betrayed her trust. In this following quote, she also alludes to this being in the context of her precocious puberty. The early onset of her development linking perhaps to an awakening she did not feel she was ready for, one that was visible for others to see, leaving her feeling increasingly vulnerable to whatever this elicited.

> *'… ''Ha, there you go, that's what you get!... I think I felt like my body, you know betrayed me. From a very young age, I think this had to do with my early puberty''. ' (Kate, 2, 10, 139-143)*

In this final quote, Kate admits to her anger, realizing however that she was punishing herself for others' wrongdoing. Her words reflect her finally becoming aware of where the responsibility of the hurt lies and a shift from her erroneous sense of self-blame. Her use of the word 'just' exudes a sense of regret for all she put herself through and felt she had to

endure. It seems that for Kate punishment feels necessary and one wonders how it would be or look like, for her to take it out on who she feels is the right person.

> *'… I mean I did feel anger. I just took it out on the wrong person I feel.. ((Kate, 2, 13, 207-208)*

3.6.2 Subtheme 2: The Quest for the Ultimate Harm

This subtheme explores Kate's efforts to develop what she considers as the ultimate harm. This includes her earlier experiences with self-injury, her search for instruments that she can use to facilitate this and her pursuit for what she considers an appropriate area to self-injure at.

In the following extract, Kate describes the process around her genital-self-injury and specifically the medium she would use to achieve this. There is a tone of paradoxical excitement and exhilaration in her use of words as she explains her search of what she deems a suitable tool to use in the form of bottles designed to scratch inside her vagina. The association between object and harm is described as automatic reflecting an instinctive and perhaps unconscious connecting process.

> *'They were all inserted and were used to scratch. Uhm. It's freaky because I would see these silly bottles of products I would never use in the supermarket and think ohh this would be good… I think it was an automatic association I'd make and I would think ohh I could use this, I could use that.' (Kate, 1, 27, 442-446)*

Below Kate offers further information on the start of her self-harming process. She describes this as experimental almost reflecting a tentative process of trial and error in search of a self-harm that feels somehow right for her.

> *'…in the very beginning I would pierce my breasts with tools and needles like the sewing needles but I didn't continue doing it.' (Kate, 1, 28, 449-451)*

And

> *'…I was very experimental when I started…' (Kate, 1, 28, 454)*

When she finally finds genital self-injury, she describes this as an ultimate punishment. The area of injury, her genitals, is labelled as ''the bullseye'' as if it is a centre and epitome of harm. An image of a dartboard comes to mind, the bullseye representing ultimate success; the ultimate according to Kate, punishment.

> *'…that was the ultimate, punishment in my head, like the bullseye…' (Kate, 2, 16, 250-251)*

and

> *'…it was very much targeted in that sense…it had to do with the sensation. So probably reliving the trauma or whatever sensation it left in my body. You know that tingling sense? When you feel (pause) you are sexual, during puberty?... I think in a way my body just found it automatically, where to self-harm. Because that's where I felt it…' (Kate, 2, 16, 254-261)*

Kate describes above, her quest for the target of her self-Injury being influenced by a search for a specific sensation. She relates this to a bodily sensation she experienced during her trauma and her use of words 'left in my body' perhaps reflects a sense of disconnection from it as if she was not the one who experienced it at the time rather the person that found this instead.

In the process of sexual awakening taking place in adolescence, she describes experiencing arousal which served as a form of baseline experience on which the area of her self-injury was based on.

Self-injury then becomes, as illustrated below, a way to re-experience the trauma that left her feeling defective, perhaps in the hope of mastering over this. The Bullseye representing a logical sequence, from the area that was hurt to the area she will hurt.

> *'… Probably living or reliving the trauma…feeling that I was missing in a way or defective…probably thinking that it comes from there so it needs to (pauses) bullseye, the self-harm needs to be there..' (Kate, 2, 18, 268-271)*

Kate further explains her thinking process in finally selecting the process of genital self-injury. According to her injuring her skin, in the way that is perhaps most commonly known, feels inadequate. She instead recognizes the paradox herself, of feeling pleased and gratified by a hurt she deems deep enough- one that causes 'her insides to hurt'.

'..If I was gonna harm me, just harming on my skin was not enough…it was a weird satisfaction to see your blood or you know…I'm sorry but your insides to hurt' (Kate, 2, 18, 283-287)

For Kate, the ultimate harm is one that reaches a centre and core of perhaps her trauma, her pain, or even herself. There is a sense of definitiveness and certainty in her words as if she has finally found something she has been searching for, for a very long time.

'…it feels like the ultimate harm that I can do to myself getting closer to the core in a way.' (Kate, 2, 19, 296-297)

3.6.3 Subtheme 3: Struggling to Care

'Struggling to Care' explores Kate's challenging relationship with herself in the context of self-care, both in general and with regards to her self-injury.

Kate admits how self-care is not something she particularly engages in. She gives an example of using sanitary pads in order to mask the blood resulting from her self-harm. Her wish to conceal her actions, either from herself or others, reflects perhaps feelings of shame and allows her to distance herself from her self-injury, a behaviour and consequently, a self that comes out only at night.

'…Not much…I would put sanitary pads. Sometimes it would bleed a lot. But that's not self-care. I was just trying to conceal whatever happened the night before' (Kate, 1, 21, 292-294)

She further describes an act of harm-minimisation in taking over the counter medication to reduce chances of infection post self-injury, focusing on doing what she calls 'the bare minimum' to 'not die'. There is a sense of unworthiness reflected in her choice of words, as if she was only allowed and deserved the least possible amount of care. There is also a sense of her wishing to just survive and exist rather than enjoy her life.

'…I would take those cystitis relief sachets…it was like the bare minimum that I could do not to die (laughs) I think… (Kate, 1, 21, 297-301)

Kate speaks as if the notion of self-care, perhaps in the way she feels is commonly defined, does not apply to her and there is a flavour of denigration towards this concept in her words, as if she feels 'above it' and therefore, rejects this. For her self-care is perceived as something trivial, perhaps even frivolous and she reflects she has only engaged in this as means of stopping others criticizing her. Self-care then becomes for her a protective door, shutting out others' judgment.

> *'…Self-care… I don't think it means much to me and I don't think I do it on a daily basis…you say self-care all I think is of a warm bath you know, and cream and make-up whatever… I think all the self-care that I've done through these years were…so that they would shut up, so it wasn't really self-care, was it' (Kate, 1, 22, 315-318)*

Kate makes a distinction around what she believes constitutes self-care, recognizing however that this is something that she still finds difficult, as if she cannot allow herself to experience this. This is organized around internalising positive relational experiences from safe others. For Kate, these include animals, children and the elderly which she views as benign and innocent. Their benevolence according to her lies in the absence of willingness to harm another. There is a sense of hierarchy in her description perhaps from safest to least safe with regards to their ability to deliberately hurt which possibly reflects an association between ability for conscious intent and cruelty.

> *'Letting myself to feel the love of either animals or children or elderly people. These are the things that count… Even that felt difficult at times…letting the love in from these three uhm sources… I believed that they don't deliberately hurt you… It was knowing that they couldn't hurt me or they wouldn't hurt me… (Kate, 1, 23-24, 331-341)*

Kate acknowledges that her difficulty around engaging with self-care or internalizing positive experiences elicits feelings of revulsion and shame. Her words form an echo of how she views herself and what she believes she is worth. Instead of warmth and care, positive experiences elicit unpleasant emotions contributing a paradoxical layer to her experience of care that further informs her narrative.

> *'…anything positive towards myself…it makes it icky. It has to do with disgust I think…or shame…' (Kate, 1, 30, 488-489)*

3.7 Superordinate Theme 5: The Healing Journey

The following subtheme navigates Kate's journey of personal growth and healing demonstrated not only via her ceasing to self-injure but also in the development of more compassionate ways of relating to herself. Kate acknowledges the factors that shaped and contributed to this aspect of her experience which included understanding and caring others who carried an accepting non-judgmental and unconditional stance towards her ultimately helping her to accept herself.

3.7.1 Subtheme 1: The Importance of Supportive Others

Kate recognizes the importance of having other factors besides therapy that contribute to her healing process. This theme, therefore, explores the significance she places in having supportive others from her personal life as well as their role and ways in which they contributed to her recovery.

Kate highlights the importance of systemic support and not just isolated provisions of encouragement and care. All these sources work collaboratively and provide containment and safety as she crosses various challenges and hardships towards a becoming gentler towards herself.
She highlights how therapy alone did not seem enough to get her to the end of her journey and emphasizes the importance of having an encouraging partner and group of supportive friends in her process. For Kate, the significance of supportive others is also in relation to the magnitude of distress she has experienced at times, characterized by significant low mood and suicidality.

> *'…having a very good support system, a very supportive partner has definitely helped, because I think only with therapy, I don't know how far I could have gone…' (Kate, 2, 25, 431-433)*
>
> *and*
>
> *'…knowing that I have a supportive family, supportive you know, group of friends and a very supportive partner, it did help. Uhm, because then I don't know how I could have dealt with my demons, because I felt really low at times, I felt, suicidal…' (Kate, 2, 25, 436-440)*

For Kate, the mere fact that those around her did not express shock, disbelief or contempt towards her self-injury and herself, held significant meaning in itself. Her experiencing of others 'not flinching', which would perhaps elicit further feelings of shame, alongside their overall response to her revelation, they unknowingly helped reduced the feelings of defectiveness that Kate held for so long contributing to her developing a kinder way of understanding herself, and a more compassionate mode of formulating her experience with self-injury.

> *'…it really helped that.. they didn't flinch.. it was really important to me, that I didn't feel like a freak in the end… to be able to come back around and say that I hurt myself to my friends, I think it was really important. And the way they reacted was really, really helpful.' (Kate, 2, 30, 563-569)*

3.7.2 Subtheme 2: Slow and Steady: Navigating the Therapeutic Process

A significant component of Kate's recovery journey lay in her experience with therapy and the factors within this that allowed this to contribute positively to her healing. The following subtheme explores Kate's, laborious, at times, therapeutic process what this meant for her.

Kate starts by highlighting how helpful she found it that her therapist was aware of genital self-injury as a behavioural manifestation. Her use again, of the expression 'didn't flinch', reveals a sense of perhaps relief of the shame she carried and associated with her self-injury, reflected in her fear of others' perception and reaction. Kate found her therapist's comments around her dissociative processes salient which perhaps allowed her to truly see and acknowledge the different sides within her and the contradicting way in which she treated others and herself.

> *'…it really helped that actually my therapist was knowledgeable on this subject and didn't flinch actually when I mentioned it…it was really striking that she made the comments on…how dissociative I must have been to function at a level where I smile and take care of people…all day every day…being very caring , too much to the point…I don't care a lot, at all about myself. To the point I harm myself at night. I think it really helped in a way to make that differentiation in my head… (Kate, 2, 23, 364-374)*

The psychoeducation that Kate obtained from her therapist, allows her to acknowledge that her self-injury is indeed an established behaviour, that although she might perceive as disturbing or senseless, this can in fact make sense when seen in a context that offers a thorough description, rationale and an explanation. Kate acknowledges with certainty how helpful she found it to 'know this is out there' as if this alleviates some of the loneliness and otherness carried in the belief she was the only one.

> *'…psychoeducation around this from my therapist…has definitely helped…knowing it's out there…ok these are generally the reasons why…this is how it manifests, and this is what you know, function it holds. ' (Kate, 2, 27, 480-487)*

Kate expands her thinking process further sharing how she realized that if her therapist has heard about genital self-injury from someone else then this serves as further proof she was not alone in engaging with this. This helps normalize further her experience, reducing her sense of shame and allowing her to feel more connecting to others around her.

> *'…it was good actually that you know she knew about it, which means she has heard about it from someone else so…I can't be the only one who's doing it. So I didn't feel like I was that much of a freak.' (Kate, 2, 24, 398-401)*

In the following extracts, Kate also illustrates how crucial obtaining coping tools in therapy has been in her recovery. With genital self-injury being a way for her to cope with the pain and hurt she carried within her and the challenging experiences that life brought, this became an established way for her to address these. In the absence of this she now faces the need for more adaptive ways to regulate her emotions and relate to herself and the language used in the quote below reflect how difficult this process must have been for her.

> *'…and also to have the tools to cope with because it's not easy when you stop self-harming in that way. Because it's…such a you know coping mechanism for you for such a long time, that you need to stop and then replace it with other things…(Kate, 2, 23, 376-380)*

With an armoury of adaptive coping strategies, and an awareness around what emotionally activates her, by her side, Kate focuses on expanding in therapy, the zone in which feels she

can function most effectively. This she recognises is an arduous process one perhaps requiring patience and perseverance on her part.

> *'…I think working on these, trying to…widen my window of tolerance…realising what my triggers were…going up with strategies techniques to just deal with these in a better and healthier way. It was a slow process- but it was a steady one!' (Kate, 2, 28, 501-506)*

Kate further acknowledges the importance of the therapeutic space in allowing her to talk about her experiences realizing how detrimental it was to feel unable to communicate her inner world and how pivotal this was in the development of her self-injury.
There is a sense of her placing additional importance in therapy providing a space for herself alone, one where she can slowly learn to speak of what might have felt unspeakable before , without the accompanied worry of failure or evaluation.

> *'…I think, to be able to talk. Because I think most of this self-harm came from not being able to express myself. …To have a space, just for myself to share and to try, and to talk…I think that only even was helpful. ' (Kate, 2, 24, 386-390)*

Ultimately, Kate recognizes the therapeutic relationship and the closeness she was able to experience in the context of this as a decisive factor helping her to lower her walls and defences, connecting with another person and sharing what she has kept to herself for some time. She describes what she experiences as her therapist's deep sense of authentic care towards her, as an aspect that helped facilitate the process of exploring and making sense of her self-injury in therapy.

> *'…I knew that she cared a lot about me, I knew in a level that you know she was genuinely caring… (Kate, 2, 28, 515-516)*

and

> *'…I think finding that you know level of closeness it really helped for me to open up and share these things in the first place.' (Kate, 2, 522-523)*

3.7.3 Subtheme 3: In a Much Better Place

This final subtheme, illuminates Kate's growth and explores her new-found perception of herself.

In the extract below, she describes her succeeding in reaching her peers, and developing alongside them at last. Her use of the word 'finally' highlights the efforts and time spent trying to reach this step. Feeling the positive changes in her self-esteem and acknowledging her progress, she no longer feels like an outcast, one that is on the outside looking in. She now feels she belongs, and this allows her to see, experience and perceive herself as someone who is emotionally healthy.

> *'I think I'm finally catching up with my peers let's say. I think I'm feeling a lot more confident, and you know mature in a way, uhmm, feel like I'm yeah I finally belong where I am now, and I'm, I'm healthy emotionally, a lot more healthy I think. Of course, I still have my days as we all have but I'm in a much better place.' (Kate, 2, 26, 461-465)*

Kate further highlights the importance that working with children holds in her developing a gentler way of relating to herself. Seeing their fragility and vulnerability especially with regards to the ease with which they see the fault on themselves, she can finally recognize the same aspects in herself. In the past, it would have been difficult for her to realize these, due to her perspective at the time.

