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Title: ‘Understanding the role of anger in self-harm: An Interpretative Phenomenological Analysis’.

Author: Wendy Patricia Scott

Thesis submitted in fulfilment of the requirements for the award of
Doctorate in Counselling Psychology
at
City University
Dept of Psychology (School of Social Sciences).

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NB: Research conducted within Coventry PCT NHS Trust

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‘I Wendy Scott the author of this thesis hereby grant powers of discretion to the City university librarian to allow the thesis to be copied in whole or in part without further reference’.

General Foreword:

This thesis contains four main sections each of which looks at different but connected areas of enquiry. Although the sections are connected by the subject of anger some of the sections seemed to require a subjective approach whilst others seemed to require a more objective approach therefore first person and third person narratives are used as follows.

Section A will be related in the first person to demonstrate the personal nature of the account and the reflective stance taken in introducing the reader to an overview of the thesis. Section B in the thesis will largely use the third person to demonstrate a more objective stance to the subjective accounts given by the participants. This is to reflect a more rigorous approach to the research undertaken. However there will be a departure in some of the paragraphs when personal reflections are narrated in line with the tradition of qualitative enquiries. These will be highlighted to the reader by the use of italics. Section C will be related in the first person to demonstrate the reflective nature of enquiry when exploring the therapeutic processes involved in a case study. Finally section D will be related in the third person as this section seemed to require an objective approach when reviewing literature.

PART A:

GENERAL INTRODUCTION

1. BRIEF OVERVIEW:

The main theme of each part of this thesis is anger, particularly looking at the way that the clinical identification of anger difficulties in the region of a complex diagnosis may be understood and treatment applied in clinical practice. My interest in anger grew after working with a number of clients whose diagnosis varied but all seemed to be having difficulties with both the feelings of anger they had and with expressing it. They had not been specifically referred for anger management as they might have been if they had encountered difficulties because of expressing anger in aggressive or violent forms. My interest was about the way that clients seemed to have difficulties with expressing anger in any form at all. In particular where they appeared to sometimes suppress the anger they felt and as a result this appeared to create further problems for them. The group of clients that seemed to have the most difficulties in this area were those with complex diagnosis and especially those who self-harmed, or had trauma symptoms, or had endured childhood abuse.

Initially I looked at gender differences as a possible explanation for the variance as I was seeing a lot more female clients with the type of difficulties described above. The gender aspect of anger was explored in the literature review (part D) which looked at the gender differences in the experiences and expression of anger. This mainly revealed that although gender differences were found to have some influence the review also highlighted the need to see things in broader contexts than just gender alone.

Developing on from this my interest turned towards the self-harming behaviour of clients. I frequently encountered clients who would self-harm after having feelings of anger that they felt they could not express. I began to search the literature on this aspect of self-harm but found the literature on participants views about self-harm was sparse and anger difficulties in self-harm were covered in a minor way often within the terms of broader affect problems (Allen, 2001; Babiker & Arnold, 2001; Conterio & Lader, 1998). This did not satisfy my need to know why anger appeared to have

such a powerful influence on clients' behaviour. Therefore, for the main research component of the thesis (part B) examined the view of participants about the role of anger in their self-harming behaviour. Finally the case study (part C) was chosen to hopefully demonstrate what it can be like to work with the type of complex presentation where anger, self-harm, childhood abuse and PTSD are all present in a single client case. It is further hoped that readers may benefit from following the construction of the formulation used in this case and how the use of a specific technique for processing traumatic memories may be of benefit in similar cases.

1.1 REFLECTIONS ON CHOOSING THE SUBJECT FOR RESEARCH:

In recognition of the traditions of qualitative approaches to research, I will give a brief account of why I chose to explore the role of anger in self-harm.

This journey started when I became aware of anger as a feature of self-harm from the accounts of clients I worked with. Some of these clients attended group sessions of therapy that I co-ran with other colleagues and others I had worked with on a one to one basis. The prominent emotional feature in their accounts was that of anger which seemed to be a component of the distress felt during the period that led to self-harm. I initially looked at the self-harm literature for guidance as to what I may do to help the clients I saw but very quickly realised that the literature was very limited in this respect. There also seemed to be an absence of literature about how to work therapeutically with those that self-harmed and whose main difficulties appeared to be with anger. I turned to the general literature on anger for guidance but the therapeutic models here did not seem to fit the clinical picture for those who self-harmed. This was to be the beginning of my search into the various components of anger in the area of self-harming behaviour.

In the absence of enough literature and research into anger's role in self-harm I was mindful that the accounts from the perspective of clients would need to be given prominence. Therefore the research study was concerned with the views of those who self-harm and to discuss the role of anger in their self-harming behaviour. Therefore to capture the views from the perspective of participants, a qualitative study was chosen.

1.2 THE RESEARCH COMPONENT:

Due to the in depth accounts given by participants in the study it was possible to map where anger featured at the time of self-harming. Findings from the study highlighted the need for anger to be elevated as a factor when considering the aetiological factors of self-harming behaviour. Therefore, therapeutic interventions may need to incorporate interventions for anger as a component of their attempts to reduce the self-harming behaviour of clients. Several preliminary suggestions for effective therapeutic intervention have been discussed.

1.3 THE CASE STUDY:

Research into the treatment of PTSD (posttraumatic stress disorder) has gained substantial momentum in recent years (Resick, 2001; Joseph et al, 1999). However there are always gaps in the literature that cannot cover every aspect of an individual case or type of presentation. This is particularly the case where complex factors feature together and there may be co-morbidity in the diagnosis. The case chosen for examination qualified for a PTSD diagnosis where the client had experienced a recent traumatic event. However there were other factors present such as self-harming behaviour, anger difficulties and childhood antecedent factors. The use of imaginal exposure in processing traumatic memories related to an event occurring in childhood has been described (Arntz, & Wertman, 1999). Also reflections on the use of this technique and what was learned from the process of working with complex factors have been highlighted.

1.4: THE LITERATURE REVIEW:

The review was concerned with examining the gender differences in the experience and expression of anger. The focus on gender difference was in response to the appearance that there may be a differential diagnosis given to men and women who displayed difficulties with anger. If therapeutic treatment is linked to diagnosis then it seemed important to understand as many of the factors that account for the differences. The areas highlighted in the review cover stereotypical beliefs of what are appropriate displays, consequences of suppression of anger, gender differences found in relation to what experiences make men and women angry and the interpersonal and relational factors that mediate in terms of accepted forms of expression of anger.

These factors may have important implications for the therapeutic treatment of those with anger difficulties.

1.5 REFLECTIVE THREADS:

The thread that runs through each part of this submission is that of the role that anger has in some mental health difficulties that bring people into therapy. Research into anger seems to be largely concentrated on the consequences of aggressive and violent displays of anger. Finding literature looking at other aspects of anger was difficult. A recent publication from the perspective of personal construct psychology brings together various aspects of anger and treatment approaches that were helpful. In particular ideas about gender differences and keeping anger in or suppressed were discussed (Cummins, 2006).

Personal experience has pointed to a lack of anger treatment in some psychology services at present and this may be linked to the lack of a diagnostic framework in DSM or ICD criteria (APA, 2000; WHO, 2004). It is hoped that the research carried out and reported in this thesis will inspire more research into anger in general and in the area of self-harm. It is also hoped that the findings will directly inform current therapeutic practice especially in terms of treating those with self-harm difficulties. What seems to be a significant focus for future treatment is the difference in treating anger at the 'what is it that makes me angry' level and not just the 'inappropriate display of anger that has to be managed' level (terms borrowed from Cummins, 2006). Personally I have found the use of this approach with understanding of the different contextual factors leading to anger affect helpful in trying to help clients reduce the need to self-harm.

Similar issues in the case study where the individual had a complex number of difficulties were highlighted. The therapeutic approach emphasised the use of a comprehensive formulation and levels of cognitive processing of past traumatic events as important. Reflections on the case may aid others who work with similar issues. The use of a specific therapeutic technique is highlighted and would be useful to practitioners where past events are compounding recent trauma symptoms.

Finally the literature review may help others to take into consideration the effects of gender/sex role differences in anger and of the cultural and social factors that determine these. In therapeutic terms it might be useful to consider these factors when working with individuals who may have diverse backgrounds and experiences. Stereotypical assumptions in the therapist may possibly be avoided and open up new levels of understanding in terms of formulation and treatment. The lack of expression of anger as well as aggressive and violent expression points to the possibility of different consequences so it may be important to understand both aspects especially in the field of self-harm. If there are different sanctions and consequences according to gender on those aspects such as differential diagnosis then this may be an important area for further examination.

References:

American Psychiatric Association. (2000) DSM-IV-TR, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, TM. Arlington, VA: American Psychiatric Association.

Arntz, A. & Wertman, A. (1999) Treatment of Childhood Memories: Theory and Practice. *Behaviour Research and Therapy*. Vol, 37. 715-740

Cummins, P (2006) Working with Anger: A constructivist approach. Chichester; Wiley.

Joseph, S., Williams, R. & Yule, W. (1999) Understanding Post-Traumatic Stress. A Psychosocial Perspective on PTSD and Treatment. Chichester: Wiley & Sons.

Resick, P.A. (2001) Stress and Trauma. Hove: Psychology press.

WHO (World Health Organisation), (2004) ICD-10 Classification of Mental and Behavioural Disorders: Clinical descriptions and diagnostic guidelines. Geneva: WHO

Part B:

RESEARCH:

TITLE: ‘Understanding the role of anger in self-harm: An Interpretative Phenomenological Analysis’.

FOREWORD:

Before readers embark on the journey through the research component of this thesis (part B) I would like to draw attention to my adoption of a third person position in most of the writing to reflect a more formal stance towards the subject under investigation and to reflect the rigour of the study. I move to the first person when reporting on my personal reflections towards the study in the traditions of reflexivity in qualitative studies. For the benefit of readers I have highlighted when I have moved out of the third person to first person throughout this section of the thesis by the use of italics.

ABSTRACT:

AIM:

To understand the role of anger within the experience of self-harm.

METHOD:

Eight adults who had self-harmed within the previous six weeks were interviewed to elicit experiences of self-harm and the role anger played within their self-harming behaviour. Transcripts of the interview data was analysed using Interpretative Phenomenological Analysis.

ANALYSIS:

Analysis revealed four super-ordinate themes. 1) Unbearable Mental Anguish 2) Regulation of method 3) Relieving mental anguish 4) Self-harm is taboo. The pathways between the super-ordinate themes were revealed and this showed that anger experiences were consistently found across participants accounts. It appears that anger experiences play a significant role in the experiences leading to self-harm and between depression experiences and self-harm.

CONCLUSIONS:

This study has highlighted the need for anger to be elevated as a factor when considering the aetiological factors of self-harming behaviour. Therapeutic interventions may need to incorporate anger affect as a component of their attempts to reduce the self-harming behaviour of clients. Further research is required to establish the extent to which anger factors are a common feature and antecedent factor of self-harming behaviour across the population of those who self-harm. As this study has placed the views of those who self-harm centrally in the analysis this has provided in depth and qualitative data that may not have been captured using standardised questionnaire measures. Limits in terms of size of sample used can be addressed in future research by incorporating questions on anger highlighted in this study.

LIST OF ABBREVIATIONS USED IN SECTION B:

APA	= American Psychiatric Association
ASP	= Anti-Social Personality Disorder
BPD	= Borderline Personality Disorder
BPS	= British Psychological Society
BSI	= Brief Symptom Inventory
CBT	= Cognitive Behavioural Therapy
DBT	= Dialectical Behavioural Therapy
DSM-IV (TR)	= Diagnostic and Statistical Manual No 4 Text Revision (2000)
HPD	= Histrionic Personality Disorder
ICD-10	= International Category Dimensions
MCMI-III	= Millon Clinical Multi-Axial Inventory; version 3
NCCMH	= National Collaborating Centre for Mental Health
NHS	= National Health Service
NICE	= National Institute for Clinical Excellence
PCT	= Primary Care Trust
PTSD	= Post-Traumatic Stress Disorder
RCP	= Royal College of Physicians
TSI	= Trauma Symptom Inventory
WHO	= World Health Organisation

CHAPTER 1: LITERATURE REVIEW

1 DEFINITION AND PHENOMENOLOGY:

1.1 DEFINITIONS

Within the existing literature, definitions of self-harm/self-injury vary enormously. Broader definitions tend to include all self-harming acts including poisoning and overdosing whereas narrower definitions tend to focus on a single criteria such as self-wounding (acts of cutting the body or self-mutilation). The inclusion of self-poisoning and overdosing in the definition of self-harm is usually dependent on the absence of suicidal intent (Jeffrey & Warm, 2002, Allen, 2001, Kennerley, 2004) although this distinction can be problematic as suicidal intent may be subject to ambivalent and competing emotions (Babiker & Arnold, 2001).

Conterio & Lader (1998) define self-injury as the deliberate mutilation of the body or body part, not with the intent to commit suicide but as a way of managing emotions that seem too painful for words to express. As mentioned earlier, sometimes the distinction between self-harm from suicide is difficult, for example, the absence of intent may still lead to death and the presence of intent be thwarted by the intervention of others thus preventing the intended death, making it difficult to accurately distinguish self-harm from a suicidal act (Allen, 2001).

Turp's (2003) definition incorporates the concept of self-neglect. Lack of care or self-neglect as self-harm by omission. I.e., self-imposed sleep deprivation, failure to seek medical attention or overwork. To summarise Turp's (2003, p36.) position, she defines self-harm as 'avoidable physical harm to self either by omission or commission and that breaches the limits of acceptable behaviour as applied in the time and place of enactment and leads to a strong emotional reaction from others'.

In a comprehensive review, Babiker & Arnold, (2001) classify self-harming and self-injurious behaviours according to their function. Thus the term *self-injury* is applied to cutting, scraping, hitting and burning acts etc, and *self-harm* is applied to suicidal, para-suicidal and overdosing acts. Other forms of harm are defined under the terms, *self-destructive behaviours* (for e.g., eating disorders, substance abuse, sexual risk-taking), *somatic expressions of feeling* (for e.g. for skin disorders, pain and accident proneness), *factitious disorders* (for e.g. Munchausen's syndrome, simulated illness and polysurgery), *body enhancement* (for e.g. cosmetic surgery, tattooing, piercing and bleaching) and finally *other marginal and self-injurious behaviours* (for e.g. smoking, reckless driving, work holism, and danger sports). These distinctions make it possible to explore the subtleties of difference between all the self-harmful behaviours described and the distinctive features of self-injury and its function in terms of survival. The view of Babiker & Arnold (2001) is that the act of self-injury as defined is an attempt at self-preservation and not self-destruction, which seems to be an important distinction.

Turp's (2003) definition of self-harm is broader and is a little more difficult to distinguish between the different types of behaviour and the functions mentioned previously by Babiker & Arnold, (2001). However both of these examples are useful in their conceptualisations of self-harm. Turp's (2003) example includes information on the hidden types of self-harm whilst Babiker & Arnold's (2001) compares and contrasts different types of self-destructive behaviours. Babiker & Arnold's (2001) emphasise the differences in intention, purpose and lethality in order to understand the function of self-injury.

For the purposes of this study it seemed necessary to include a wide enough definition that encompassed the different forms of self-harmful acts that were not just restricted to self-injury as described by Babiker & Arnold (2001) but made a distinction between suicide attempts. Therefore both Turp's (2003) and Allen's (2001) definitions were included to encompass the relevant range of behaviours that were described by all the other authors cited in the field of self-harm.

To summarise, the definition of self-harm that was used in this research was as follows: **‘an act or behaviour that results in physical harm to the self that breaches accepted norms culturally and by self report was not intended to end the person’s life’** (please see appendix 1).

1.2 EXAMPLES OF BEHAVIOURS:

A wide range of behaviours were included in the literature above and some examples that give a broad overview of these are listed as follows:-

- Bodily injury external e.g. by cutting, scratching, burning etc (Conterio & Lader, 1998, Smith et al, 1998, Gardner, 2001, Allen, 2001)
- Bodily injury internal e.g. ingestion of substances such as cleaning fluid, tablets, razors, safety pins etc (Smith et al, 1998, Conterio & Lader, 1998, Allen, 2001)
- Self-destructive behaviour such as being reckless enough that it is likely to put self and or others in danger e.g. driving vehicles too fast, aggression, alcohol/drug abuse, eating disordered behaviour, impulsive acts, taking high risks etc (Allen, 2001).