> *'…it definitely helped working with children…it's having a first-hand experience in how their mind works…and how easily they can turn on themselves really.' (Kate, 2, 31, 603-606)*

Kate's words evoke a sense of regret as she comes to terms with the realization of the harsh and punitive way she has related to herself and the erroneous sense of self-blame she carried for her experience of abuse. This unfortunately contributing to her felt sense of defectiveness becoming a mediating factor to her self-injury. Her language also reveals a sense of absolution and self-forgiveness as if she offers herself pardon for a crime she now recognizes she didn't commit.

> *'…all I can say is, I was not to blame…how easily I punished myself for whatever was going on. Because I think I saw myself as defective, as a result of the abuse…' (Kate, 2, 31, 623-626)*

This final extract, inspired through her own professional experience, illustrates Kate's new found voice in the form of a piece of advice she shares with her students. This time it seems she also applies this to herself – and advice that exudes kindness, gentleness and compassion.

> *'…as I said to our kids…"be kind to yourself" and be kind to everyone of course it's just…be kind to yourself…because I think we all deserve it" (Kate, 2, 32, 669-671)*

Isabelle

3.8 Superordinate Theme 1: It's in the Name

The first superordinate theme looks into Isabelle's conceptualization of her experience as self-injury in the context of her perception of what she believed constituted self-harm.

3.8.1 Subtheme 1: Calling it What it Is

Isabelle shares her newfound realization that her experience reflects a type of self-harm. She uses the word 'taboo' to describe her behaviour as if it is something that is unmentionable and distasteful and one that others as well as herself, might find crude, offensive or shocking. In light of this, she perhaps distances herself from exploring what her behaviour represents. Her use of language around 'not thinking anything of it' reveal her stance towards it and her perception of her experience as insignificant and not unusual therefore unworthy of reference or discussion. This might mean that the only topics worth exploring or expressing are those that enter her conscious awareness and consequent thought process. There is an additional layer of contradiction in her statement and in the acknowledgment of her behaviour potentially as taboo, yet one that she didn't give special consideration or meaning to.
For Isabelle, this was 'something that happened' and her words evoke a sense of nonparticipation as if she is a passive receiver of someone else's actions. What initially seems as a laissez-faire attitude towards this, might reflect Isabelle's sense of disconnection from her actions and what these might arouse in her.

'…I've only recently realized that this could be a type of self-harm… it is considered taboo but even if it wasn't…I didn't think anything of it in the past so it wasn't worth mentioning, it was something that happened.' (Isabelle, 1, 14-20)

As seen in the extract below, Isabelle made sense of her experience in stages, initially considering this a bodily experience and her word 'thing' reveals perhaps an attempt to trivialize this, underestimating its significance. This reflects another aspect of her understanding, illustrated in a parallel process from the superficial, somatic level to the deeper layers of her psyche.

'…First I thought it was just a physical thing, like itchiness that leads you to scratch yourself so nothing psychological involved there but I've done some reading, I've been to therapy, and I think that I've come to realise that it is not as simple as that' (Isabelle, 3, 56-60)

Educating herself on the area of self-harm either through her own reading and through the psychotherapeutic process and the psychoeducation this often offers, allowed Isabelle to acknowledge and appreciate the complex, multifaceted and often nuanced nature of self-injury thus informing her understanding of her own experience further and ultimately, making sense of it as self-harm.

3.8.2 Subtheme 2: Self-harm is Something that's Bad for You

Isabelle offers a binary conceptualization and definition of self-harm, one that is seen and rooted in its capacity to cause hurt or damage. She acknowledges that this however can present itself in a variety of ways, some more obvious than others.

'I think self-harm can come in various forms… (Isabelle, 2, 41)

And

'…it can be anything that can be bad for you either short-term or long term…using drugs, cutting yourself, maybe drinking heavily…even knowingly making bad decisions, even that' (Isabelle, 3, 41-46)

Her choice of word 'bad' brings to mind something unpleasant, undesirable, and unfortunate. Isabelle offers a number of examples of what one might anticipate as pradigms of self-harm ranging from the more abstract maladaptive behaviours to the more physical manifestations such as cutting oneself. In the context of this, a question is perhaps raised as to why she would not consider her behaviour as such and elicits further speculation as to the factors that she considers relevant to something being theorized as self-harm in her mind.

3.9 Superordinate Theme 2: Destructive Pleasure

'Destructive Pleasure' explores the antithetic facets that characterize the experience of Isabelle's self-injury- one that is rooted in a need for relief and that feels at times intensely pleasurable yet also is destructive and harmful.

3.9.1 Subtheme 1: Relieving the Unbearable

The extracts below, highlight Isabelle's search for some form of release through her self-injury. She likens this to scratching a mosquito bite, pointing perhaps at the urge one instinctively feels to alleviate an itch and the almost involuntary, automatic nature of the scratch that follows this. The physicality that her description exudes, illuminates how difficult, if not impossible it would have felt for her to act against this. This is further impacted by her wish to feel something she deems compelling and intense.

> *'…maybe it's a way to get some kind of release?... I just know it gives you some kind of release.' (Isabelle, 3, 64-66)*
>
> *and*
>
> *'It's both physical uhm like when a mosquito bites you and you scratch it, it gives you some tiny pleasure… but the uhmm (prolonged) psychologically I dunno maybe you feel something that is powerful, intense. (pause).' (Isabelle, 4, 69-74)*

She further describes the feeling she obtains from the act of self-injury as an orgasm and climax implying reaching through this, an intense sensation that feels relieving if not also pleasurable.

Isabelle also speaks about reaching a peak, defined as the point when she cannot withstand the harm of her self-injury any longer similar to the accentuated sensitivity experienced post-orgasm.

'…even if there is nothing sexual in the act, even if it is just an itch, there is something, this release is very similar to an orgasm.' (Isabelle, 9, 178, 180)

and

'…when you get to that point, when you can't take anymore of the harming…it peaks.' (Isabelle, 9, 183-184)

and

'It's where it peaks, so it feels similar to a climax' (Isabelle, 9, 186)

For Isabelle, there seems to be a clearly-defined end point to her self-injury and recognizes that beyond this point, she finds this no longer gratifying. This elucidates the pleasurable aspect she seems to find in an activity that does eventually cause her pain and the distinction she makes from a pain that feels enjoyable to one that is stripped of that quality and feels purely unpleasant.

'Yeah, that's the maximum. You know if you get past that, you feel that it won't be pleasurable anymore. It will feel just, just, pain I guess. But in a bad way.' (Isabelle, 9, 189-191)

Isabelle poses a question that seems almost rhetorical in nature. This reflects her perception of self-injury being a logical step towards relieving what feels agonizing to her, one that she perhaps hopes would make sense for everyone. In this, self-injury becomes a paradox; it almost can be seen as a form of care and compassionate treatment of herself and to not engage with this, would almost constitute cruelty.

'…It's unbearable that itch…so why not do it if you can? And you know it's gonna relieve, you know give you relief?' (Isabelle, 7, 135-137)

Isabelle speaks about a feeling of needing to burst open and makes reference to the point of bleeding. There is a sense that blood coming out of her holds a particular significance as if

the hurt or harm is not sufficiently relieving. Blood, could also simultaneously signify the ending of the self-injurious process. Her expressed need for something to burst open brings to mind something forceful, that breaks apart suddenly and violently. Her words paint a graphic image of a rupture as a result of unwavering internal pressure perhaps reflecting her need as well for a symbolic emotional release.

> *'…it is right…at the point where there is some blood coming out of you.' (Isabelle, 11, 248-250)*
>
> *And*
>
> *'It is like something that needed to burst open…' (Isabelle, 12, 252)*

In the extracts below, Isabelle speaks about a sense of accomplishment she acquires through her self-injury. She describes a clearly defined point when she feels she has reached her goal, almost recognizing her own efforts and skill in what she perhaps almost perceives as a 'job well done'. Isabelle addresses herself, reassuringly and encouragingly as if wishing to acknowledge her endurance and determination.

> *' …it feels like ''It's okay. You did it''…I feel like my job is done when there is blood coming out.' (Isabelle, 12 300-301)*
>
> *and*
>
> *'…apart from the pleasure it gives you some sense of achievement. It is not the same if you don't bleed.' (Isabelle, 13, 309-311)*

There is a palpable sense of almost joyful excitement as Isabelle recounts out loud the times when she has been able to bleed through her self-injury further describing this sense of relief as a 'good feeling'. In speaking about the comparison between self-injury leading to her bleeding in contrast to the times when this does not occur, she uses language that makes it seem as if the outcome of this is out of her control and not a result of the severity of an injury she herself, causes.

'…when it does happen, cause it doesn't always happen…it's aaah it is a good feeling.' (Isabelle, 13, 315-316)

3.9.2 Subtheme 2: Finding Pleasure in an Unpleasant Thing

This theme explores Isabelle's contradicting and at times ambivalent stance towards her injury.

Isabelle recognizes that although her self-injury can give her a sense of pleasure, this is ultimately not something she views as pleasant.

'…it just isn't a pleasant thing, it can give you pleasure but it is not a pleasant thing…' (Isabelle, 2, 24-25)

There is a sense of a time divided as she holds different thoughts and feelings during the process of her self-injury and after she has stopped. This creates an image of a disconnected self. On the one hand, one that might feel engulfed in pleasurable sensations, not cognizant of the nature of her actions, oblivious to their impact and another that experiences a sharp awareness that feels deeply disturbing and unpleasant. A division between the light of an almost blissful ignorance and the darkness that follows the heavy realization of what has occurred.

'…when you do it, it gives you pleasure…but afterwards you feel bad. It is bad things…' (Isabelle, 6, 110-111)

In the quote below, Isabelle offers a powerful symbolism that further confirms the uncertainty and oscillation that characterizes her feelings towards her experience. Here she describes this similar to orgasming through an unpleasant and shame-inducing sexual activity. This seems to reflect her own sense of criticism, judgment and perhaps contempt towards what gives her pleasure.

'…the best way that…I can think of it is uhm, an orgasm after some really (pauses) nasty, shameful sex…' (Isabelle, 38, 907-908)

Isabelle further explains the reasons behind her preferring and enjoying intense feelings and sensations, despite their sometimes negative nature or the unpleasantness they evoke, as their strength makes these impossible to dismiss and not take into consideration.

> *'…intense feelings are always feelings, right? Even if they are bad. And intensity is something I like. Because you can't ignore it.' (Isabelle, 6, 118-120)*

There is a sense of denigrating contempt as Isabelle acknowledges that for her, sensations that she perceives as mild, are of no value to her. There is almost a contrasting sense of admiration and appreciation for the Intense, as if due to its mere nature, it commands attention and elicits a wish to engage with it.

> *'…if it something mild, it doesn't matter. If it is intense it is there. You have to face it. You have to feel it.' (Isabelle, 6, 124-125)*

As she describes the progression of her self-injury through time, to one that became increasingly more damaging and forceful she describes experiencing a sense of freedom as crossing some sort of imaginary line that allows her to feel liberated. This seems to coincide with her becoming more cognisant of her actions which in turn led her to engage with this even more vigorously. Her choice of word 'passion' to describe her process reflects a strong and almost uncontrollable emotion, equating to a sense of overpowering and almost overwhelming excitement.

> *'…it has become more aggressive, more violent…because the more aware you are of what's happening, the more free you feel. Like when I started realizing that it's something, I did it with more passion. (Isabelle, 36, 856-859)*

Although Isabelle acknowledges the pleasure she gains from her self-injury, she remains unaware on the reasons behind this. In the absence of a rationale or concrete explanation in her mind, she concludes that this might be as she simply takes pleasure on what she perceives as abnormal or perverse.

> *' I think it gives me more pleasure. I don't know why. Maybe…I get off on dysfunctional things…' (Isabelle, 36, 862-863)*

3.10 Superordinate Theme 3: The Function in the Harm

This theme illustrates Isabelle's attempt at making sense of her self-injury, beyond a superficial narrative and to explore the underlying function this might hold for her.

3.10.1 Subtheme 1: It's How You Cope

For Isabelle, self-injury becomes a way for her to manage with whatever life brings for her and especially her feelings of numbness and subdued experience alongside the judgments she holds around this. There is a sense of disapproval in the way she relates to herself as if the mere fact she does not 'feel as much' as she feels she should, means she is somehow defective.

> *'…the best way I can describe it would be that if these two were connected, which they probably are, I would say..it is how you cope. Maybe it is how you can cope with that. The fact that maybe you're not feeling as much as you should be feeling.' (Isabelle, 5, 92-96)*

Self-harm therefore becomes for her a coping strategy for a variety of challenges she perhaps does not even know or cannot articulate. Although she expresses her wish to stop her behaviour, perhaps realizing the maladaptive nature of it and the destructive impact it has, she simultaneously admits she might not feel ready to be without this at present. For Isabelle, it seems that self-injury meets some of her needs in a way that no other coping mechanism has been able to achieve.

> *'…I think it is a coping mechanism for whatever… A lot of things I suppose… I definitely want to stop it at some point, I just don't know if I am ready cause for now I might feel bad about it…it gives me something that nothing else does.' (Isabelle, 36, 876-881)*

3.10.2 Subtheme 2: Dealing with a Disconnected Self

This subtheme follows Isabelle's making sense of her self-injury in the context of a self that appears to be disconnected and fragmented and perhaps reflects her efforts towards integration.

For Isabelle, self-injury becomes an attempt to engage with her sense of humanity and to escape the way she currently perceives herself. Her use of the word robot reflects her seeing herself as emotionless and depersonalized, alien and excluded from those around her.

> *'…maybe it doesn't make me feel like I am a robot?' (Isabelle, 5, 99)*

She makes further associations between the significance of blood as proof that one can feel, can be hurt serving as ultimate evidence that they are human. This further elucidates the importance Isabelle places in being able to feel, which consequently manifests in her self-injury.

> *'…if you can bleed and you can feel pain, you can feel in general.' (Isabelle, 5, 102-103)*

Isabelle speaks about her belief around the link between her long-standing experience of dissociation and her self-harm. Her words exude a felt sense of failure and allude to her conviction that her self-injury serves almost as a last resort to address the disconnection she experiences from herself and her inability to address this in a different, perhaps more adaptive manner. The use of the clinical term 'dissociation', refers to her experience of a mental process characterised by a sense of detachment from her thoughts, feelings, sensations and aspects of her identity.

> *'…I think that if I was able to, to deal with being in a dissociative state half my life, this wouldn't happen.' (Isabelle, 25, 604-605)*

Her strongly expressing that she does not wish to harm herself when she is not in a dissociative state showcases her strong feelings around this. Her use of language in 'when I am being myself' implies she recognizes her dissociative self as a separate part, one that does not belong to or with her. Self-harm for Isabelle therefore, becomes a way to ground herself, and to step out of a headspace that feels foreign, unfamiliar or perhaps frightening.

> *'….because when I am being myself, I don't want to harm myself. When I am not in a dissociative state, I don't really want to hurt myself.' (Isabelle, 26, 609-611)*

Isabelle further describes the dissociative state that leads her to self-injure as one that takes her 'back' to a feeling that she recognizes and has felt in the past. Her tone reflects a sense

of hesitation as if she discusses something that feels difficult for her. The associated memories that this mental state might bring and whatever meaning they hold for her are held in a dissociative fog she wishes to escape from.

> *'Maybe (elongated) maybe it is something I go back to somehow. Maybe it is a familiar feeling…' (Isabelle, 26, 615-616)*

Isabelle elaborates on the factors that influence her entering this state of disconnection. Although according to her, dissociation shows itself when things feel overwhelming for her, and holds a seemingly protective function, she makes a point of noting how this was 'worse' in the past and her use of words might reflect any judgment she holds around this as if she ought to be able to control his. Her past experience of fainting describes a loss of consciousness and awareness which she formulates as losing herself at times. Self-injury then becomes a way for her to reconnect to herself, to become cognisant and to regain a sense of control, agency and ownership of her experience.

> *'…when it is something I can't deal with, when something is too much. A feeling.. whatever it is. Maybe it is happiness, maybe it is sadness.. maybe it is shame. And it used to be worse because… I used to faint… yeah but I do lose myself sometimes…' (Isabelle, 26, 624-630)*

Despite her being cognisant of self-injury holding a function for her as a wish to exit dissociative states, the act remains dissociative in nature, one where Isabelle 'goes through the motions', in an automatic manner, disconnected from her behaviour, her thoughts and feelings around her and eventually from herself.

> *'…it's that feeling that you are going through the motions and you almost have no memory of it…' (Isabelle, 27, 635-636)*

3.11 Superordinate Theme 4: Feeling Defective

This theme explores Isabelle's feelings towards herself in the context of her self-harm, specifically perceiving herself as one who is deeply flawed and defective.

3.11.1 Subtheme 1: There's Something Wrong with Me

Isabelle seems to be clear that the fact that one, including herself, engages in self-injury serves as evidence of abnormality and wrongdoing. There is a palpable sense of frustration in her tone as if this is an obvious assumption and judgment that anyone would make and questioning this is perceived as patronising condescending.

> *'…it is negative because it means there is something wrong with me!' (Isabelle, 14, 350-351)*

And

> *'… isn't there something wrong with everyone that harms themselves?' (Isabelle, 15, 354-355)*

Isabelle further expands on her thinking, sharing her view that people that are 'healthier' do not engage in self-injury and self-injury in itself is something that can be fixed. For her, there seems to be a clear distinction on the nature of people that self-harm and those who don't insinuating the former to be somehow broken, problematic and in need of fixing.

> *'…it is something that could be fixed. Maybe it is something that other people that are healthier don't experience.' (Isabelle, 15, 360-362)*

She turns her perception around self-injury and those that engage in this, towards herself, seeing herself as someone whose life did not go according to plan and one whose history and possibly difficult experiences had a direct implication in the development of her self-harm.

> *'… I am doing this because something has gone wrong. Somewhere along the way…maybe growing up, maybe growing older…you feel like something has gone wrong.' (Isabelle, 15, 365-368)*

Isabelle clearly experiences herself as broken due to her self-injury and her tone exudes a sense of isolating otherness as she compares herself to those that don't harm themselves which she perceives as healthy and whole.

> *'…I feel broken compared to others maybe that don't do it.' (Isabelle, 15, 375-376)*

3.11.2 Subtheme 2: The Skin I live In

Isabelle's self-injury does not happen in vacuum but is also in the context of a skin condition she has inherited from her mother with whom she shares a difficult relationship.

Her skin condition, which she perceives as disgusting, elicits feelings of repulsion in her. Isabelle further, expands on the harsh associations she has formed in her mind, in which what she perceives as a revolting exterior reflects a similar inner world. A distinction between the outside and inside ceases to exist, and any perceptions around herself integrate, forming a whole marred by repugnance and self-loathing.

> *'…just goes back to self-disgust. Like if you are disgusting on the outside, you are even more disgusting on the inside…' (Isabelle, 19, 448-450)*

Isabelle offers detailed descriptions of her skin condition as if they serve as form of evidence and confirmation of her own self-image and which is a direct consequence of the view she firmly believes others hold about her condition. Her tone and choice of words reflect a sense of undeniable certainly and communicates her view in a matter-of-fact manner that allows no room for disagreement.

> *'…this also has to do with the skin condition that I have… which I think other people might find disgusting and maybe then so do I. Because everyone would…it's scars and spots and cysts and it's by definition disgusting' (Isabelle, 20, 471-476)*

For Isabelle there seems to be a logical consequence between how she feels about her body and the fact she feels she has to harm it as a result. This reflects a form of a binary thinking process where only absolutes exist and all nuance is lost.

> *'…because maybe it is a part of my body I don't like and so I treat it badly.' (Isabelle, 21, 496-497)*

Her feelings of self-loathing in the context of her skin disorder seem to be exacerbated by the permanent and progressive nature of her condition and her use of language in the phrase 'what was happening to me' reflect possible underlying feelings around helplessness, powerlessness and loss of control.

'…I hated what was happening to me…it will be there all my life and it will probably get worse as it goes. (Isabelle, 35, 847-850)

For Isabelle it seems that having such a condition carries with it a sense of futility as her there is no point in looking after this in the context of this and maintaining good health. To the contrary, Isabelle sees this as damaged enough already so engaging in self-injury and offering herself some sense of pleasure via doing so, even if there is the possibility of this worsening her condition, feels like a compromise she is happy to make. Her choice of words in the phrase 'scratch the fuck out of it' brings to mind a notion of violence and aggression and attack. Referring to the area of her body as 'it' further reflects her sense of disconnection from parts of herself, as if they don't belong to her and therefore cannot bear the consequences of her actions.

'…thinking even if you do self-harm, how much worse could it get? It's already bad, you might as well enjoy it. If it itches, scratch the fuck out of it.' (Isabelle, 22, 501-503)

For Isabelle, the fact that this condition was inherited from her mother seems to carry particular significance and aggravates her. In the context of their difficult relationship and all the feelings that this likely elicits, sharing the same medical condition might be seen as a side of her living inside Isabelle, one that is visible to the eye and carries a link that she cannot dismiss or ignore.

'…this is a condition that I've inherited from my mother. Maybe it has to do with that. We don't really get along and it's something that she's given me…' (Isabelle, 23, 542-545)

Isabelle therefore becomes a passive recipient of a burden she feels forced to carry, one that reminds her of a person she possibly carries many complicated feelings towards.

'…this was given to me, I didn't have a choice, no one asked me if I wanted it…and it is something that she gave me…' (Isabelle, 24, 564-566)

3.11.3 Subtheme 3: It's What You Deserve

The following subtheme explores the punitive way in which Isabelle relates to herself in the context of her skin condition which further informs her self-injury.
For Isabelle, self-injury becomes something she believes she deserves as if her condition is somehow a fault of her own. Her negative feelings that having this condition brings up for her, justify in her mind a punishment through the symbolic attack that her self-injury carries.

> *'It has to do with what you think you deserve…' (Isabelle, 22, 519)*

and

> *'… it is making me feel like shit so I take it out on (pause) it…' (Isabelle, 23, 528-529)*

These perceptions are further expanded to include her sense of harming herself because she feels she derives pleasure from it which in her mind she equates as being 'fucked up'. Her use of profanity carries significance for her and reflects her perceiving herself as disordered and deeply damaged.

> *'It feels like I am doing it to someone who is fucked up enough to enjoy it.' (Isabelle, 25, 590-591)*

In this final quote below, Isabelle offers another layer of interpretation around her experience of self-injury as she explains she perceives her condition as a form of punishment in itself for what she sees as a lack of self-care on her part further contributing to her view that she deserves to harm herself as a result.

> *'…I used to think my condition was just a punishment. For not taking care of myself. Proper care of myself' (Isabelle, 32, 771-773)*

3.11.4 Subtheme 4: What Have I Done?

"What have I done" explores the aftermath of Isabelle's self-injury and focuses on her feelings and how she perceives herself as she becomes more cognizant of her behaviour.

Isabelle describes an image of her physically getting up and opening her eyes as if she were waking up from deep sleep, reflecting coming out of a process that does not seem

consciously driven. Isabelle seems to be quickly flooded by the realization of her self-injury and all the meaning this carries for her, describing this as 'not pretty'. Her choice of words possibly reflects her wish to minimize the impact of the negative qualities she attributes to this.

> *'…it's like you get up, you open your eyes, you realize what you are doing and it is not pretty.' (Isabelle, 6, 114-115)*

In the quote below, Isabelle gets in touch with how she feels about herself after she has self-harmed, and describes a sense of being horrified and almost repulsed with herself. This further alludes to a fragmentation of the self that Isabelle experiences. This includes a part of her that allows the self-harm to occur, as well as finding pleasure and satisfaction in this, and another part that feels deeply ashamed and appalled. Her tone exudes a sense of almost sheer panic and profound regret, as she attempts to grapple with her actions.

> *'I feel horrible…it feels REALLY bad. Like shame and all that…you realise what you are doing and you are kind of appalled with yourself...' (Isabelle, 8, 154-157)*

Although it might take a few seconds for her to come back to herself and reality, she ultimately cannot escape this and questions herself around this as if she is trying to put pieces of a puzzle together and make sense of something she finds incomprehensible and senseless.

> *'…but after a while, like 5 or 10 seconds, you realise what has just happened and you say to yourself ''Oh not this again. Why are you doing this?''…' (Isabelle, 13, 326-328)*

The process of coming to terms with her self-injury proves to be too challenging and overwhelming to bear and Isabelle attempts to push this out of her mind and to distract herself in order to not think further about it, as if she wishes to deny its occurrence.

> *'…after I'm done, I just want to not think about it. I do anything to distract myself from thinking what has just happened.' (Isabelle, 34, 827-829)*

What Isabelle is now left with; she describes as a feeling of emptiness. This is in great contrast to the feelings of pleasure and almost arousal she experienced moments before which in turn speaks of a sense of loneliness and alienation as illustrated in her phrase 'left

with yourself'. The realization that this is indeed what she has done becomes quickly a way of identifying herself, her actions becoming her.

> *'…the turn on is gone and you're just left with the feeling of emptiness…you're just left with yourself and what you've done… it's you by yourself and you think ''Well, this is me. I do these things, This is me.' (Isabelle, 39, 942-950)*

3.12 Superordinate Theme 5: The Challenge of Self-Care

This final superordinate theme illustrates the challenging relationship Isabelle holds around the notion of self-care and the difficulties that engaging in this carries, for her.

3.12.1 Subtheme 1: Self-Care isn't my Strong Point

Isabelle almost finds my question around her engaging in any form of self-care in general as well as in the context of her self-injury almost preposterous as illustrated by her laughter and her choice of phrase 'absolutely not'.

> *'I (laughs), absolutely do not.' (Isabelle 31, 737)*

There is a sense of minimization of the significance that self-care carries in her use of language as she explains this is not her 'strong point'. She goes on to explain how she believes this is linked to her experiencing neglect from a very young age.
It seems that for Isabelle there is a link between receiving and experiencing care from another, especially when young, and being able to offer and engage with self-care as an adult. Her words and tone reflect a perceived sense of failure as if self-care requires aptitude and a sense of competence that she somehow lacks.

> *'…self-care is something that wasn't my strong point until I was quite old…it has to do with the fact that I was uhm neglected as a young child or baby and so self-care wasn't my strong point and still isn't…' (Isabelle, 31, 740-744)*

For Isabelle, self-care ultimately reflects a sense of love towards oneself which consequently becomes a compassionate and caring way of treating yourself. For her, it therefore seems like a logical and rational step, to treat her body badly as she does not appreciate this.

'…self-care is first of all about loving yourself and treating…yourself well… When I don't like something on my body, I treat it badly. So when you love yourself you treat your body well. When you don't you do the opposite.' (Isabelle, 33, 789-793)

3.12.2 Subtheme 2: It Starts when You're Young

Self-care for Isabelle, is a necessary behaviour learned when one is young and there is a sense of time lost as she describes how this notion relates to her own experience.

Isabelle carries feelings of shame around not having learned this as if this reflects to a skipped developmental milestone the impact of which, she now has to face and catch up on.

'…I guess it is something that you really have to do and learn how to do that when you are really young and maybe I have a bit of shame in me because I didn't…' (Isabelle, 31, 750-752)

Her perception around 'not even doing the basics' reflects to a profound sense of failure the weight of which adds to her feelings of defectiveness. It further highlights the expectations she perhaps carries and associates with a healthy way of relating to oneself which further contribute to her negative self-image.

'Because some things, some things are just basic hygiene. You keep hearing that expression And when you don't do it, you think, I am not even doing the basics.' (Isabelle, 32, 759-761)

Although Isabelle acknowledges she has now started to engage in forms of self-care, there is still a palpable sense of regret perhaps marked by disappointment or guilt for not being able to do this sooner. This serves as an underlying acknowledgment of the importance she places in self-care.

'…I've been doing much better lately but I think that I've spend most of my life not taking care of myself at the slightest…Now I've started.. but I spent most of my life not doing it' (Isabelle, 33, 799-803)

3.13 Master Themes

The following themes are an attempt to integrate the findings of both Kate's and Isabelle's case via identifying and expanding on any commonalities, overarching patterns and shared themes in their experience of genital self-injury, in the hope that it enhances the understanding we hold of this particular form of self-harm.

The use of quotes was purposefully omitted from this section, in an effort to avoid repetition and redundancy.

3.13.1 Making Sense of Self-Harm

This master theme explores the participants' difficulty in making sense of their experience and their journey towards conceptualizing this as self-injury.

For Kate, her experience was characterized by a sense of confusion due to it being at times in the context of masturbation. The alternating feelings of pleasure and pain as well as the space where these two meet, made it difficult for her initially to identify this as self-harm. This was further challenging due to Kate's misconceptions and attitudes towards what constitutes self-injury. This included her earlier stance of self-harm being predominantly seen as an attention seeking behaviour that followed commonly held stereotypes and informed her narrative.

With genital self-injury being a hidden behaviour for her, she struggled to see how this would be similar to other more well-known and visible types of self-injury such as cutting or burning in areas that others may see and therefore comment on. This allowed for her self-injury to remain undetected and unaddressed for much longer compared to some of her peers that engaged in this. Her confusion is also met with layers of frustration as she met professionals who were unaware of the concept of genital self-injury which caused further self-doubt around her experience.
The lack of awareness around this meant that she struggled to develop a language to describe and label what she was engaging in and to consequently being able to conceptualize it in her mind and finally address it. Her work with her therapist offered her an opportunity to formulate her behaviour and to obtain psychoeducation that proved to be paramount in her recovery process.

Similarly, Isabelle struggled herself to make sense of her behaviour in the context of self-harm. The factors around this are two-fold; firstly due to her self-harm being at times in the context of masturbation and in the background of a skin condition that caused intense irritation and elicited a strong urge to scratch the affected area, compelled by the wish to relieve this sensation. Secondly, the pleasurable sensations this at times elicited, made it difficult for her to see her behaviour as harmful or conscious especially since this was in the context of something that at times felt pleasant. Isabelle's at times binary way of formulating behaviours, feelings and sensations meant that it was difficult for her to see the 'bad' in the 'good' and vice versa. Similarly to Kate, this also meant for her a delay in making sense of her self-injury and seeing this in a greater context of a range of thoughts, feelings and experiences that impacted its development. Like Kate, the education she obtained through therapy as well as other sources helped her recognize and label her behaviour.