1.3 ICD-10 & DSM –IV-TR DIAGNOSTIC CRITERIA FOR SELF-HARM:

Within ICD 10 (WHO, 2004, p 204) the only reference to self-harm lies within the diagnostic category of ‘Emotionally unstable personality disorder’ described as:-

‘A personality disorder in which there is a marked tendency to act impulsively without consideration of the consequences, together with affective instability. The ability to plan ahead may be minimal, and outbursts of intense anger may often lead to violence or “behavioural explosions”, these are easily precipitated when impulsive acts are criticized or thwarted by others. Two variants of this personality disorder are specified, and both share this general theme of impulsiveness and lack of self-control’.

F60.31 (p205) specifically Borderline type contains the reference to self-harm as follows:-

‘Several of the characteristics of emotional instability are present; in addition, the patient’s own self-image, aims, and internal preferences (including sexual) are often unclear or disturbed. There are usually chronic feelings of emptiness. A liability to become involved in intense and unstable relationships may cause repeated emotional crises and may be associated with excessive efforts to avoid abandonment and a series of suicidal threats or acts of self-harm (although these may occur without obvious precipitants)’.

The reference to self-harm here seems a bit vague in that it states that ‘acts of self-harm can be associated with efforts to avoid abandonment’, ‘although can occur without this as a precipitant’ and gives no further guidelines as to what other precipitants are likely. This is a much shorter descriptive account of behaviour without the level of distinctions afforded by the DSM-IV-TR (APA, 2000 p710) on borderline personality disorder.

The only criteria directly related to self-harm in DSM-IV-TR (APA, 2000) is contained within the criteria for borderline personality disorder in category 5 below. The general descriptive features of borderline personality disorder from DSM-IV-TR (APA, 2000) is ‘a pervasive pattern of instability in interpersonal relationships, self-image, and affects and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five or more of the following’:

- 1. frantic efforts to avoid real or imagined abandonment. Note: do not include suicidal or self-mutilating behaviour covered in Criterion 5.***
- 2. a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation***
- 3. identity disturbance: markedly and persistently unstable self-image or sense of self***
- 4. impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.***

5. *recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour*
6. *affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)*
7. *chronic feelings of emptiness*
8. *inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)*
9. *transient, stress-related paranoid ideation or severe dissociative symptoms*

DSM-IV-TR (APA, 2000)

There are two issues with regard to personality diagnosis as described in DSM-IV-TR (APA, 2000). Firstly, from my own clinical experience of working in this field many who self-harm would not meet the required five categorical descriptions for the diagnosis of borderline personality disorder and some have features that meet other personality disorder criteria (e.g. avoidant, depressive or histrionic) or other co-morbid disorders (e.g. anxiety or depression). Secondly, there is disagreement amongst authors as to the usefulness of the categorisations used in DSM-IV-TR (APA, 2000) and the pejorative nature of the term personality disorder (Roth & Fonagy, 1996, p200).

The DSM-IV-TR (APA, 2000) sets out the problematic behaviours of various disorders but it was never designed to conceptualise or formulate the nature and origin of the problems it presents (Bell, 2003). Conceptualisations of borderline personality disorder in the literature are based on clinician experience and little research has been carried out to test the various categorical dimensions (Linehan, 1993; Bateman & Fonagy, 2004; Kennerley, 2004). This is partly due to the large numbers of categories contained in borderline personality disorder and estimates vary as to the number of ways that someone can meet the criteria Bateman & Fonagy, (2004).

Several authors have examined the symptoms that are present in adulthood as a result of childhood sexual abuse (Bell, 2003; Van der Kolk, 1998; Chu, 1998),

which seemed to fit within the diagnostic criteria of borderline personality disorder in DSM IV TR, (APA 2000). This suggested that borderline personality disorder could be a result of suffering childhood sexual abuse (Bell, 2003). However, Koerner & Linehan (1996) carried out a review of the literature on borderline personality disorder and found several methodological flaws. They found that family psychopathology may have been a more important causal factor of borderline personality disorder than childhood sexual abuse. They concluded that childhood sexual abuse therefore cannot always be directly linked as a causal factor of borderline personality problems.

To summarise: it appears that there is considerable overlap within the literature on childhood abuse and borderline personality disorder both of which feature highly in the literature on self-harm. However no direct causal links can yet be assumed between childhood abuse and borderline personality disorder. Self-harm only features within the borderline personality disorder criteria which may leave out those who do not meet the borderline personality disorder diagnosis within DSM –IV-TR(APA, 2000) & ICD-10 (WHO, 2004).

Therefore it is essential that an individual formulation or conceptualisation be carried out on each person who self-harms to determine the function of the self-harming behaviour and any relationship to other psycho-pathological features (Sidley, 1998).

1.4 NICE GUIDELINES:

NICE (National Institute for Clinical Excellence) who commissioned an extensive review on the current literature on self-harm. Guidelines were published as to appropriate treatment for self-harm covering all mental health services within the National Health Service in England and Wales (National Collaborating Centre for Mental Health, 2004).

The guidelines specifically address the way that services within the NHS should respond within the first 48 hours after an episode of self-harm and does not consider in detail the longer-term care of people who self-harm, including those who repeatedly self-harm (NCCMH, 2004).

An extensive review of literature on self-harm was carried out and several recommendations were put forward. The definition adopted by the guideline is that self-harm covers both, self-poisoning or self-injury regardless of the purpose of the act and has dropped the term 'deliberate' from self-harm in recognising that for some self-harm is sometimes carried out outside of the persons awareness (whilst in a dissociated state for example). Similarly with suicide the term 'commit' has been dropped as again suicide can occur outside of awareness or of intent and these have been recognised to cause offence or distress to service users (NCCMH, 2004).

From experience the word 'attempt' after suicide can also be seen negatively by those who have absolutely intended to kill themselves but where intervention by third parties or mistakes were made, had prevented the outcome intended. Sensitivity on the terminology used within the various definitions for people who self-harm has been helpful and adopted within this text and research.

2. EPIDEMIOLOGY:

2.1 PREVALENCE OF SELF-HARM:

It is difficult to get a true picture of the rate of self-harming as people who self-harm may not report their self-harm or come into contact with official services (NCCMH, 2004; Hawton, et al, 2002a; Bowen, & John, 2001; Babiker & Arnold, 1997).

Another difficulty is the type of self-harm under survey, with self-poisoning likely to come to the notice of services and thus be easier to record incidences from Accident and Emergency admissions statistics for example. Figures of 80% of self-harm presentations to emergency departments are of self-poisoning from an overdose of either prescribed, over the counter or illegal drugs (NCCMH, 2004).

Hawton et al, (2002a) who carried out a survey on school aged children in England estimated that 13% of young people between the ages of 15-16 reported self-harming at some time. They concluded that incidence of self-harm is three times as likely in girls as in boys during adolescence (Hawton et al, 2002a). They also state that the method of self-harm varies with higher incidence of self-poisoning for girls and higher rates of self-injury for boys.

Although Hawton et al's (2002a) survey comes from continuous monitoring the data comes from a localised sample of the population which may not be representative of other parts of the country. Also the data is confined to an age cohort (grouping), which may not be representative of the rest of the population. Many acts of self-injury do not come to the notice of the services so it would be difficult to estimate what ratio to gender would apply to the rest of the population (Bowen, & John, 2001). Even where a national survey had been carried out the figures estimating that between 4.6%-6.6% of people self-harmed was thought to be an under-estimate (Meltzer, et al in NCCMT, 2004).

In long-term follow up studies (Hawton et al, 2003; Zahl & Hawton, 2004) looking at the repetition rates for self-harm it was found that repetition of self-harm is associated with a higher risk of suicide in both males and females, with higher risk indicators for females especially young females. Self-harm included self-injury as well as self-poisoning but did not separate these in terms of risk for suicide.

Hawton et al, (2003) study mentions that the majority of people that took part in their study as participants had self-poisoned and this could be because as was said earlier that fewer people who self-injure report to mental health services or attend accident and emergency departments (NCCMH, 2004) and where they do data collection is not consistent in every area of the UK (Owens et al, 2002). However it may also be that the study was specifically looking for information about suicide risk and the method of self-harm includes the lethality of taking or ingesting poisonous substances as opposed to cutting which may be less lethal and not intended to kill (Babiker & Arnold, 2001).