3.13.2 Perceived Defectiveness

Both women spoke about profound feelings of self-loathing and defectiveness both in terms of how they viewed themselves as a whole, as well as their self-injury and themselves as a result of engaging in this.

These feelings had a significant impact in the way the way they related to themselves which ranged from dismissing, neglectful to incredibly harsh and punitive.

Their self-perceptions around this sense of being flawed and defective permeates every aspect of their experiences and is linked to various aspects including medical conditions they had no control over. For Kate this refers to experiencing precocious puberty, which resulted in her body developing in a much more rapid way compared to her peers and which was not in line with her emotional development and felt in contrast to the further delay she believed she presented with, with regards to social expectations and constructs.

For Isabelle, her feelings were primarily in the context of a pre-existing, progressive and severe skin condition that left her feeling repulsed in herself contributing to a sense of overwhelming and unbearable at times shame.

Both Kate and Isabelle, although attempting to manage and regulate a range of emotions and experiences through their self-injury, unfortunately find themselves in a cycle of further shame fuelled by their engagement in self-harm.

Another shared theme observed, relates to their mutual experience of trauma. For Kate, this related to having experienced severe bullying and being a survivor of child sexual abuse and for Isabelle, this related to her experiencing severe neglect as a child and alluding to other

negative experiences that she said she was not comfortable exploring further during our interview.
Although both women were at times unclear on the exact impact that these adverse childhood experiences carried, they both acknowledged their significance and how this might present itself in their overall experience of self-injury and the difficulties they faced.

3.13.3 The Struggle of Practicing Self- Care

Another overarching theme was around their perception and struggle to engage in self-care. This was both in the context of their self-injury ie. engaging in harm-minimisation following this as well as their overall sense of looking after their physical and mental health and treating themselves in a caring and compassionate manner.
Both women treated the questions around self-care with seeming contempt and alongside their narrative this revealed further feelings of shame around their difficulties in this area. With regards to self-care, both Kate and Isabelle spoke about doing 'the bare minimum' around this which revealed further feelings of failure around something they perhaps consider fundamental and straightforward for others around them to engage in.

For Kate this looked like concealing the outcome of her self-injury with sanitary pads or engaging in harm-minimisation by using over the counter medication to mitigate against infection and further medical complications. For Isabelle, self-care related more to engaging in hygiene, a notion she found particularly challenging in the context of having experienced neglect as a child and feeling she did not have the opportunity to experience and learn how to engage in this, growing up.

There was also a separate layer of self-care that both women alluded to, as an attitude towards oneself that goes beyond any physical manifestations of this.
Through both participants' accounts, the distinct function that harm-minimisation and self-care hold in their journey, becomes evident. For Kate her struggle to engage in self-care is perhaps reflected in the pragmatic fashion in which she focuses on specific harm-minimisation rather than a broader and more proactive attitude towards her overall health. In Isabelle's narrative, the acknowledgement of the holistic and integrative nature of self-care is clearer and her shift towards engaging in this, may reflect her holding a more comprehensive stance towards this.
Taking into consideration these nuanced conceptualisations, helps elucidate the complexity that characterises both participants' engagement with themselves and overall wellbeing.

3.13.4 Targeted Harm

The final master theme titled ‘Targeted Harm’, refers to the specificity of the location of their injury- their genitals. Although Kate briefly also spoke about self-injuring in her breasts in the past, both women described their self-harm as strongly focused towards this specific area of their body and spoke at length about how the feelings they associate around this ultimately inform their choice in the type of self-injury they engage in.
For Kate this seems to be directly linked to the difficult experiences she has encountered and the feelings they elicited in her. For Isabelle this seemed to be associated with her feelings towards her skin condition and how this shows in her genitalia.

Both women seem to derive a sense of control, ownership and power through their self-injury in this particular area. This is in contrast to the experiences they have faced which left them feeling powerless, overwhelmed, lacking agency and control. In this way, their targeted harm carries an almost restorative and healing quality for them enabling them a sense of mastery over their individual circumstances. Their self-injury is direct and highly focused and in this, seems to serve as specific purpose.

In the context of their narratives, it is logical to conclude that self-injuring in a different area of their body, would not serve the same purpose and might have not been perceived as effective in whatever outcome they were hoping for.

Discussion

4.1 Chapter Overview

The final chapter of this research project aims to provide a summary and discussion of the findings of this study, in the context of existing literature and theoretical background whilst further exploring any associations and differences from findings in the research available. It is important to note however that since this study is the first to explore the experience of genital self-injury in adult women, using interviews and analysing these using Interpretative Phenomenological Analysis, it can be expected that all findings to an extent, are unique in nature.

Moving on, the strengths and limitations of this study will be explored and suggestions for future research will be outlined. Furthermore, clinical implications of this study, and especially with regards to its significance to the counselling psychology field, will be discussed.

Finally, overall reflections on my subjective experience during this research process as well as concluding remarks will also be explored.

4.2 Exploration of findings in light of existing literature

4.2.1 Making Sense of Self-Harm

One of the key findings evident from the analysis of the data was in how the participants made sense of their behaviour as well their journey into understanding this in the context of their self-injury. Conceptualizing this is a self-harming behaviour proved to be a complex endeavour due to a variety of factors, most importantly due to the phenomenon of genital self-injury having unclear boundaries as well as participants holding a pre-existing view and attitudes around self-harming behaviours and those that engage in these.

Making sense of one's experience and further, addressing this, is undoubtedly easier when one is able to identify and label this accurately. This reflects the common understanding that something cannot be known until it is named (Piaget, 2013). The significance in being able to define and label experience is supported by existing literature such as in the words of Merleau-Ponty (2005, p.206), "the most familiar thing appears indeterminate as long as we have not recalled its name" and "the thinking subject himself is in a kind of ignorance of his thoughts so long as he has not formulated them for himself".

Furthermore, Willig (2013) contended that, ''the words we use to describe our experiences play a part in the construction of the meanings that we attribute to such experiences (Willig, 2013, p.10). It is when one gains awareness into what is happening, that the start of what can be named as experience, can be achieved (Smith et al. 2009)
An interesting observation in the context of the use of language, relates to participants not using the term 'self-injury' but 'self-harm' instead. Two hypotheses that might explain this, is a lack of understanding around the variations in terminology and the nuance they represent, as well the popularity of the umbrella term 'self-harm'. Moreover, this might also reflect an aversion to the use of the term 'self-injury' as it might link to a more graphic and intense interpretation of their behaviour. Finally, the preferred use of language by the participants may also be associated to the cultural norm in the United Kingdom and Europe where the term 'self-harm' is more widely used in comparison to the United States which refers to this as 'Non-Suicidal/Suicidal Self-Injury'.

Both women expressed confusion around their behaviour and what this constituted as. This was in the context of a number of factors; namely lack of awareness around this type of self-injury, a sense of confusion between underlying factors that impacted this, such as a difficulty distinguishing this from nonpathological sexual practices, and the associated pleasure and climax that occurs and maladaptive or compulsive sexual behaviours, such as in the case of compulsive masturbation where the individual feels unable to control and stop engaging in their behaviour despite the harmful consequences this carries (Sahithya & Kashyap, 2022; Sanderson, 2006). This reflected as an underlying confusion for both participants, especially around the notions of pleasure and pain; where these two meet, as well as separate. This was further compounded by the difficulty in making sense whether the act in itself or the underlying motivation made it pleasurable, alongside further difficulties around accepting pleasure in itself.
Whereas in Kate's account there seems to be a somewhat absence of desire, in Isabelle's case in contrast, there is an expressed mention and attempt in her narrative, to engage in and distinguish pleasurable from unpleasant pain. This brings to mind the distinction between the notion of ego-syntonic 'good pain' vs ego-dystonic 'bad pain' as seen in the context of those that might engage in BDSM related activities, and in the context of further differentiating such activities from genital self-injury (Shahbaz & Chirinos, 2021).
Although BDSM was not explicitly discussed in Isabelle's narrative and any potential associations were not explored further during her interview, we cannot preclude whether engaging both in BDSM-related practice as well as in self-injury may play a role in her behaviour. This potential interplay may be further understood in the context of her own

experience of trauma and research that suggests an increase in sadomasochistic tendencies in individuals that have experienced this (Abrams et al., 2022).

For Kate, her own pre-existing view around self-injury being a behaviour that is visible for example as seen in more common manifestations ex. cutting oneself, and the internalization of common misconceptions and subsequent judgments she had internalized such as it being an attention seeking behaviour, resulted in a delay with regards to her identifying her behaviour as self-harming. Isabelle also carries judgments around what it means to self-injure, specifically it being a sign of something being 'wrong' and 'unhealthy 'with regards to the person that engages in this.
These findings are supported by the existing literature around perceptions and attitudes towards self-injury and it carrying significant stigma, and especially in the context of the fear of it being perceived as a socially 'deviant' behaviour or 'attention seeking' (Adler & Adler, 2007; Klineberg et al. 2013; Staniland et al., 2021). It therefore is unsurprising that Kate and Isabelle would have internalized these judgments, which would have coloured how they view themselves and their behaviour which in turn has further implications on disclosing this. This coincides with relevant research findings (Long., 2018; Staniland et al., 2021; Cleary, 2017; Rowe et al., 2014)

Making sense of their experience in context, such as Kate's experience of child sexual abuse, sexual victimization and severe bullying and Isabelle's experience of childhood neglect, also coincides with literature demonstrating an association between self-injurious behaviour in survivors of trauma. Ford and Courtois (2009) and Dyer et al (2009), have demonstrated a significant association between surviving complex trauma, as defined by a series of repetitive, severe, persistent and prolonged traumatic incidents at a sensitive developmentally age and especially experiencing child sexual abuse, and engagement in self-injurious behaviour. This is also supported by literature exploring mediating factors between experiencing complex trauma and self-injury engagement, such as in the case of dissociation and emotion dysregulation which both Kate and Isabelle described and demonstrated as note-worthy in their accounts (Boon et al., 2011; Sanderson, 2013; Dyer et al., 2009; Geddes et al., 2013; Low et al., 2000; Yates et al., 2008; Cernis et al., 2019; Hoyos et al., 2019).
Although there is poverty in the existing literature with regards to genital self-injury and any clear associations and conclusions around this, most of which consisting of single case studies, there have been accounts of genital self-injury linked to having experienced child sexual abuse which can be understood as a way of coping with the impact of these traumatic experiences (Sanderson, 2006; Hyman, 2010; Denov, 2004). These findings resonate with

Kate's experience of genital self-injury in the context of trauma of a sexual nature, and are further supported by the recent, independent study by Aves (2023) who noted that 77% of respondents related trauma such as experiencing childhood abuse and sexual violence to their engagement in genital and breast self-injury.

The notion of compulsive masturbation that Kate describes in her account as 'merged' with her self-injury, is also further associated with traumatic experiences, especially of sexual nature (Sanderson, 2006; Castellini et al., 2018; Kowalewska et al., 2020). Compulsive masturbation can be conceptualized as the urge to engage in frequent masturbation, usually multiple times a day, resulting in feelings of emptiness rather than satisfaction, pleasure or release of sexual tension (Sanderson, 2006). This is also documented as a sexual response to child sexual abuse which can range from dysfunction and avoidance to compulsive or hypersexual responses (Kendall-Tacket, Williams, & Finhelhor, 1993; Easton et al., 2011; Aaron, 2012).

In addition, the notable confusion between pleasure and pain and any potential associations it may have with compulsive masturbation in the context of genital self-injury, may also be explained by the notion of 'sex as self-Injury'. This is characterised by behaviours of sexual nature that cause emotional and bodily harm, an example of which is masturbation to the point of pain and recreating experiences of child sexual abuse via injuring their own genital area and differ from BDSM activity (Zetterquist et al., 2018; Fredlund et al., 2020; Mellin & Joung, 2022.)

4.2.2 Perceived Defectiveness

Both participants expressed feelings of a profound sense of defectiveness, shame and self-loathing. These were in the context of a range of factors and reflected a sense that there is something deeply wrong with them, for who they felt they were, what they had been through and their subsequent engagement in self-injury. For Kate these were also associated with a sense of shame around a self she perceived as disconnected, a 'Dr Jekyl, Mr Hyde' as she describes one that can be and behave differently during the day, and night which reflects a dissociated self and her associated feelings of shame around this realization.

Isabelle also describes how her self-injury helps her to not 'feel like a robot' and a sense that self-injury would not occur if she were 'able to' manage her dissociative experience.

Both women discuss experiences of significant dissociation reflecting perhaps different mental states and a less integrated sense of self, a common occurrence in survivors of complex trauma such as child sexual abuse and neglect. This can be conceptualised in the context of existing literature on structural dissociation of the personality, which is understood as a disintegrated sense of self, manifesting in a range of dissimilar and often contradicting mental states, each characterized by a different emotional and behavioural profile as well as variations in the way the individual perceives themselves and others (Van der Hart, Nijenhuis & Steele, 2006; Mosquera, Gonzalez & Leeds, 2014). Experiences of complex trauma also link to a range of trauma-related phobias such as *"a classically conditioned fear or other aversive emotion (e.g shame, sadness) toward stimuli that survivors have associated with their traumatic experiences"* as well as "*conditioned escape and avoidance"* (Van der Hart et al., 2006, p.195).

These processes may in part explain the way both participants perceive as well as related to themselves and others around them. Self-injury in particular, can be understood in this context, as a way of escaping trauma-related memories (Van der Hart et al., 2006).
In addition, research has demonstrated a significant relationship between having faced complex trauma and experiencing heightened levels of shame (Courtois & Ford, 2013; Herman, 2011).
Furthermore, the relationship between shame and engagement in self-injurious behaviour is also supported by the existing literature (Schoenleber, Berenbaum and Motl, 2014; Favazza, 2011; Adler and Adler, 2011; Gunnarsson, 2021; Sheehy et al., 2019). This is also highlighted in the association between self-critical and self-denigrating attacks towards the self, such as the ones both participants express in their accounts, and self-injury (Xavier, Pinto Gouveia and Cunha, 2016).

Moreover, the association between self-injury and shame as well as shame around subsequent scarring is also supported by research (Bachtelle & Pepper; 2015; Curtis, 2016). This may serve as an additional explanation between Isabelle's self-injury in the context of her skin condition and the vicious cycle of how she feels about the scars this has caused as well as the scars that are a direct result of her genital self-injury and her further engagement in this.

Interestingly, there is no mention in the existing literature around genital self-injury being in the context of a skin condition such as in the case of Isabelle however the impact of having a skin condition on a person's mental health has been widely recognised and the implications that having a chronic skin condition can have on one's mental health have been extensively

documented and is a focus of the field of psycho-dermatology (Hee-Sun Moon, Mizara & McBride, 2013; Walker & Papadopoulos, 2005; Strangier and Ehlers, 2000; Tugnoli et al., 2020). Therefore, a skin condition and the impact this carries for the individual, transcending in feelings of associated shame, may serve as a mediating factor, manifesting in self-injury.