Horrocks et al's (2003) study carried out from A&E departments in Leeds, found higher rates of self-injury being recorded when self-injurious and self-poisoning acts were included. Self-injurious acts included wider definitions than self-cutting although self-cutting had a higher percentage than other forms of self-injurious behaviour. They also found that the two groups were not mutually exclusive as some participants were recorded in both self-poisoning and self-injurious records. Where histories of self-harm or contact with mental health services were recorded, higher rates of self-injurious episodes were reported than self-poisoning. This is consistent with the view that reporting of self-injury is lower in A&E departments in general maybe due to lower lethality and self-care of injuries not requiring hospital care. But any individual may report a higher number of episodes of self-injurious behaviour especially those who repeatedly use self-harm as a means of escape for instance (Favazzia, 1992; Rodham et al, 2004).

Self-injury covers a variety of behaviours and the social constructs used to define behaviour may make it difficult to differentiate prevalence rates between different population cohorts. Gender bias in particular can affect differences in classification and diagnosis between male and females with similar behaviour patterns (Bowen & John, 2001).

In summary the literature to date gives an indication that prevalence rates are likely to be higher for young adolescents than older cohorts, that there may be elevations for more self-poisoning in females than males at this age and that overall prevalence in the population as a whole is estimated to be between 4-6%. However data is inconclusive and does not indicate what prevalence is likely to occur across the population for either self-poisoning or self-injurious acts of self-harm or gender ratios within them.

2.2 VULNERABILITY FACTORS:

2.2.1 TRAUMA:

Major research has linked the effects of childhood abuse to trauma. This body of research grew after the recognition in the 1970's from observations of some of the USA military personnel returning after engagement in the Vietnam War who developed reactions to traumatic and stressful events. They had symptoms of hyper vigilance, high startle response, re-experiencing memories, and reliving experienced memories and dissociative behaviours, which were subsequently termed Post Traumatic Stress Disorder. Links were then made between the effects seen on those men and on civilian populations who had suffered a traumatic event and then subsequently women and children who had been subjected to childhood abuse or rape and adult women who had been raped and or physically abused (Van der Kolk, et al, 1996; Chu, 1998; Herman, 1992; Foa, 1998).

Childhood trauma is hypothesized to play a role in the development of a variety of psychiatric disorders such as Borderline Personality disorder, (as discussed above) Somatization disorder, Dissociative disorders, Substance abuse, Eating disorders and Self-harm (Van der Kolk, 1998).

Van der Kolk, (1998) suggests that people suffering from these disorders spend a lot of their time organising their lives around repetitive patterns of reliving and warding off traumatic memories, reminders and effects.

Interpersonal traumas are found to be particularly significant and are considered to interfere with a child's ability to trust and feel secure in their relationships and subsequently in adult relationships. As a result the regulation of affective states such as anger, anxiety, and sexuality are disrupted and therefore the development of pathological attempts at self-regulation is engaged in instead, resulting in behaviours such as self-harm, eating disorders, and substance abuse (Allen, 2003; Van der Kolk, 1998; Chu, 1998). Most research into self-harm has focused on childhood abuse as

a contributing factor with childhood sexual abuse consistently being found to be a leading factor in many studies (Allen, 2001; Duggan et al, 2000).

However it may be that traumatic experiences in adulthood also play a role in the development of self-harm. Herman's research work with victims of domestic violence and rape sufferers comments on the presence of trauma symptoms which would possibly meet the diagnosis of PTSD (Herman, 1998). The presence of PTSD can lead to lasting changes in physiological arousal, emotion, cognition and memory (Joseph et al, 1999; Resick, 2001). It is speculated that the additional impact of this following childhood sexual abuse may compound these changes (Herman, 1998, Chu 1998,). Having said this in a survey (Arnold & Babiker, 1997) only 14% of women with a history of self-injury attributed their behaviour to experiences in adulthood. Rape and sexual abuse were cited most frequently, followed by emotional and physical assault, and lack of support or communication (Arnold & Babiker, 1997).

Separating the traumatic effects of childhood sexual abuse from other factors can be problematic (Allen, 2003). Heffernan & Cloitre's, (2000) study comparing a group of patients with a diagnosis of post traumatic stress disorder & borderline personality disorder, with a post traumatic stress disorder only group, found that age of onset of childhood sexual abuse was earlier in the former group. The most significant finding was that verbal and physical abuse by the mother was the strongest contributor to the co-morbidity of the (posttraumatic stress disorder & borderline personality disorder group) with verbal abuse the strongest. The severity of posttraumatic stress disorder symptoms was similar across groups. However the posttraumatic stress disorder & borderline personality disorder group had higher scores on measures of dissociation, anger, anxiety and interpersonal problems. It would seem therefore that physical and especially verbal abuse increases the potential to develop borderline personality disorder. In addition the prevalence of post traumatic stress disorder increases as a consequence of childhood sexual abuse (Heffernan & Cloitre, 2000).

2.2.2 Loss:

Clinical literature confirms that rejection, separations, and feelings of abandonment often precipitate episodes of self-cutting (Allen, 2001). This is thought to be linked to earlier experiences in childhood where neglect and abuse have been present (Allen, 2001). Speculative accounts on emotional withdrawal, failure to protect, and inconsistent treatment by the caregiver are cited as factors that contribute to insecure attachment patterns in the child that contribute to adult psycho-pathology later, which may lead to self-harming behaviour (Fonagy, et al, 2004; Allen, 2003).

In Arnold & Babiker's (1997) study, loss and bereavement experiences in adulthood that led to self harm; included miscarriage, loss of a child (death or separation) and the inability to have children. They also found that the start or increase of self-injury followed whilst being in prison or psychiatric hospital (likely to involve isolation and or rejection) and for some women after the break up of a relationship where intense feelings of loss and desperation ensued (Arnold & Babiker, 1997).

2.2.3 HOPELESSNESS AND SUICIDE:

Hopelessness has been linked to suicidal behaviour and para-suicidal (self-harm) behaviour and the absence in the belief of future positive events has been cited as a factor (Sidley, 1998).

Hopelessness described as pessimism for the future, (Hunter & O'Connor, 2003) is thought to predispose a person to increased suicide risk.

Perfectionistic thinking styles are argued to be a component of hopelessness. Specifically socially prescribed perfectionism, described as the 'excessive expectations we perceive significant others to have of us'. Research supports that higher levels of social perfectionism are associated with greater hopelessness and greater suicidal ideation (Sidley, 1998; Hunter & O'Connor, 2003).

As has been explored earlier, people who self-harm are diagnosed with a variety of disorders where childhood difficulties are featured. Abusive

relationships may feature critical and excessive expectations on the child by the caregiver. Also where general non-abusive but nevertheless critical caregiving is given again the child may develop the tendency to be self-critical and have perfectionistic thinking styles (Fennell, 1999; Fennell, 2004). This may help to explain why some people who self-harm pose a greater suicide risk especially in repeated episodes of self-harm where hopelessness is a component (Sidley, 1998; Hunter & O'Connor, 2003).

2.2.4 CO-MORBIDITY:

People who self-harm appear to have a number of possible co-morbid disorders present such as those that have already been mentioned above, i.e., borderline personality disorder, other personality disorders and post-traumatic stress disorder. Depression and anxiety can also be found in people who self-harm ((Haw et al, 2001).

Haw et al, (2001) found that 70% of participants they interviewed who self-harmed reported depression and 14% reported anxiety difficulties. They question whether affective disorders were under-recognised and under-treated in self-harm patients and concluded that anti-depressant treatment should be considered and not just psycho-social intervention to prevent higher rates of suicide. The diagnosis of personality disorder for approx 45% of the participants was also thought to pose difficulties in appropriate treatment and using a multi-agency approach was recommended.

Owens et al, (2002) reported that suicide risk in patients who self-harm was thought to be about a hundred times higher than the general population after reviewing 90 studies to estimate rates of fatal and non-fatal repetition of self-harm. Although they did not look at the reasons for the rates found, it may be that higher rates of suicide occurred where depression was present in a higher proportion of those who had previously self-harmed.

Rodham et al's, (2004) study looked at differences between those who self-poison and those who self-cut. They found that participant's who had self-cut, spontaneously reported depression as a reason whereas participants who

self-poison, spontaneously reported escape as a reason for self-harm. This study used a set of questions to ask each participant about their reasons for self-harm however participants also had an opportunity to write what reason they had for self-harm and it is these responses that are being referred to here.

The presence of depression in people who self-harm would indicate the need for treatment to incorporate treatment strategies already employed for depression (Haw et al, 2001). Anxiety difficulties may also require to be treated in a similar fashion. It is also possible that symptoms of hyper-vigilance and arousal, features of Post-Traumatic Stress Disorder could account for some of the population where anxiety was found (Allen 2003). Also intrusive memories of abuse and or rape can be highly disturbing and cause anxiety and evidence exists that memories of this nature may precipitate acts of self-harm (Herman, 1998; Van der Kolk, 1998; Chu, 1998) please see trauma section above.

3. UNDERSTANDING SELF-HARM:

Reasons for self-harm vary and often a number of different factors contribute which appear to form a complex picture. The following theoretical studies look at some of the factors that account for self-harming behaviour which may help to draw together the different aspects already explored.

3.1 PSYCHODYNAMIC THEORIES:

Attachment theory appears to offer some explanation for why people self-harm. Allen, (2001) links traumatic early experiences with insecure attachment relationships as a causal factor for the development of a number of mental disorders including self-harm. The inability to manage unbearable emotional states such as rage, despair, anxiety, loneliness and the sensation of numbness are linked to poor ability to mentalize effectively with these states and produce the perceived need to self-harm (Allen, 2001).

Mentalization is a concept derived from the writing of Fonagy et al, (2004) which has been developed into a specific treatment for borderline personality

disorder (Bateman & Fonagy, 2004). Fonagy et al, (2004) specifically base their approach on 'attachment theory' and 'theory of mind' to bring together cognition and affect. It is thought that 'attachment theory' provides the evidence that an infant's sense of self emerges from the affective quality of the relationship with the primary caregiver; whereas the 'theory of mind' concept is the ability to understand mental states in others and self (Baron-Cohen & Bolton, 1993). Fonagy et al, (2004) stress that this is not just a cognitive process but one where affects are discovered through the developmental route with primary-object relationships. Understanding of self as a mental agent grows out of interpersonal experience and interaction with more mature minds that are required to be both benign and reflective.

Mentalization involves both a self-reflective and an interpersonal component. These combined provide the child with the capacity to distinguish inner from outer reality. That is intrapersonal mental and emotional processes from interpersonal communication (Fonagy et al, 2004). 'Affect regulation' is the capacity to modulate affect states and is a prelude to mentalization.

Mentalized affectivity is the mature capacity to discover the subjective meaning's of one's affect states. It represents the experiential understanding of one's feelings in a way that extends beyond intellectual understanding. Self-reflection as well as the ability to reflect on others minds evolving (or not) out of early relationships is the basis for human social functioning (Fonagy et al, 2004).

In relation to self-harm, insecure attachment patterns are thought to exist whereby the capacity to mentalize is effected and therefore the ability to regulate affects is compromised (Bateman & Fonagy, 2004; Fonagy et al, 2004). Traumatic early experiences and neglect are thought to have a significant impact on the ability to mentalize effectively and is thought to be a significant factor in the development of personality disorders (Bateman & Fonagy, 2004). Childhood abuse causing distress increases the need for proximity to the abusive caregiver making mental proximity unbearably painful (Bateman & Fonagy, 2004). Observations of patients with BPD appear to avoid thinking about the mental states of self and others and this is

thought to be because thinking about this produces unbearable emotional pain where it is connected to earlier maltreatment (Bateman & Fonagy, 2004).

Bateman & Fonagy, (2004) & Fonagy et al, (2004) have brought together 'attachment theory' with 'theory of mind' to hypothesise the development of personality disorder and specifically borderline personality disorder that partially helps in understanding the reasons for self-harm. It is useful for understanding the impact of interpersonal factors and regulation of affects that appear to be a common feature in the experiences of those who self-harm (Allen.2001). However it does not adequately explain why some who self-harm don't fall into the categories representing personality disorders or explore alternative routes for self-harm (DSM-IV-TR, APA, 2000).

3.2 DBT (DIALECTICAL BEHAVIOUR THERAPY):

Linehan (1993) describes DBT as an integrative cognitive behavioural treatment specifically designed to tackle the broad range of cognitive and behavioural difficulties associated to BPD (Borderline Personality Problems) and suicidal behaviours.

DBT combines standard cognitive behavioural therapy procedures with 'Dialectics' that is, a bringing together of opposites. Behaviours and thoughts are frequently displayed in polar opposites in people diagnosed with borderline personality disorder. Typically this is presented as oscillations between extremes of 'all bad' all good' or feeling 'wonderful' to 'hopeless' and suicidal. The therapist's job is to move the patient and self to the middle ground and embrace both positions as part of the whole with an emphasis on discovering the missed ground in the middle (Linehan, 1993).

The core treatment procedures are problem solving, exposure techniques, skill training, contingency management and cognitive modification (Linehan, 1993). Emotional regulation, interpersonal effectiveness, distress tolerance, core mindfulness and self-management skills are taught so that patients can move towards an acceptance of themselves. These are designed to help the person become aware of them-selves and their world based in the moment.

This is an orientation towards what actually is as opposed to following any preset perceptions based in past experiences. Altering the perceptions is the first step before any behavioural changes can be made (Linehan, 1993).

There is also a greater emphasis on the therapeutic relationship than is to be expected with traditional forms of CBT. Therapy also directly targets therapy interfering behaviours as part of the overall process (Linehan, 1993).

DBT was specifically developed for those who met Borderline Personality Disorder diagnosis. It specifically targets the range of behaviours that are contained within the criteria of DSM-IV-TR (APA, 2000) and therefore is very useful for people displaying this range of behaviours. However as mentioned previously people who self-harm may not merit the diagnosis of Borderline Personality Disorder and have other diagnosis instead. That is not to say that some of the treatment strategies could not be adapted for use with others who self-harm but the requirement of a clear formulation of an individual's difficulties may highlight difficulties that may not be covered by the strategies of DBT (Sidley, 1998).

3.3 CBT (COGNITIVE BEHAVIOURAL THERAPY) THEORY:

CBT (Cognitive Behavioural Therapy) was devised by Aaron Beck (1991) and combines two aspects that are 1) cognition (thoughts) and 2) behaviour in treatment. A wide range of mental health difficulties are treated using the basic theory of CBT (Hawton et al, 1999) including personality disorders (Beck et al, 1990). The basic concept of CBT rests on targeting negative thoughts and challenging negative behaviour patterns.

Kennerly (in Bennett-Levy, 2004) has devised a theoretical conceptualisation of self-harm, which appears to be free from any associated diagnostic classification using cognitive behavioural theory as a base. This is helpful in that people who self-harm may have considerably different diagnostic patterns from each other (please see section 2.2 above on Vulnerability Factors). Because it is free from any diagnostic links it allows for the possibility of alternative outcomes and factors for self-harming behaviour (Crowe & Bunclark, 2000).

Kennerly's (in Bennett-Levy, 2004) perspective identifies four general categories of cognitions that maintain the pattern of self-harming behaviour. These are as follows:-

- 1) *fundamental beliefs* about self, others and the world such as 'I am bad and I deserve to hurt', I am nothing and it doesn't matter what happens to me, etc,
- 2) *facilitating beliefs* such as assumptions and predictions 'I cannot tolerate these feelings and there is no other way to deal with it',
- 3) *reactions to self-injury*, fuelling the negative belief system with 'this proves that I am bad, weak, worthless' self statements or supporting facilitating beliefs with 'it does feel good', 'this made them sit up and listen' statements,
- 4) *flashbacks and other intrusive memories* of painful and traumatic events can drive self-injurious behaviour in order to distract or to dissociate from the distress.