Finally, Kate's genital self-injury in the context of precocious puberty may also be understood by the impact the latter holds for the developing child. The relationship between precocious puberty and mental health concerns has also been supported by existing literature (López-Miralles, Lacomba-Trejo, Valero-Moreno et al., 2022). This association can be explained due to the physical manifestations that accompany an early puberty, not equating to the cognitive and emotional aspects of the child's development which in turn result in psychosocial difficulties (Lee, Ahn & Choi, 2016).
A link between a negative evaluation of the self, depressive symptomatology and precocious puberty has also been demonstrated in the existing research (Wang & Chen, 2015; Shawq, Maala & Abid-Al Jabbar, 2019).

In addition, Huang, Liu, Su & Xie (2021) explored rates of self-consciousness and depression in children presenting with precocious puberty. Their study revealed that compared to children that did not present with this, children with precocious puberty had considerably increased rates of depression with girls being more predisposed to feelings of anxiety and unhappiness, compared to boys with the condition (Huang et al., 2021)

4.2.3 The Struggle of Practicing Self-Care

A theme that was prevalent in both Kate's and Isabelle's accounts was with regards to their misconceptions around the notion of self-care and their difficulty engaging in this. The notion of self-care, refers to a broad range of strategies and practices that aim to improve or maintain an individual's physical and mental health and overall quality of life (NIH, 2024)
Both participants' struggle with self-care further refers to the way these women related to themselves and the struggle to view themselves, their self-injury and their overall difficulties in a kind and compassionate way.

Harm- reduction or harm minimisation, refers to an intervention which focuses on reducing the harm caused by high-risk behaviours such as self-injury, rather than solely focusing on prevention and abstinence (Haris et al., 2022; Inckle, 2017)
The principles of harm minimisation, are underpinned by the conceptualization of self-harming behaviours as a coping mechanism, whilst also recognizing that the individual that

engages in these might not be able to or feel prepared to stop and that stopping these, might in some cases be counterproductive or further harmful (Haris et al., 2022; Inckle, 2017) Harm-reduction alternatives might include a variety of strategies that serve a dual function. These are undoubtedly the physical benefits of caring after one's wounds as well as the positive psychological impact that engaging in aftercare holds for the individual which is associated to their own motivations for engaging in self-injury (Inckle, 2017). Strategies involved in harm-reduction include physically caring for one's injuries and implementing a range of strategies aimed to prevent further harm. Examples of these range from but are not limited to using clean, sterile instruments or washing hands and cleaning fingernails, owning and using a first-aid kit to use if necessary, avoiding self-injury in high risk/never safe areas in the body, knowledge around injuries that necessitate urgent medical attention as well as steps to take following their self-injury which may depend on level of severity (Inckle, 2017). Harm-reduction principles also involve the component of emotional harm-reduction which is aimed in assisting the individual to "*integrate their experiences of self-injury in a life enhancing-way"* (Inckle, 2017, p 177). Emotional harm-reduction is especially significant in "*developing resilience against the emotional harms that result from the stigma and misunderstanding of self-injury in wider society"* (Inckle, 2017, p 178).
Although harm-minimisation/harm-reduction and self-care are related constructs they are distinct concepts and distinguishing these is crucial in making sense of the function that each hold in the management of self-harm as well as in making sense of the overall attitudes individuals hold around self-injurious behaviour.

In Kate's case, she describes struggling with practicing self-care as she acknowledges the difficulty in internalizing anything positive towards herself which she attributes to feelings of shame and self-disgust. In her words, following her self-injury she would 'do the bare minimum not to die' via engaging in harm-minimisation and using for example cystitis relief sachets in the aim of reducing infection risk. She further describes her use of other strategies such as using sanitary pads as efforts to conceal her self-injury from others which is likely to reflect more her shameful feelings around this and is not an expression of an attempt to self-care.
Both women approached and answered their questions around engaging in self-care with a seeming sense of scorn which might reflect an overcompensating response to underlying feelings of shame around their self-injury or lack of self-care engagement around this. In Isabelle's account her attitude towards engaging in self-care, reflects perhaps elements of her making sense of this engagement in in an all-or nothing manner rather than in an continuum- something you either do or you don't. With her viewing engaging in self-care as a reflection of 'loving oneself and as a result treating oneself well' she therefore concludes

that, 'if one does not like their body or does not love oneself, they treat themselves badly'. Her recognition of the comprehensive nature of self-care however as a loving approach towards oneself and their body and her ultimate engagement in this, may reflect a more holistic way of her approaching this compared to Kate's more practical and reactive stance. The denigrating and perhaps contemptuous manner with which both women relate to themselves and reflect around self-injury and the lack of a considerate and kind approach towards themselves and their struggles, may be explained taking into account the impact of adverse experiences such as Kate's experience of childhood sexual abuse and bullying and Isabelle's experience of childhood neglect.

These difficulties may also be mediated by feelings of shame and the association between this and having experienced complex trauma, which we have already discussed in the previous section of this chapter (Courtois & Ford, 2013; Herman, 2011). Shame has also been positively correlated specifically with direct experiences of sexual traumata and being shamed by peers which can have a profound impact to an individual's sense of self, rendering them vulnerable to further feelings of shame and self-judgment (Gibb, Abramson, & Alloy, 2004; Wetterlov et al., 2021).

The above, serve as a further explanation for Kate's difficulty internalizing care and engaging with self-care in the context of her self-reported feelings of shame and self-disgust.

If shame, which according to DeYoung, is a manifestation of a sense of self in relation to others and in the context of ruptures and disconnections, then a "*chronic sense of self-in disconnection becomes a profound sense of isolation, which in turn leads to feelings of despair and unworthiness*." (DeYoung, 2015, p 18)

As a result, the healing of chronic shame requires for the individual to engage with connections that enable empathy and emotional joining (DeYoung, 2015).

Isabelle and Kate's struggles around self-care can be further understood in the context of a difficulty relating to themselves in a compassionate manner, the latter serving as an antidote to high levels of shame and self-criticism (Gilbert & Irons, 2005)

Compassion, which originates from the mammalian caring motivational system, is understood as an intrinsic drive, which predisposes individuals to be mindful of their own and others' suffering alongside a sense of determination to ensure this does not occur and a wish to relieve this, when encountering this (Gilbert & Choden, 2013; Gilbert, 2019; Matos & Steindl, 2020).

One can understand the profound impact that Isabelle and Kate's experiences had on them, especially with regards to how they relate to themselves. This further makes sense in the context of evidence associating having received care during sensitive developmental periods and the positive impact this has on one's sense of self (Mitchell & Black, 1994; Siegel, 2001; Gerhardt, 2004; Cozolino, 2007).

Therefore Kate's and Isabelle's struggles with self-care can be understood as internalized punitive and neglectful ways of interacting with themselves which relate to how others have treated them.

4.2.4 Targeted Harm

An interesting theme emerging from the data was the specificity of the location of self-injury and the underlying functions genital self-injury served, for both participants.
Both Kate and Isabelle's accounts reflected a sense of intentionality and targeted harm, albeit this choice being somewhat automatic and perhaps one they were not always conscious of making.
For Isabelle, it seems that genital self-injury reflects her own feelings around her genitalia especially in the context and impact of her skin condition. As a result of this, Isabelle experiences herself as erroneously deserving genital self-injury. This is further compounded by the fact that her condition is inherited from her mother, with whom she has a difficult relationship with and whom she may symbolically wish to punish for passing this condition on to her as well as neglecting her.
In addition, genital self-injury for Isabelle partly relates to a less symbolic function, that is in the context of the mechanism underlying the often-uncontrollable itch-scratch cycle often accompanying skin conditions. In the context of this mechanism, scratching reflects a wish to relieve the itching sensation which offers temporary pleasure but ultimately extends the itching sensation and exacerbates both this as well as the condition itself (Rinaldi, 2019).
Kate's genital self-injury also reflects a self-punitive stance, with her choice in location described as 'bullseye' which she believes is the ultimate punishment. Kate speaks about seeking a particular internal sensation by self-harming her genitals, acknowledging that for her, cutting her skin was not sufficient. Her targeted harm relates not only to the associated sensations that arousal as well as self-injury cause, but also her view of self-injury being a way to re-live her trauma and punish herself for what she feels was her body betraying her.
For both women, genital self-injury seems to provide perceived elements of control, agency and empowerment that contradict the feelings of powerlessness and overwhelm that form the legacy of their life experiences.
The themes discussed in Kate's accounts, can be understood taking into consideration Finkelhor and Browne's 'Traumagenic Dynamics Model' explaining the impact of sexual violence and especially with regards to attempting to regain a sense of control through traumatic re-enactment and in the context of traumatic sexualization which manifested in her

engagement with compulsive masturbation, which she perceived as fused in part to her self-injury (Finkelhor and Browne, 1985).

Furthermore, both women's accounts with regards to the sense of punishment and targeted harm can be conceptualized under Freud's repetition theory and the notion of compulsion to repeat the trauma (Mc Williams, 1999; Aaron, 2012) According to this, and in the context of an attempt to gain a sense of mastery over their traumatic experience, whether this is experiencing sexual violence or the traumatic impact of having a chronic, painful skin condition, both women compulsively re-enact their trauma.
These compulsive, behavioural re-enactments however, despite the fleeting sense of achievement, control or satisfaction they might offer, eventually prolong the long-standing sense of helplessness, defectiveness and uncontrollability (Van der Kolk, 1989).

4.3 Strengths, Limitations and Suggestions for future research

At present, there is poverty of existing research exploring the issue of genital self-injury with the limited literature available primarily focusing on males' experience of this, as well as it being in the form of outdated case studies which largely give accounts of clinicians' interpretations of patients states of mind in the context of their self-injury.
Furthermore, the very recent, independent research by Aves (2023) published in the blog 'Psychiatry is Driving Me Mad', is the only research that explores the lived experience perspectives of genital and breast self-harm and offers some new viewpoints in this area. Aves's 2023 study, utilizes an anonymous online questionnaire which includes a mixture of closed and open questions. This incorporates quantitative data analysis as well as allows for participants to offer some additional comments around their self-injury in the open comments section at the end of the questionnaire, if they wished to.

To my knowledge, research on the topic of genital self-injury- and specifically in women- using interviews and analysing these qualitatively, has not previously been done. The research design and analysis selected in this study, allowed for the exploration of accounts of the experience of genital self-injury and supported participants to express their thoughts, feelings as well as other aspects relevant to their self-injury, in great depth. Many of the findings of this study can be supported by existing literature especially with regards to shame, dissociation, and impact of trauma. This study also highlighted new significant themes around the importance that the location of self-injury holds for these individuals, as well as in the context of underlying conditions. Examples of these, are genital self-injury in

the context of experiencing precocious puberty and in the context of diagnosis of a skin disorder.

Both participants reflected on the importance that awareness around this type of self-injury holds and the impact that the lack of available knowledge and discussion around this had for them thus far.
The use of IPA as a preferred methodology to analyse the data not only enabled access to underlying thoughts and emotions associated with their self-injury but also allowed for the capturing and exploration of nuances in these women's accounts. This endeavour might have been challenging or not possible if other qualitative or quantitative methods were utilized instead of IPA.

It is important to also acknowledge however, a number of limitations of this study. Challenges in recruitment in combination with this being a significantly stigmatised and under researched form of self-injury, contributed to a very small number of participants coming forward to take part, and although these still are deemed sufficient for an IPA study, perhaps impact the generalisability of the findings to a broader population of individuals that genitally self-injure.
A potential limitation that may have impacted the number of participants coming forward could be related to having a two-week cooling off period following expressing initial interest in taking part in the study, in order to reflect on their decision. This may have been perceived as too long and may have resulted in a loss of interest in potential participants as well as could carry the possibility of interested participants forgetting about the study and their participation in this. The limitation described could be further compounded by the decision around the participants initiating contact with the researcher unless previously decided otherwise, as no follow-up contact was to be made by the researcher in the case they had not heard back from the participant at the end of the cooling-off period. A consequence of this may lead to missed opportunities to remind or encourage potential participants or to discuss any concerns or queries they may have, that could result in their hesitation to take part in the study. Therefore, shortening the cooling-off period to a timeframe that would both allow adequate space for reflecting whether they wish to take part whilst still maintaining the interest and motivation of the participant, could be beneficial.
Furthermore, an additional suggestion that could have been implemented to increase participant numbers would be to consider offering small incentives such as a voucher, gift-card of small monetary value or access to educational material which could increase motivation in participation without it becoming coercive and compromising a genuine interest in taking part in the study.

In addition, the fact that these participants attended a different number of interviews each, meant that they did not respond to all of the same questions therefore some of the themes were not explored for one of them.

Finally, both individuals primarily used the term 'self-harm' to describe their experiences as opposed to the term 'self-injury'. Although this might reflect an absence in knowledge differentiating these two concepts, it might also be a reflection of both terms being used in the interview schedule as well as the advertisement flyer. This might have nevertheless affected their thoughts and emotions as they reflected on their experience and therefore, also their descriptions. Having said this, I also wished for participants to use the terms that best portrayed their experience in the hope that this will provide a more authentic account that is congruent with how they make sense of their self-injury.

With regards to recommendations for future research, I sincerely hope that the findings of this study serve not only as a stepping stone but also as a source of inspiration for further exploration of the topic of genital self-injury.
To start, research utilizing a large quantitative study on genital self-injury might shed light into the actual prevalence of this behaviour which is estimated to be greatly underreported. This study can also examine in more detail any differences in the ways individuals genitally self-injure and whether these differences relate to distinctive themes that underpin their self-injury.
An example of another recommended area for further exploration is a qualitative study exploring age and gender differences in the context of genital self-injury as this might reveal differences in presentations, underlying functions, and motivations as well as variations with regards to responses to treatment.
It could also be interesting to explore the impact that any cultural and societal factors may have in individuals' engagement with genital self-injury and the ways in which these factors influence its presentation as well as their engagement with and response to treatment.

Moreover, research can also investigate the experience of therapists or other multidisciplinary professionals working with genital self-injury which may offer valuable insights not only on the phenomenon of genital self-injury itself but also insights into their own thoughts and feelings towards this behaviour as well as those that engage in it.
Finally, and with regards to IPA studies exploring genital self-injury, these may further include the incorporation of a variety of methods such as the use of journals or diaries, drawings, paintings or other non-verbal mediums. This will allow a more holistic and comprehensive conceptualization of the experiences of those that genitally self-injure.

4.4 Clinical Implications for Training and Practice

The current study and its findings have identified a number of clinical implications for training and practice both for counselling psychologists, as well as other healthcare professionals. Awareness around the concept of genital self-injury and factors that may impact its presentation is of paramount importance not only for counselling psychologists but also any mental health professionals that work with presentations were self-harm is a likely and frequent occurrence. These include but are not limited to, personality disorders as well as presentations relating to experiences of single event or complex traumata and associated symptomatology. Evidence from findings also supports an association of genital self-injury and experiences of trauma of a sexual nature, therefore professionals and organizations that work with survivors of child sexual abuse and sexual violence should be particularly mindful of the presentation of genital self-injury.

In addition, professionals need to be especially aware during any risk assessment process, approaching questions around self-injury with increased sensitivity, as well as demonstrating awareness and openness in discussing genital self-injury, in the context of conveying an overall compassionate and non-judgmental stance.
Moreover, and in the context of demonstrating awareness and reducing feelings of shame in clients and service users, professionals can further attempt to normalize engagement in genital self-injury as an attempt to manage challenging emotions and in the context of an individual's unique life circumstances and experiences.

Professionals working with individuals that genitally self-injure, should primarily focus on exploring and addressing any underlying factors and motivations for this, prior to stressing the need for this behaviour to be replaced. This will increase the likelihood that the individual they are working with feels heard and respected instead of dismissed and invalidated. Considering and offering information around harm minimisation and harm reduction strategies in this context, may be particularly helpful as it may contribute to the individual experiencing a sense of control, empowerment, and agency through their healing process. This is highly significant for those that have survived trauma of interpersonal nature where the individual has been violated and made to feel powerless and defective.

The above recommendations were also inspired by the account of one participant of this study upon reflecting on the factors that helped her cease her self-injury as well as develop a more compassionate stance towards herself. These were identified as the therapist being aware and knowledgeable around genital self-injury, offering psychoeducation around this as

well as coping strategies and finally, offering a therapeutic presence that felt genuinely caring to the person.

This study carries significant clinical implications for professionals of other disciplines outside the mental health arena, such as doctors and nurses and A & E staff. Awareness of the phenomenon of genital self-injury and the associated short and long-term implications this carries for the individual's health, enables them to consider and provide and inform a range of treatments and care plans.

Finally, it is of crucial importance that information around genital self-injury is included in training and education programmes, as well as relevant organizations and healthcare settings. This will contribute to the awareness around this phenomenon, which also result in a reduction of stigma around this, and the increase in likelihood that individuals will come forward to receive support and care around their self-injury.

4.5 Overall Reflections and Concluding Remarks

As I reflect on my research journey, I recall experiencing a range of thoughts and emotions and have found this process highly impactful in a number of ways.

Throughout my experience working in the mental health field, I have aspired to make sense of individuals' inner world and the ways in which they relate to themselves and others. I have been deeply moved by stories revealing tremendous hurt yet also profound resilience and have had the privilege of building meaningful relationships that have undoubtedly shaped who I am.

It is during this process that I have come across the different manners with which individuals' attempt to navigate their everyday life, sometimes in the aftermath of great adversity.

Many of the behaviours' individuals engage in the context of this such as in the case of self-destructive behaviours, puzzle or concern professionals and are often described as maladaptive. Time and time again however, and in our attempt to support our clients in building lives they find meaningful, we are required to make sense of these behaviours and the underlying function they hold for an individual, without judgment or assumption.

Working with individuals that engage in self-injury, shaped my understanding of this behaviour as an often attempt to cope with extremely painful emotional states and frequently in the absence of alternatives that feel adequate for the person at the time. During those encounters I have myself experienced a number of feelings ranging from sadness and daunt to deep admiration, respect and compassion.

In the context of my encounters with those that engaged in genital self-injury I have noticed common themes of self-stigma that fuelled states of isolation and secrecy as well as overwhelming feelings of shame. In the context of these, those that engaged in this, kept their self-injury hidden from others, largely due to the fear of how they might be perceived, delaying necessary access to support and treatment.

Unfortunately, some of these fears were not unfounded as I discovered during my research process. Upon discussing this research topic with other professionals from various disciplines, I encountered a small minority of individuals, namely mental health professionals that had heard of the concept of genital self-injury or had worked with someone that engaged in this. To my surprise, given general awareness around self-harm, many individuals expressed shock and disbelief around the existence of such behaviour revealing a range of erroneous misconceptions and stigmatising attitudes around this presentation.

These encounters, in combination with the challenges in the recruitment process, left me feeling in doubt and deeply concerned and discouraged at times, on the feasibility of this project and whether this could ever come into fruition. These challenges were characterised by the majority of services contacted either not responding to my enquiry to recruit via them or by refusing for a number of reasons including the sensitivity of the topic researched.
In addition, recruiting and working on this thesis during the Covid-19 Pandemic posed an additional layer to this challenging process. This was further compounded by my own diagnosis of a chronic physical health condition which contributed to my concerns around managing this in the context of the pandemic as well as this research process.

In addressing the impact of the above, I have found the support and guidance of my research supervisor and the use of personal therapy paramount in ensuring I continue to engage in necessary self-care and in maintaining my passion and determination to complete this project. Furthermore, my own efforts to reflect on and bracket my feelings through the use of my reflexive journal, was particularly helpful and ensured my focus remained entirely on my participants accounts and making sense of their experience.

To conclude, this study aimed to make sense of the women's experience of genital self-injury which included an understanding around their behaviour, the factors that may have impacted their engagement in this as well as the underlying function this may hold for them. While there is abundant research around self-harming and self-injurious behaviours in general and the various contexts in which these may present in, research on genital self-injury is extremely limited, primarily historical and is mostly in the context of individual case

studies. Existing research does not offer adequate insight into this behaviour, nor does it represent the variations in presentation and underlying motivations for this.

Ultimately, this study is the product of not only my hope to contribute to the awareness and shed light on the topic of genital self-injury, but also my attempt to give voice to the individuals that entrusted me with their experiences and for whom I am deeply grateful and hold utmost respect and regard.

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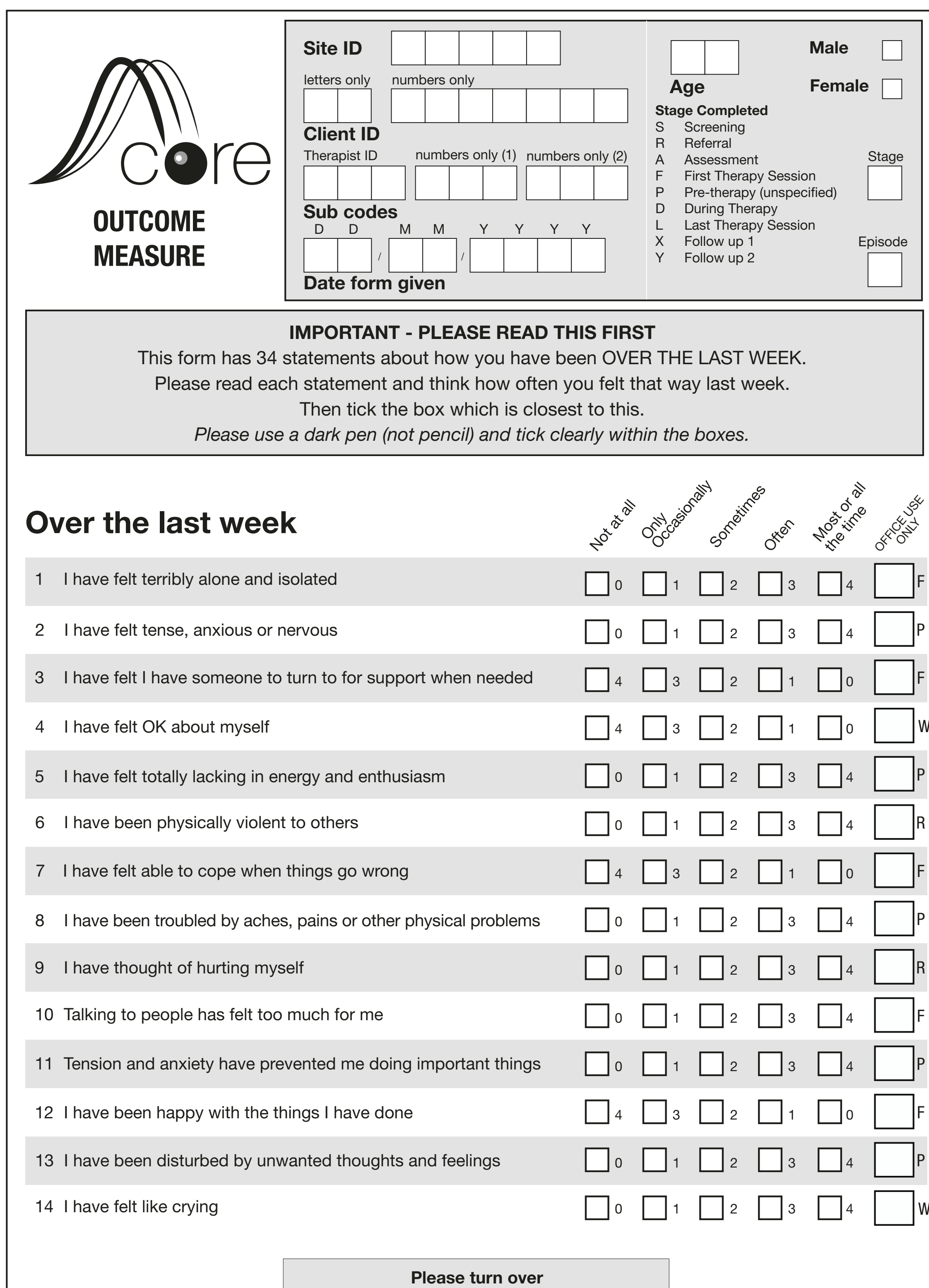
Appendices

Appendix A: CORE Outcome Measure



CORE OUTCOME MEASURE

Site ID
letters only | numbers only
Client ID
Therapist ID | numbers only (1) | numbers only (2)
Sub codes
D D / M M / Y Y Y Y
Date form given

Age | Male | Female

Stage Completed
S Screening
R Referral
A Assessment
F First Therapy Session
P Pre-therapy (unspecified)
D During Therapy
L Last Therapy Session
X Follow up 1
Y Follow up 2

Stage
Episode

IMPORTANT - PLEASE READ THIS FIRST
This form has 34 statements about how you have been OVER THE LAST WEEK.
Please read each statement and think how often you felt that way last week.
Then tick the box which is closest to this.
Please use a dark pen (not pencil) and tick clearly within the boxes.

Over the last week

	Statement	Not at all	Only Occasionally	Sometimes	Often	Most or all the time	OFFICE USE ONLY
1	I have felt terribly alone and isolated	0	1	2	3	4	F
2	I have felt tense, anxious or nervous	0	1	2	3	4	P
3	I have felt I have someone to turn to for support when needed	4	3	2	1	0	F
4	I have felt OK about myself	4	3	2	1	0	W
5	I have felt totally lacking in energy and enthusiasm	0	1	2	3	4	P
6	I have been physically violent to others	0	1	2	3	4	R
7	I have felt able to cope when things go wrong	4	3	2	1	0	F
8	I have been troubled by aches, pains or other physical problems	0	1	2	3	4	P
9	I have thought of hurting myself	0	1	2	3	4	R
10	Talking to people has felt too much for me	0	1	2	3	4	F
11	Tension and anxiety have prevented me doing important things	0	1	2	3	4	P
12	I have been happy with the things I have done	4	3	2	1	0	F
13	I have been disturbed by unwanted thoughts and feelings	0	1	2	3	4	P
14	I have felt like crying	0	1	2	3	4	W

Please turn over

Survey: 151

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Over the last week

	Not at all	Only Occasionally	Sometimes	Often	Most or all the time	OFFICE USE ONLY
15 I have felt panic or terror	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
16 I made plans to end my life	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ R
17 I have felt overwhelmed by my problems	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ W
18 I have had difficulty getting to sleep or staying asleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
19 I have felt warmth or affection for someone	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐ F
20 My problems have been impossible to put to one side	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
21 I have been able to do most things I needed to	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐ F
22 I have threatened or intimidated another person	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ R
23 I have felt despairing or hopeless	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
24 I have thought it would be better if I were dead	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ R
25 I have felt criticised by other people	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ F
26 I have thought I have no friends	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ F
27 I have felt unhappy	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
28 Unwanted images or memories have been distressing me	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
29 I have been irritable when with other people	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ F
30 I have thought I am to blame for my problems and difficulties	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
31 I have felt optimistic about my future	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐ W
32 I have achieved the things I wanted to	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐ F
33 I have felt humiliated or shamed by other people	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ F
34 I have hurt myself physically or taken dangerous risks with my health	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ R

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE

	(W)	(P)	(F)	(R)	All items	All minus R
Total Scores	☐	☐	☐	☐	☐	☐
Mean Scores (Total score for each dimension divided by number of items completed in that dimension)	☐	☐	☐	☐	☐	☐

33126

Survey: 151

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Appendix B: Recruitment Flyer

Are you interested in taking part in a study about genital self-injury?

We would like to reach out to people to find out about their experiences of genital self – injury. We are looking for female participants aged 18+, that are currently engaging or have engaged in the past, in genital self-harm.

Very little is known about this sensitive topic, and in this qualitative research we will be interviewing participants about their experiences, aiming to contribute to the current body of literature and to inform good practice guidelines.

Please note, that in order to participate, you will need to be currently supported by a mental health professional.

If you would like to participate in the study or want to hear more about it, please contact Elli Kimpouropoulou (Research Investigator) at [redacted] or at [redacted]
Or Dr. Jacqui Farrants (Research Supervisor) at [redacted]

This study has been reviewed by and received ethics clearance through the School of Arts and Social Sciences, City, University of London. If you would like to complain about any aspect of the study, please contact the Secretary to the Senate Research Ethics Committee on 02070403040 or via email Anna.Ramberg.1@city.ac.uk
City University of London is the data controller for the personal data collected for this research project. If you have any data protection concerns about this research project, please contact City's Information Compliance Team at dataprotection@city.ac.uk

Appendix C: Interview Schedule

Interview Schedule

1) How do you feel about being here today, talking with me about your self-injury?
2) What motivated you to decide to take part in this research?
3) What understanding do you have about different types of self-harm?
4) Could you please tell me what does your self-harm mean to you?
5) After your self-harm, how do you feel? What do you do? Do you self-care?
6) What does self-care mean to you?
7) When did you first harm yourself?
8) Could you tell me a bit about the nature of your self-injury when you first started self-harming?
9) Could you tell me a bit about the nature of your self-injury today.
10) Do you feel that it has changed over time, if yes, in what way?
11) What sense do you make of your self-injury, how do you understand it?
12) How did it feel answering these questions today? Was there any aspect of this interview that you found particularly hard?
13) Is there anything else that you would like to add?

Appendix D: Second Interview Schedule

INTERVIEW SCHEDULE

Title: The experience of genital self-injury in adult women.
Researcher: Elli Kimpouropoulou, Trainee Counselling Psychologist, City University London
Supervisor: Dr. Jacqui Farrants
Contact: elli.kimpouropoulou@city.ac.uk

ORIGINAL INTERVIEW SCHEDULE:

1) How do you feel about being here today, talking with me about your self-injury?
2) What motivated you to decide to take part in this research?
3) What understanding do you have about different types of self-harm?
4) Could you please tell me what does your self-harm mean to you?
5) After your self-harm, how do you feel? What do you do? Do you self-care?
6) What does self-care mean to you?
7) When did you first harm yourself?
8) Could you tell me a bit about the nature of your self-injury when you first started self-harming?
9) Could you tell me a bit about the nature of your self-injury today?
10) Do you feel that it has changed over time, if yes, in what way?
11) What sense do you make of your self-injury, how do you understand it?
12) How did it feel answering these questions today? Was there any aspect of this interview that you found particularly hard?
13) Is there anything else that you would like to add?