A diagrammatic representation of this model is illustrated below:

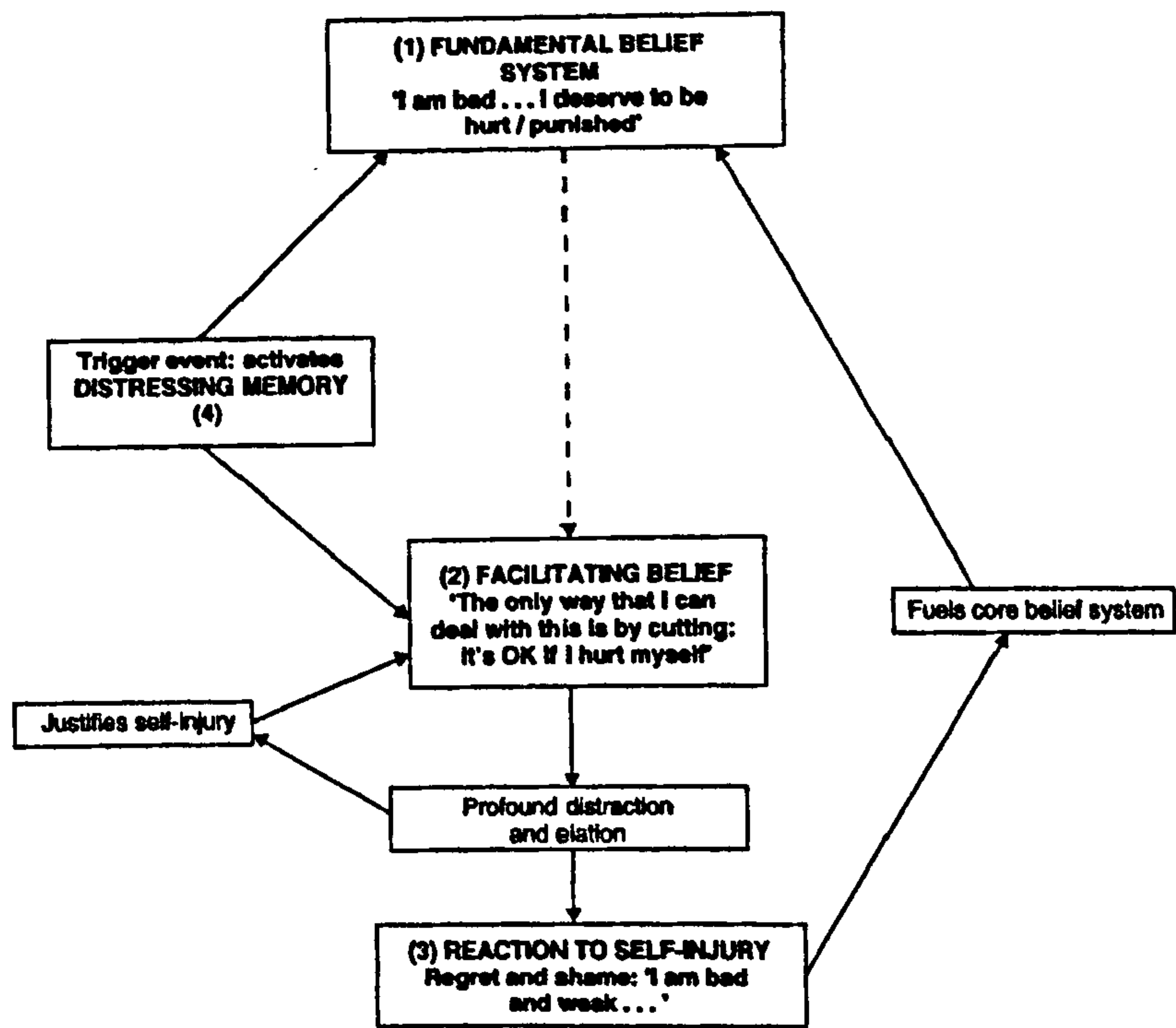


Fig. 18.1 The maintenance of self-injurious behaviour.

From: Kennerly in Bennett-Levy, (2004).

The model above has the potential to draw upon the cognitive and behavioural components involved in self-injurious behaviour. It also offers an explanatory route for the repetition of self-harming behaviour which is based on the beliefs that are activated within the cycle. It includes the feelings of elation that are thought to occur where the production of Enkephalins a form of neurotransmitter produces pleasant effects akin to taking opium or heroin and can become addictive (Favazzia, 1992).

The model sets out the key cognitions that drive self-injurious behaviour so that these can then be challenged in therapy to assist the person to look for alternative action (Kennerly in Bennett-Levy, 2004).

Limitations for use of the model may occur when trying to address all the issues that may be present in an individual case where multiple difficulties are present and variations for diagnosis exist. Addressing the long-term effects of childhood abuse, neglect, post-traumatic symptoms, interpersonal difficulties, and personality difficulties can be partially addressed in challenging a person's core beliefs but would not necessarily adequately cover these areas without substantial understanding and an in-depth exploration of the development of these difficulties (Sidley, 1998).

Other complimentary theories such as Attachment Theory (Bateman and Fonagy, 2004) as discussed above and or Schema focussed therapy (Young et al, 2003) may be required to formulate an understanding before addressing the complex nature of the range of difficulties encountered. Although Kennerly's (in Bennett-Levy, 2004) model includes 'distressing memories', a programme designed to directly tackle any other Post-Traumatic symptoms (Chu, 1998; Harvey & Miller, 2000; Joseph et al, 1997) may also need to be implemented within the whole of the treatment. Again the use of a detailed assessment and formulation for the individual would be required to be carried out so that a clearer picture of the differing levels and complexities can be clearly defined and then addressed accordingly (Sidley, 1998).

3.4 BIOLOGICAL THEORIES:

Repetitive self-harm has been linked with the neurotransmitter serotonin found in all areas of the brain. Serotonin is more concentrated in the hypothalamus, a region of the brain that is thought to regulate impulsivity and aggression, appetite, mood and the sleep wake cycle (Favazzia, 1992). People who have been diagnosed with borderline personality disorder are thought to have reduced serotonin levels and this is thought to correlate with suicide attempts, assaultiveness, instability, aggression and impulsiveness. Favazzia, (1992) reports on a study of people with personality disorder some who self-mutilated and some who didn't and concluded that lower serotonin levels were found in those who had self-mutilated.

Enkephalins are another type of neurotransmitter that are produced in the brain to suppress pain and regulate emotions and are likely to be produced after self-mutilation. They have a pleasurable effect reportedly akin to taking opium or heroin and may also play a role in the development of repetitive self-harm. It is thought that the auto-addictive model teaches the person who self-harms to associate self-harm with positive feelings linked with the Enkephalin effects (Favazzia, 1992).

Developments in mapping emotional processing in the brain linking sensory input with fear response for example, have found that emotional memories appear to be more permanent and follow a different pathway in memory (Le Doux, 2004). This has important implications for those who experience trauma and other distressing events.

Le Doux, (1994) explains that there are two memory systems working in parallel. Declarative memory is mediated by the hippocampus and cortex regions of the brain, which stores information on what, when and where. Whereas the amygdala stores emotional information that contains information about the sensory details such as being tense, anxious, depressed. Emotional memory can be stored in declarative memory but it will be stored as fact. Emotional and declarative memories are stored and retrieved in parallel and their activities are joined into conscious experience but we do not

have access to emotional memory directly only to the consequences such as how we feel or behave (Le Doux, (1994). Immature development of the brain in infancy means that early memories of events are unable to be stored and therefore are inaccessible but the emotional content will be stored and can therefore effect mental and behavioural functioning in later life (Le Doux, 1994).

In terms of childhood abuse, trauma and neglect this has important implications for therapeutic work. Kennerley, (2005) has incorporated this understanding of memory processes into a schematic formulation for therapeutic practice working with people who experienced childhood abuse. Working with the development of schemata in childhood can help understand the impact of earlier experiences in present day experience and may help those who self-harm, and with other disorders.

3.5 THE ROLE OF DISSOCIATION:

Dissociation plays a significant role in self-harming behaviour (Duggan et al, 2000). Smith et al, (1998) describe how self-harm provides a means to reconnect with the world after becoming dissociated. The dissociated state occurs when feelings of pain, shame, and humiliation reverts to anger which cannot be expressed outwardly. Self-harm provides the means whereby the anger is directed towards the self and for reconnection back to the world again.

Dissociation is highly correlated to Post Traumatic Stress Disorder (PTSD) and is listed as an associated feature within the diagnostic criteria for PTSD (DSM-IV-TR; APA, 2000). Dissociative symptoms are thought to occur where interpersonal stressors such as domestic violence, childhood physical and sexual abuse have occurred and fits in with common factors in those who self-harm as previously discussed (Herman, 1998; Van der Kolk, 1998; Chu, 1998).

A recent study of women looking at self-wounding (injury) identified two major pathways. The first was called a 'spring' where tension mounts and a

threshold is reached, the second is called a 'switch' where the impulse to self-harm is switched on. During the switch phase dissociation is often associated with the craving for cutting suggesting further support for the idea that dissociation is a factor in self-harming behaviour. It also may help the person to reach a euphoric state making it possible to cut themselves (Huband & Tantam, 2004). Out of eight emotional themes identified as being present prior to self-harm, feeling powerless, uncared for, shame and anger were the most common (Huband & Tantam, 2004).