ADDITIONAL INTERVIEW SCHEDULE BASED ON FEEDBACK FROM PREVIOUS INTERVIEWS:

For participants that have already taken part previously:

13a) Having had more time to reflect on your experience, is there anything that came up for you since our last interview? (PROMPT: was there anything you felt you wanted to speak more about?

14) Could you tell me a bit more about why you think your self-injury developed?
15)Could you tell me a bit more on how do you think things would be/feel for you, if you did not self-injure?
16)What sense do you make of you self-injuring, in that particular area?

Appendix E: Participant Information Sheet

Title of study The experience of genital self-injury in adult women.

Name of principal investigator Elli Kimpouropoulou (Research Investigator); Dr Jacqui Farrants (Research Supervisor)

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

What is the purpose of the study?

The aim of this study is to explore the experience of genital self-injury in adult women. This is a type of self-injury that has rarely been researched in women and existing research indicates that there are differences between men and women regarding the reasons they engage in this behavior. This has unique implications for treatment which is relevant to the area of psychology. Exploring women's experience of genital self-injury will aid our understanding of this type of self-injury as well and promote awareness and reduce stigma. The proposed duration of the study is from August 2019 to September 2020. This study is undertaken as part of the Professional Doctorate in Counselling Psychology.

Why have I been invited?

For the purposes of this study, 8 adult women are invited to participate, who are currently genitally self-injuring or have genitally self-injured in the past, that is self-injury in the genital area. These participants will need to currently be supported by a mental health team, for example via a charity, private organization or a private therapist.

Do I have to take part?

Should you decide to take part in this study, I would like you to know that participation is voluntary which means that you can choose to not participate in part or all of this project.

You may withdraw at any stage or decline to answer any questions that you might feel are too personal or intrusive. This will not affect in any way, any future treatment you might receive.

It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. You are still free to withdraw at any time and without giving a reason. Data analysis will begin 1 month after the interview has taken place. However, once the data analysis begins, there will no longer be an option to withdraw your data from the study. In addition, once the research study has been written up and if it is published, there will not be an option to withdraw your data from the study.

What will happen if I take part?

In the case that you are interested in participating, you can contact me and we will then arrange a phone conversation where I will provide further information and explain to you, briefly what you can expect from the process as well as outline confidentiality and its limitations. During this time, I will also share with you information on the questions that you will be asked. At this point, I will also be informing you that we would like you to take a period of two weeks to allow you some time to consider whether or not you wish to participate. We can decide during this conversation whether you would prefer to contact me or if you would rather that I contacted you. This would include a decision about the method of contact that you would prefer. If you have shared that you would rather contact me but I do not hear from you when two weeks have passed, I will assume you do not wish to participate and I would not be contacting you again.
Should you still wish to take part, you can contact me to confirm this at which point we can arrange a date to meet and for the interview to take place. During this stage, you will be asked to choose a pseudonym, that is a name of your choosing, different to your given name to further ensure confidentiality. The interview will last approximately 60-90 minutes and will take place at City University or at the mental health service you are currently being seen, if this is more comfortable for you. Should you not wish to meet in person, there is also the option for the interview to be conducted over the phone or online via Skype.
Following your participation in the study, you will be given a debrief sheet with further information should you be interested in exploring this research area further.

Should you wish to meet me at City University, your travel expenses will be covered and you will be reimbursed at the beginning of our meeting.

What do I have to do?

If you are interested in taking part in this study, you will need to confirm by signing a Participant Consent Form once reading this information sheet. You are then kindly requested to answer to a few open- ended questions around your experience of genital self-injury. This process should not take more than 90 minutes. The interview should take place in a relatively quiet environment due to the nature of the discussion and the importance of obtaining a clear recording.

What are the possible disadvantages and risks of taking part?

As the nature of this research and the topic discussed is sensitive and personal, you may find the experience triggering and/or upsetting. Should you find any of the interview material

overwhelming, please do not hesitate to let me know. Please also keep in mind that we can stop the interview at any point.

What are the possible benefits of taking part?

This research aims to shed light to this underreported form of self-injury and to add to the currently limited body of literature on this area and your contribution is greatly appreciated. You also might find participating in this research and being able to share your experience rewarding.

What will happen when the research study stops?

Once the research study stops, the results will be written up as part of a doctoral thesis. Any data relating to this research, other than the digital recordings, will be stored securely on encrypted documentation for 10 years at City, University of London. The audio recordings from the interviews, will be destroyed immediately once they have been transcribed. You will have the opportunity to be sent a summary of the research study should you wish, by providing your email address on the Consent Form.

Will my taking part in the study be kept confidential?

The only individuals having access to your information would be the researchers involved in this study, which include my research supervisor Dr. Jacqui Farrants and myself. All interview recordings will be deleted once they have been transcribed. Any names of individuals including yourself, will be kept anonymous. Any data stored on hard-drives will be kept on encrypted documents. If you choose to withdraw your data in the future, please do so by contacting me. No data will be shared with other outside organizations. If information relating to risk to you or other individuals is reported during the interview, confidentiality may need to be breached. If this is the case, I will first discuss this with you and may need to inform other parties in order to protect you or other individuals that may be at risk of harm. The interview data will be archived for 10 years in line with statutory requirements at City, University London. After 10 years this data will be destroyed.
Should you have any more questions regarding this, please do not hesitate to contact me .

What should I do if I want to take part?

Should you wish to take part, you can contact me via phone at [redacted] or via email at [redacted] at which point I can provide further information regarding the study. Following a period of two weeks, you can contact me via email or phone to confirm whether you still wish to participate. You can also request that I contact you via your preferred method, should you find this more convenient. At this point, we can arrange a date to meet and for the interview to take place. This will also give you the opportunity to ask any questions or highlight any concerns you might be having with regards to your participation.

What will happen to results of the research study?

The results of this study will be written up as part of a doctorate thesis. There is a possibility that this research might be published in academic journals. In both the thesis as well as in any possible publications, some direct quotes from your interview might be used. Once again,

please know that in any case, personal details will be anonymized and there will be no identifying marker.

What will happen if I do not want to carry on with the study?

You are free to withdraw from the study without an explanation or penalty at any time. Withdrawing your participation will not affect your ability to access services you currently have access to or any services in the future.

Who has reviewed the study?

This study has been approved by City, University of London Psychology Department Research Ethics Committee.

Further information and contact details

Should you require any further information, please do not hesitate to contact Dr Jacqui Farrants at [redacted] as well as myself at [redacted]

Data Protection Privacy Notice: What are my rights under the data protection legislation?

City, University of London is the data controller for the personal data collected for this research project. Your personal data will be processed for the purposes outlined in this notice. The legal basis for processing your personal data will be that this research is a task in the public interest, that is City, University of London considers the lawful basis for processing personal data to fall under Article 6(1)(e) of GDPR (public task) as the processing of research participant data is necessary for learning and teaching purposes and all research with human participants by staff and students has to be scrutinised and approved by one of City's Research Ethics Committees.

The rights you have under the data protection legislation are listed below.

- right to be informed
- right of access
- right to rectification
- right to erasure
- right to restrict processing
- right to object to data processing
- right to object

For more information, please visit www.city.ac.uk/about/city-information/legal

What if I have concerns about how my personal data will be used after I have participated in the research?

In the first instance you should raise any concerns with the research team, but if you are dissatisfied with the response, you may contact the Information Compliance Team at dataprotection@city.ac.uk or phone 0207 040 4000, who will liaise with City's Data Protection Officer Dr William Jordan to answer your query.

If you are dissatisfied with City's response you may also complain to the Information Commissioner's Office at www.ico.org.uk

What if there is a problem?

This research is undertaken in the UK. Should you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through City's complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: **The experience of genital self-injury in adult women.**
You could also write to the Secretary at:

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

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

Appendix F: Debrief Information Sheet

THE EXPERIENCE OF GENITAL SELF-INJURY IN ADULT WOMEN

DEBRIEF INFORMATION SHEET

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

This research was conducted in order to gain an insight into your experience of genital self-injury. The data from the interviews will be analysed using Interpretative Phenomenological Analysis which seeks to explore how you make sense of these experiences and what they mean to you.

The experience of female genital self-injury has rarely been researched. The majority of cases of genital self-injury reported in the body of literature involve men and most are explored from a medical standpoint. In addition, there seem to be several differences between genders regarding underlying reasons for engaging in this behaviour which has unique implications for treatment, relevant in the area of counselling psychology.

Exploring the lived experience of those who genitally self-injure, could furthermore benefit mental health professionals and counselling psychologists into better supporting the individual as well as in influencing the development of appropriate treatment options.

We hope you found the study interesting. If you have any other questions or have any concerns about what has been discussed, please do not hesitate to contact us at the following:

If you would like any support after what has been discussed in the interview today, please feel free to contact the following organizations:

***Samaritans** at 116 123 and www.samaritans.org*

***Mind** at 03001233393 and www.mind.org.uk*

***Napac** at 08088010331 and www.napac.org.uk*
(Support Line for survivors of childhood abuse)

Thank you for participating in this study.

Appendix G: Consent Form

CONSENT FORM

Title of Study: The experience of Genital Self-injury in Adult Women

Please initial box

1	I confirm that I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records.	
	I understand this will involve:	
	• Being interviewed by the researcher	
	• Allowing the interview to be audiotaped	

2	This information will be held by City as data controller and processed for the following purpose: Public Task: The legal basis for processing your personal data will be that this research is a task in the public interest, that is City, University of London considers the lawful basis for processing personal data to fall under Article 6(1)(e) of GDPR (public task) as the processing of research participant data is necessary for learning and teaching purposes and all research with human participants by staff and students has to be scrutinised and approved by one of City's Research Ethics Committees. I understand that the following special category data will be collected and retained as part of this research study: *data concerning mental health.* City considers the processing of special category personal data will fall under: Article 9(2)(g) of the GDPR as the processing of special category data has to be for the public interest in order to receive research ethics approval and occurs on the basis of law that is, inter alia, proportionate to the aim pursued and protects the rights of data subjects and also under Article 9(2)(a) of the GDPR as the provision of these personal data is completely voluntary.	
3	I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation.	
4	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalised or disadvantaged in any way. Data analysis will begin 1 month after the interview has taken place. However, once the data analysis begins, there will no longer be an option to withdraw my data from the study. In addition, once the research study has been written up and if it is published, there will not be an option to withdraw my data from the study.	
5	I agree to City recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on City complying with its duties and obligations under the General Data Protection Regulation (GDPR).	
6.	I agree to the arrangements for data storage, archiving, sharing.	
7	I agree to the use of anonymised quotes in publication.	
8	I agree to take part in the above study.	

______________________ ______________________________ ______________

Name of Participant	Signature	Date
Name of Researcher	Signature	Date

Appendix H: Transcript Extract – Initial Coding

135 P25: I think definitely, that was involved as well. I can't say that the nature of **136** my self-harm or what it meant to me was something specific because I can't **137** pinpoint it because I think these were all contributing factors	**135-137** strong agreement of self-harm as a way of reclaiming control. 'nature of my self harm': meaning of self-harm, vague? Malleable? Fluid? 'contributing factors'- clinical language? Distancing self from emotions?
138 R26: Oh, okay	
139 P26: Because I think in my mind, I couldn't even think that being hurt in a **140** worse way, or I think it was the extent that it goes, and I was like you know **141** making sure I would do to it to myself so that you know.. Yeah I don't know. In **142** that sense it sounds like you know (chuckles) like kinda of a self-care. To make **143** myself stronger as well but I'm sure I didn't think about that (laughs)	**139-** 'couldn't even think': thinking the unimaginable. What makes it the 'worst possible way'? **139-143** Feeling powerless, need to control? Take power back? Preparing for the worst=self-care? How does self-harm and self-care link? Is harming herself caring for herself in some way? SI as a form of self-care/ SI as a way to feel stronger/ taking care of herself in order to feel stronger/ preparing self?
144 R27: (Overlapping) Could you tell me a bit more about that?	
145 P27:...now looking back.	
146 P28: Uhm, I thought I was you know, in a twisted way, you know, preparing **147** myself you know for the pain of the world something like that. Yeah, I was **148** making sure that I was hurt enough by me so that nothing else hurt me. And I **149** think that's what made things very difficult when I stopped self-harming.	**146-** use of word 'twisted': reflects contradiction? Paradox of self-harm as self-care. Use of word twisted'- need to judge it first before anyone else might? **147-** 'pain of the world': world as a source or place of suffering? Needing to prepare self for it? Sense of being on her own against the world? Lack of support against unimaginable pain? **148-** need to get to the pain first. If pain is

Appendix I: Tables of Themes - Kate

KATE, INTERVIEW 1

EMERGENT THEMES	SUPERORDINATE THEMES and SUBTHEMES
1) Does this Count? (22-29,36,232-236) 2) Confusing Pleasure with Pain (46-51, 55, 62-66, 460-462) 3) Taking it out on Myself (85, 87-92, 99-102, 104, 414-423, 543, 550) 4) Feeling Defective (114-122, 124, 126-129, 524-529) 5) Taking Control of the Hurt (130-132, 141, 146-148, 154-155, 512-515, 517-518, 536-541) 6) Life without a Shell (151-152, 157-158, 160-163) 7) Dr Jekyll, Mr Hyde (170-178, 193-206, 358-373) 8) You are not a freak! (219-230) 9) It's about me! (241-246) 10) Going through the Motions (272-275, 277-281, 185-287) 11) The Challenge of Self-Care: i) Self-Care as Means to Conceal (292-294) ii) Doing the Bare Minimum (300-303) iii) Self- Care as a Way of Shutting Them Up (309-318, 320-325, 327) iv) Letting the Love in (330-335, 338-341, 352, 373) v) Disgusting positives (486, 488-490) 12) The Things I couldn't be (388-404/ 531-534) 13) As if Nothing Ever Happened (429-438) 14) My Weapon of Choice (442-446, 449-451, 453-456) 15) My loyal, protective friend (472-474, 476-478)	**1) Struggling to Make Sense** -Does this count? (1, 9) -Confusing Pleasure and Pain (2) - You are not a freak (8) **2) Fragmented Self** -Dr Jekyll, Mr Hyde (7) -Going through the Motions (10) -As if nothing ever happened (13) **3) Something's Wrong with Me** -Feeling defective (4) -The things I couldn't be (12) **4) With Self – Harm by My Side** -Taking Control of the Hurt (5) -Life Without a Shell (6) -My loyal, protective friend (15) **5) The Challenges of Self Care** -Doing the bare minimum (11ii) -To shut them up (11i, 11iii) - The struggle of letting good in (11iv, 11v) **6) Deserving Punishment** - Taking it out on myself (3) - My weapon of choice (14)