There was speculation from (Huband & Tantum's, (2004) account that dissociation helped the person to experience a euphoric state in order to carry out self-harm. This may be linked with the biological process present when extreme emotion such as anger produces a hormonal response reaction in the nervous system. Unlike the fight and flight response a defeat response is activated instead to trigger opiate release. There is speculation that this 'freeze' response may have more survival value for females and children where this has been more frequently observed (Resick, 2001). However, Herman's, (1998) view may be more useful in that she states that, anger directed outward is often not possible for children subject to abuse for fear of retaliation and further abuse and has direct consequences for the way in which the child's perceptions of her/himself are understood (please see chapter 1 section 3.7.2).

3.6 SUMMARY:

The interconnectivity between PTSD, BPD, dissociation, depression and anxiety and childhood abuse in the symptomatology of self-harm makes it difficult to establish any clear theoretical correlates between diagnosis and behaviour. People who self-harm have a variety of reasons and causes for developing the behaviour and self-harm can also be used as a solution for some (NCCMH, 2004).

Anger is reported in relation to self-harm in some of the literature (Linehan, 1993; Kennerley, 2004; Allen, 2001), but it appears that as yet there is no systematic study that has been specifically carried out to identify anger's role

in self-harm. The following paragraphs will examine the literature on anger and on self-harm in an attempt to forge the links between them and includes the literature where both are already featured together.

3.7 THE ROLE OF ANGER:

Anger contains multiple components such as cognitive, behavioural, physiological and experiential mechanisms of emotional responding and is usually perceived to be an unpleasant or negative emotion. Anger may occur in response to an actual or perceived threat, a disruption to ongoing behaviour, or in response to the perception of deliberate, or unjustifiable harm or neglect. Anger often occurs in interpersonal situations, where being treated unfairly, being threatened, insulted, witnessing another person being violated or being the recipient of someone else's anger acts as a trigger for the anger experienced (Kring, 2000).

The importance of differentiating between angry feelings and expression of these feelings is important (Spielberger et al, 1995). One of the most widely used measures for anger is the STAXI (State-Trait Anger Expression Inventory, Spielberger, 1998), which contains questions to measure anger-in or anger-out expression. When people express their anger by directing it outwardly towards other people or objects by verbal or motor aggressive means, this is termed anger-out. On the other hand when people suppress those feelings by holding them in this is termed as anger-in. A distinction is made between this definition of anger-in and the psychoanalytic conception of anger turned inward toward the ego or self. From the psychoanalytic conception, angry feelings as well as thoughts and memories connected to anger provoking situations, are repressed and therefore have not been experienced, resulting in guilt and depression (Spielberger et al, 1995).

3.7.1 ANGER, DEPRESSION AND SELF-HARM:

In earlier theories on depression, anger seemed to play a central role. More recent conceptualisations appear to leave this aspect out of depression (Gilbert, 1999). With cognitive behavioural theories the literature focuses

largely on treating the inappropriate displays of anger such as aggression and violence (Kassinove & Tafrate, 2003). Thus the suppression of anger or anger-in aspect appears to be neglected when it comes to treatment and there is little mention of anger playing any role in depression.

Gilbert, (1999) on the other hand sees anger and resentment as the key affects in the development of depression, and inhibited aggression and intra-punitive ness (self-punishing thoughts) were associated with higher rates of depression (Gilbert, 1999). Social ranking theory is thought to exert influence on the expression of anger. In that anger may be suppressed towards others of higher social ranking whilst more freely expressed towards other of lower social or power ranking (Gilbert, 1999).

This pattern fits well with issues of domestic violence for example seen in cases of childhood abuse, and a major factor in the development of complex PTSD or personality disorders with links to self-harm (Herman, 1992; Linehan, 1993; Weiderman, 1999). This factor may also relate to the development of poor interpersonal skills a factor picked up on in the diagnosis of borderline personality disorder (Gilbert, 1999; DSM-IV-TR, APA, 2000; Linehan, 1993; Bateman & Fonagy, 2004).

For example; research into the diagnosis of borderline personality disorder has shown that this is the most likely diagnosis given to intensely angry clients, especially those who are female, (Eckhardt & Deffenbacher, 1995). There is also some evidence that stereotypical beliefs of clinicians may reflect bias in clinical judgement based on what constitutes an appropriate display or expression of anger which may effect the diagnosis given (Kelly& Hutson-Comeaux, 1999). Therefore this may preclude efforts to express anger and constitute a factor in the development of depression in some.

In Parker et al's (1998) study looked at acting out and acting in scores in a sample of 270 depressed patients. Rates of self-injury across the groups were increased where both acting out and acting in scores were high.

Members of this group tended to be younger, have a clinical diagnosis of neurotic depression and have made a previous suicide attempt and had higher rates of previous self-injury.

The acting out behaviours that were included were, yelling, hitting someone, breaking things, head and fist banging, and driving recklessly etc. Acting in behaviours were, withdrawal from others, going quiet, ruminating, brooding, with some becoming self-injurious.

What the authors found of significance was that the oscillation between the extremes of each response style correlated with many of the features of borderline personality disorder. This fits with the dysfunction of emotional regulation, dramatic overreaction and impulsivity strategies listed in the DSM-IV-TR, (APA, 2000) criteria for borderline personality disorder. The authors noted that their findings were subject to the participant's responses to stress but were also more likely when participants were depressed.

Depression is also linked with acts of suicide and para-suicide in the literature. The term para-suicide is another used for self-harm and seems to link self-harm to suicidal ideation when applied. However a distinction between suicide and para-suicide (self-harm) seems to lie in the function it has. Self-harm appears to be linked to expressions of anger, to regain normal feelings and distraction; whereas suicide seemed to be linked with the perception that killing oneself would lessen the burden for others (Brown et al, 2002).

3.7.2 ANGER AND SELF-HARM

Herman (1998) describes three major forms of adaptation that allows the child to survive chronic abuse. These are dissociative defences, identity fragmentation, and pathological regulation of their emotional states. Anger directed outward is often not possible for children subject to abuse for fear of retaliation and further abuse. Re-directing the anger involves a process where negative feelings are directed at self. This can lead to altered

perceptions of self whereby the survivor's self image becomes very negative and they become filled with self-loathing. Survivors of abuse persistent and deeply held feelings of self-loathing seem to act as a motive to direct their aggression at themselves by self-harm when faced with confrontation in interpersonal contexts (Herman, 1998). This is also likely to lead to depression as was discussed earlier (Gilbert, 1999).

Childhood sexual abuse is also thought to be a factor in difficulties in intimate sexual activity and a source of deeply held rage against past abuse. Of the women who were studied most felt that they could not express the rage they felt as children but also within current relationships too, therefore self-harm appeared to be the only alternative for some of them (Painter & Howell, 1999).

In a recent study by Milligan & Andrews's (2005) on offender women, the role of anger and shame in childhood abuse was reported and the relationship to self-harm showed significant effects for both anger and shame. Anger was reportedly found to be experienced frequently, but anger was both suppressed by turning it towards self (self-harm) and expressed towards people and objects in the environment. This may link in with interpersonal relational difficulties discussed earlier in (Gilbert, 1999) where incarcerated women may have more restrictions on expression in some situations but have more opportunities to express in others.

Van der Kolk et al's, (1996) study comparing community participants with clinical participants for a relationship between PTSD, Somatization Disorder, and Dissociative disorders found that participants who had suffered interpersonal abuse at or before the age of 14 developed significantly more dissociative problems as well as difficulties with modulating anger, (including aggression against self and others) and self-destructive and suicidal behaviours, than either the older victims of interpersonal trauma or the victims of disaster did.

In Allen's (2001) substantial work on understanding the effects of trauma on the development of mental health disorders he explores the role that anger has in self-harm. The literature that he cites confirm that self-harm is used to direct anger, aggression, and rage at self as a form of self-punishment, retaliation, a safer target than at the person they are angry with, fear of aggression and consequences, and a symbolic release of anger through cutting to release badness. This supports Herman's (1992) and Gilbert's (1999) view mentioned earlier that directing anger at self is safer and provides the means for self-punishment from feelings of badness or self-loathing.