KATE, INTERVIEW 2

<table>
<tr><th>EMERGENT THEMES</th><th>SUPERORDINATE THEMES and SUBTHEMES</th></tr>
<tr><td>1) Searching for Answers (32-37, 63-66, 68-73, 413-419)
2) Connecting the Dots (48-60, 78-89, 94-104)
3) Feeling Different: On the Outside Looking in (108-116, 118-121, 123-125)
4) Playing Catch-up (128-129, 192-203)
5) Taking it out on me (131-136, 138-140, 142-149, 151-153, 207-208, 210-215)
6) It had to come out of somewhere: SI as an outlet (159-165, 167-169, 171-172, 174-179, 343-347)
7) The inevitability of SI/ The inevitable nature of SI/ It's Inevitable (228-229, 231)
8) Bullseye (250-252, 254-258, 260-261, 263-271, 273-374, 299-301, 314-316, 321-325)
9) In search for the ultimate harm (277-280, 282-284, 286-287, 296-297)
10) Self-care in the punishment: the contradicting function of SI (332-335)
11) Controlling the Hurt (337-341)
12) Speaking/Unearthing the Uncomfortable (362-375, 407-411)
13) Acquiring Compassionate Outlets (376-382, 452-455)
14) Learning to Talk 386-390 (can go in 12?)
15) Not the only one 395-403
16) Unleashing the Kraken (429-430, 441-444)
17) Therapy alone is not enough/what helps (431-440)
18) In a much better place (461-465)
19) The importance of psychoeducation (480-481, 483-488)
20) Slow and Steady: the therapeutic journey towards healing (499-506, 515-520, 522-532, 544-552)
21) Please don't flinch, I am not a freak (562-569)
22) I was not to blame (603-606, 615-627, 669-671?)</td><td>1) Searching for Answers
-Connecting the Dots (1, 2)
-On the Outside Looking In (3, 4)

2) Function in the Harm
- An inevitable outlet (6,7)
-Self-care in the punishment (10)
-Controlling the Hurt (11)

3)The Makings of Self-Injury
-Taking it out on me (5)
-The Quest for the Ultimate Hurt (9)
-Bullseye: Hitting the Spot (8)

4)The Healing Journey
-The importance of supportive others (16,17,21)
-Slow and Steady: navigating the therapeutic process (12, 13, 14,15, 19, 20)
-In a much better place (18, 22)</td></tr>
</table>

Superordinate Themes

Superordinate Theme 1: Struggling to Make Sense

Subthemes	Emergent Themes from	
Subtheme 1: Does this Count?	First Interview: **1, 9**	
Subtheme 2: Confusing Pleasure and Pain	First Interview **2**	
Subtheme 3: Connecting the Dots	First Interview: **8**	Second Interview: **1, 2**

Superordinate Theme 2: Something's Wrong with Me

Subthemes	Emergent Themes from	
Subtheme 1: Dr Jekyll, Mr Hyde	First Interview: **7, 10, 13**	
Subtheme 2: The Things I Couldn't Be	First Interview: **4, 12**	
Subtheme 3: Trying to catch-up		Second Interview: **3, 4**

Superordinate Theme 3: With Self – Harm by My Side

Subthemes	Emergent Themes from	
Subtheme 1: Taking Control of the Hurt	First Interview: **5**	Second Interview: **10 and 11**
Subtheme 2: My Protective Friend	First Interview: **6, 15**	
Subtheme 3: An Inevitable Outlet		Second Interview: **6, 7**

Superordinate Theme 4: Relating to Myself

Subthemes	Emergent Themes from	
Subtheme 1: Taking it Out on Me	First Interview: **3**	Second Interview: **5**
Subtheme 2: The Quest for the Ultimate Harm	First Interview: **14**	Second Interview: **8, 9**
Subtheme 3: Struggling to Care	First Interview: **11**	

Superordinate Theme 5: The Healing Journey

Subthemes	Emergent Themes from	
Subtheme 1: The Importance of Supportive Others		Second Interview: **16, 17, 21**
Subtheme 2: Slow and Steady: Navigating the Therapeutic Process		Second Interview: **12, 13, 14, 15, 19, 20**
Subtheme 3: In a Much Better Place		Second Interview: **18, 22**

Appendix J: Tables of Themes - Isabelle

ISABELLE INTERVIEW 1

EMERGENT THEMES	SUPERORDINATE THEMES and SUBTHEMES
1) Calling it what it is/Realising Self-Injury (14-15, 17-20, 56-60) 2) Finding Pleasure in an Unpleasant Thing (24-26, 109-112, 907-909) 3) Self-Harm is something that's bad for you (41, 43-46) 4) SH as a form of Release (63-66, 69-70, 72-74) 5) It's how you cope (92-96, 876-881) 6) I'm not a robot (99, 102-103) 7) What have I done? (114-115, 154-157, 326-328, 583-587, 827-829, 942-943, 945-947, 949-950) 8) Intensity is Something I like (118-120, 124-125, 856-859) 9) Relieving the Unbearable (135-137, 141-142) 10) It's like an Orgasm (178-180, 183-184, 186, 189-190) 11) It's in the Blood/It needs to Burst Open (248-250, 252, 300-302, 309-311+ 314-316) 12) Facing Reality (334-336, 344-346) 13) There's something wrong with me (350-351, 354-355, 360-362,365-368, 374-377+ 862-864) 14) It starts with an itch (397-402) 15) It's in the Skin: GSI in the context of a skin condition (448-450, 471-472, 474-476, 483-484, 496-497, 847-850, 501-503)	**1) Destructive Pleasure** -Relieving the Unbearable (9, 14) -It's like an Orgasm (10, 4,) -It's in the blood (11) -Intensity is something I like (8) -Finding pleasure in an unpleasant thing (2) **2) It's in the name** -Calling it what it is (1) -Self-harm is something that's bad for you (3) **3)The function in the harm** -It's how you cope (5) -I am not a robot (6) -Disconnected Self (18) **4) Feeling Defective** -There is something wrong with me (13) -It's in the skin (15, 16) -It's what you deserve (17) -What have I done? (7) -Facing Reality (12) **5) The challenge of self-care** - Self-care isn't my strong point (19a) - It starts when you are young (20a) - Doing the basics (20b) - Self-care means loving myself (19b)

16) It was given to me I had no choice (542-545, 564-566) 17) It's what you deserve 519-524, 528-529, 590-591, 770-773 18) Dissociation as a mediating factor to GSI (604-605, 609-611, 615-616, 624-630, 635-639) 19) a) Self-Care isn't my strong point (737, 740-745) Self-care is loving yourself 789-795 20) a) It starts when you are young, 750-752, (756) Doing the Basics 759-761, 799-803	

SUPERORDINATE THEMES	INITIAL SUBTHEMES	FINAL SUBTHEMES
1) It's in the name	-Calling it what it is (1,) -Self-Harm is something that's bad for you (3)	-Calling it what it is (1,) -Self-Harm is something that's bad for you (3)
2) Destructive Pleasure	Relieving the unbearable (9,14) It's like an orgasm (10, 4) Needing to burst open (11) Intensity is something I like (8) Finding Pleasure in an Unpleasant Thing (2)	Relieving the Unbearable (4, 10, 9, 11, 14) Finding Pleasure in an Unpleasant Thing (2, 8)
3) The function in the harm	-It's how you cope (5) -I am not a robot (6) -Disconnected Self/Reconnecting the Self (18)	-It's how you cope (5) -Dealing with a disconnected self (6, 18)
4) Feeling Defective	-There's something wrong with me (13) -It's in the Skin (15, 16) -It's what you deserve (17) -What have I done? (7) -Facing Reality (12)	-There's something wrong with me (13) -The Skin I live in (15, 16) -It's what you deserve (17) -What have I done? (7, 12)
5) The Challenge of Self-care	-Self-care isn't my strong point (19a) -It starts when you are young (20a) -Doing the Basics (20b) -Self-Care means I love myself (19b)	-Self-care isn't my strong point (19 a, 19b,) -It starts when you are young (20a, 20b)

Appendix K: Ethical Approval – July 2019

City, University of London

Dear Elli

Reference: ETH1819-0875

Project title: The experience of genita self-injury in adult females: An Interpretative Phenomenological Analysis

Start date: 1 Aug 2019

End date: 30 Sep 2020

I am writing to you to confirm that the research proposal detailed above has been granted formal approval from the Psychology committee: medium risk. The Committee's response is based on the protocol described in the application form and supporting documentation. Approval has been given for the submitted application only and the research must be conducted accordingly. You are now free to start recruitment.

The approval was given with the following conditions:

- **Any space used for interviews within the mental health service is separate from the one used for therapy.**
- **The standard text re complaints is added to the bottom of the recruitment flyer - see template at https://www.city.ac.uk/research/ethics/how-to-apply/participant-recr...**

Please ensure that you are familiar with City's Framework for Good Practice in Research and any appropriate Departmental/School guidelines, as well as applicable external relevant policies.

Please note the following:

Project amendments/extension

You will need to submit an amendment or request an extension if you wish to make any of the following changes to your research project:

- Change or add a new category of participants;
- Change or add researchers involved in the project, including PI and supervisor;
- Change to the sponsorship/collaboration;
- Add a new or change a territory for international projects;
- Change the procedures undertaken by participants, including any change relating to the safety or physical or mental integrity of research participants, or to the risk/benefit assessment for the project or collecting additional types of data from research participants;
- Change the design and/or methodology of the study, including changing or adding a new research method and/or research instrument;
- Change project documentation such as protocol, participant information sheets, consent forms, questionnaires, letters of invitation, information sheets for relatives or carers;
- Change to the insurance or indemnity arrangements for the project;
- Change the end date of the project.

Adverse events or untoward incidents

You will need to submit an Adverse Events or Untoward Incidents report in the event of any of the following:

a) Adverse events

b) Breaches of confidentiality

c) Safeguarding issues relating to children or vulnerable adults

d) Incidents that affect the personal safety of a participant or researcher

Issues a) and b) should be reported as soon as possible and no later than five days after the event. Issues c) and d) should be reported immediately. Where appropriate, the researcher should also report adverse events to other relevant institutions, such as the police or social services.

Should you have any further queries relating to this matter, please do not hesitate to contact me. On behalf of the Psychology committee: medium risk, I do hope that the project meets with success.

Kind regards

Psychology committee: medium risk

City, University of London

Ethics ETH1819-0875: Elli Kimpouropoulou (Medium risk)

Appendix L: Approval of Amendments - February 2020

City, University of London

Dear Elli

Reference: ETH1920-0920

Project title: The experience of genita self-injury in adult females: An Interpretative Phenomenological Analysis

Start date: 1 Aug 2019

End date: 30 Sep 2020

I am writing to you to confirm that the research proposal detailed above has been granted formal approval from the Psychology committee: medium risk. The Committee's response is based on the protocol described in the application form and supporting documentation. Approval has been given for the submitted application only and the research must be conducted accordingly. You are now free to start recruitment.

Please ensure that you are familiar with City's Framework for Good Practice in Research and any appropriate Departmental/School guidelines, as well as applicable external relevant policies.

Please note the following:

Project amendments/extension

You will need to submit an amendment or request an extension if you wish to make any of the following changes to your research project:

- Change or add a new category of participants;
- Change or add researchers involved in the project, including PI and supervisor;
- Change to the sponsorship/collaboration;
- Add a new or change a territory for international projects;
- Change the procedures undertaken by participants, including any change relating to the safety or physical or mental integrity of research participants, or to the risk/benefit assessment for the project or collecting additional types of data from research participants;
- Change the design and/or methodology of the study, including changing or adding a new research method and/or research instrument;
- Change project documentation such as protocol, participant information sheets, consent forms, questionnaires, letters of invitation, information sheets for relatives or carers;
- Change to the insurance or indemnity arrangements for the project;
- Change the end date of the project.

Adverse events or untoward incidents

You will need to submit an Adverse Events or Untoward Incidents report in the event of any of the following:

a) Adverse events

b) Breaches of confidentiality

c) Safeguarding issues relating to children or vulnerable adults

d) Incidents that affect the personal safety of a participant or researcher

Issues a) and b) should be reported as soon as possible and no later than five days after the event. Issues c) and d) should be reported immediately. Where appropriate, the researcher should also report adverse events to other relevant institutions, such as the police or social services.

Should you have any further queries relating to this matter, please do not hesitate to contact me. On behalf of the Psychology committee: medium risk, I do hope that the project meets with success.

Kind regards

Psychology committee: medium risk

City, University of London

Ethics ETH1920-0920: Elli Kimpouropoulou (Medium risk)

Appendix M: Approval of Amendments – January 2022

City, University of London

Dear Elli

Reference: ETH2122-0468

Project title: The experience of genital self-injury in adult females: An Interpretative Phenomenological Analysis

Start date: 1 Aug 2019

End date: 30 Sep 2020

I am writing to you to confirm that the research proposal detailed above has been granted formal approval from the Psychology committee: medium risk. The Committee's response is based on the protocol described in the application form and supporting documentation. Approval has been given for the submitted application only and the research must be conducted accordingly. You are now free to start recruitment.

Please ensure that you are familiar with City's Framework for Good Practice in Research and any appropriate Departmental/School guidelines, as well as applicable external relevant policies.

Please note the following:

Project amendments/extension

You will need to submit an amendment or request an extension if you wish to make any of the following changes to your research project:

- Change or add a new category of participants;
- Change or add researchers involved in the project, including PI and supervisor;
- Change to the sponsorship/collaboration;
- Add a new or change a territory for international projects;
- Change the procedures undertaken by participants, including any change relating to the safety or physical or mental integrity of research participants, or to the risk/benefit assessment for the project or collecting additional types of data from research participants;
- Change the design and/or methodology of the study, including changing or adding a new research method and/or research instrument;
- Change project documentation such as protocol, participant information sheets, consent forms, questionnaires, letters of invitation, information sheets for relatives or carers;
- Change to the insurance or indemnity arrangements for the project;
- Change the end date of the project.

Adverse events or untoward incidents

You will need to submit an Adverse Events or Untoward Incidents report in the event of any of the following:

a) Adverse events

b) Breaches of confidentiality

c) Safeguarding issues relating to children or vulnerable adults

d) Incidents that affect the personal safety of a participant or researcher

Issues a) and b) should be reported as soon as possible and no later than five days after the event. Issues c) and d) should be reported immediately. Where appropriate, the researcher should also report adverse events to other relevant institutions, such as the police or social services.

Should you have any further queries relating to this matter, please do not hesitate to contact me. On behalf of the Psychology committee: medium risk, I do hope that the project meets with success.

Kind regards

Psychology committee: medium risk

City, University of London

Ethics ETH2122-0468: Miss Elli Kimpouropoulou (Medium risk)

Section B
Extended Case Study

"Uncomfortable in My Own Skin": The relationship between early maladaptive schemas and atopic dermatitis.

An Extended Case Study Using Schema Therapy

This content has been redacted for confidentiality purposes.

Section C:
Publishable Journal Article

Formatted according to the author guidelines for the Journal of Trauma and Dissociation

“It’s how you cope”: The Experience of Genital Self-Injury in Adult Women

The full text of this article has been removed for copyright purposes.