Osuch et al (1999) developed a Self-Injury Motivation Scale (SIMS) to assess the motivations for self-injury and found that patients with different SIMS factor profiles had different psychopathology. High scores on the SIMS were more likely to have high scores on the Dissociative Experiences Scale (DES), Beck Depression Inventory (BDI) and the Davidson Trauma Scale (DES) and be in the pathological range on the Millon Clinical Multiaxial Inventory- II (MCMI-II) measure for avoidant, passive-aggressive, self-defeating, schizotypal and borderline character traits/dysfunctions.

The SIMS lays out six major clusters of factors involved in motivation for self-harm, 1) Affect Modulation, 2) Desolation, 3) Punitive Duality, 4) Influencing Others, 5) Magical Control and 6) Self-Stimulation. In clusters 1, 3, and 4 there are items that support the ideas mentioned previously that the motivation for the self-harm is as a form of self-punishment, or anger directed at self but with a message to others, and to decrease feelings of rage.

In Low et al's (2000) study of the association between childhood trauma, dissociation and self-harm on a female offender population had higher inward and outward directed irritability scores, and had higher dissociative scores. This study focused on the role of dissociation as a mental mechanism that is likely to lead to self-harm but took note of the experience

of intolerable affect just prior to the dissociated state. They concluded that there are links between the re-enactment of the original trauma, intolerable affect, dissociation and self-harming behaviour. The integration of events into normal memory is impaired by the trauma experienced, thus affect remains heightened.

From the literature above, anger has been commonly presented as a factor in self-harm. However the exact function of anger itself has also been subsumed within other factors when discussed. This might be expected as there seems to be complex motivations and emotions involved in any single act of self-harm. However the literature does provide some evidence that the suppression of anger may contribute to the development of depression, which is also a factor in self-harm. Also where anger cannot be directly expressed, this may sometimes require individuals to take that anger out on themselves in the form of self-harm. The literature is not conclusive in these respects and therefore examining this further through research is important.

3.7.3. SELF-HARM, ANGER AND SOCIO-CULTURAL FACTORS:

Self-harm is subject to socio-cultural restraints and sanctions on what is deemed to be appropriate in terms of behaviour. In countries where cultural traditions allow or even encourage bodily mutilation on religious and social grounds, acts of self-harm may be seen as acceptable within those contexts (Babiker & Arnold, 2001, Favazzia, 1996).

Likewise anger expression can also be subject to social and cultural sanction. Studies have shown that there is little difference in the way that men and women experience anger but differences have been detected in expression and situational contexts (Kring, 2000). In Gilligan's (1990, in Turkel, 2000) study of adolescence for example, girls generally are reported to lose their ability to express anger from the pressure created in trying to be seen as good and popular. In Minick & Guelder's (1995) study of older women between the ages of 62-79 years were also found to inhibit expression of anger to avoid conflict and to prevent disruption of their personal relationships. This can be seen

within the display rules that socially control the way that men and women are allowed to display their emotions. Studies have shown that stereotypes operate when men and women are asked to judge anger displays (Kring, 2000). For further information on gender and anger issues please see literature review included in section D in this thesis.

Cultural and social norms can also operate within different sections of a population such as regional variations across different countries and within a single country (Thomas, 1993; Cox et al, 1999). Different ethnic populations within a single country may operate different display rules for expression of anger (Cox et al, 1999) even although they may be subject to the same legal and social sanctions etc. This has important implications for those seeking to help people who have difficulties with self-harm and or anger. Therefore treatment strategies may need to take these aspects into account (Sidley, 1998).

4. THE TREATMENT OF SELF-HARM:

4.1 PHARMACOLOGICAL

Haw et al, (2001) question whether affective disorders were under-recognised and under-treated in self-harm patients and concluded that anti-depressant treatment should be considered and not just psycho-social intervention to prevent higher rates of suicide. However the NCCMH, (2004) studied anti-psychotic medication and anti-depressant medication for people who self-harmed. Unfortunately there was inconclusive evidence as to the effectiveness of either type of medication.

SSRI's (Selective Serotonin Reuptake Inhibitors) are currently widely used for treatment in depression and anxiety. Anxiety medication such as Buspirone act by stimulating serotonin. Medication is usually taken orally and sometimes by injection and act by flooding the brain with the chemical to produce the required effect. However it is the particular synaptic circuits in specific regions of the brain that require targeting but unfortunately drugs that can target specific sites have yet to be developed (Le Doux, 2002). This

hit and miss effect causes side effects because ultimately the chemicals from the administered drugs affect other areas of the brain.

Treating the hardware (brain circuits) as opposed to the underlying problems (psychotherapy) are different routes in altering brain patterns and where treatment combines both this has been found to be very effective (Le Doux, 2002).

Pharmacological effectiveness for help in reducing self-harm may be hard to prove given the number of different possible reasons and causes involved (MCCMH, 2004; Linehan et al in Barlow, 2001; Roth & Fonagy, 1996). However where depression is a factor the use of anti-depressants may be of benefit. Where self-poisoning has been used as a method of self-harm the use of anti-depressant medication prescribed in smaller packet size with close monitoring may be advisable (MCCMH, 2004).

4.2 PSYCHOLOGICAL TREATMENTS

Due to the variation in diagnostic terms for self-harm it is difficult to compare psychological treatments or the efficacy of them. Therefore I will attempt to separate the various pieces of literature on treatment designed for self-harm.

As mentioned earlier self-harm is described in only one dimension on ICD10 (WHO, 2004) and DSM-IV-TR (APA, 2000) category's; that is borderline personality disorder. In a comprehensive literature review on the effectiveness of treatment for personality disorder, Bateman & Fonagy (2000) found difficulties in generalising of findings across different treatment approaches. The lack of specificity in the different psychotherapeutic approach made differentiating and comparing the effectiveness of each impossible, (Bateman & Fonagy, 2000). 'Manualised' treatments that were tested were identified as follows, psychoanalytic psychotherapy (Kernberg et al 1989; Clarkin et al, 1999), DBT (Linehan, 1993) and object relations/interpersonal approaches (Dawson, 1988) and untested Cognitive

Analytic Therapy (Ryle, 1997); (Bateman & Fonagy, 2000). There is some but limited evidence for the effectiveness of treatments of personality disorder.

A recent psychodynamic based therapy has been developed and offers a mentalization-based treatment specifically for borderline personality disorder that incorporates behaviour strategies to tackle self-harming behaviour (Bateman & Fonagy, 2004). The concept of attachment theory has been around for some time as has theory of mind. However bringing these two concepts together to form the basis for mentalization has been developed relatively recently. As yet there is insufficient data to support the efficacy of this approach.

Dialectical Behaviour Therapy of Borderline Personality Disorder combines cognitive behavioural therapy with dialectics, mindfulness and acceptance, and relational components (Linehan, 1993). Controlled trials have been conducted and empirical data supports effectiveness (Linehan, 1993, Roth & Fonagy, 1996). The treatment also specifically targets self-harming behaviour both of self-injurious and self-poisoning types (Linehan, 1993). The treatment was originally designed for outpatient therapy but recent trials have proved its effectiveness for inpatients (Bohus, et al, 2000).

Cognitive Therapy of Personality Disorders reports some success for the effectiveness of treatment but controlled trials were limited and thus inconclusive (Beck, Freeman et al, 1990). More recent trials have yet to report further evidence for efficacy (Linehan et al in Barlow, 2001). Variations on cognitive behavioural success in treatment for personality disorders rests on variations of treatment such as DBT above and Schema based therapy (Young et al, 2003). But again no empirical evidence had been found to support schema therapy for personality disorders (Linehan et al in Barlow, 2001).

A cognitive based approach that is specifically designed to tackle self-harming behaviour was developed by Kennerley, as discussed earlier within

the section on theoretical approaches above (Kennerly in Bennett-Levy, 2004). Kennerley combines schematic, biological, cognitive and behavioural components in her approach and the tools for intervention are simple but through careful case conceptualisation can tackle complex and chronic difficulties (Kennerley in Bennett-Levy, 2004).

Only two treatment approaches directly tackle self-harming behaviour. DBT (Linehan, 1993) conceptualises self-harm within the borderline personality diagnosis whereas Kennerley (in Bennett-Levy, 2004) approaches self-harm in its own right. The advantages of developing a model for self-harm in its own right are that people who do not meet the criteria for borderline personality can have an intervention conceptualised free from a specific diagnosis. This can include all the co-morbid diagnosis such as PTSD, other personality disorders, Depression, Anxiety and those who experienced childhood abuse.

5. SUMMARY AND RATIONALE:

The grounds for this project were that the literature did not give enough information on the experience of anger in self-harm and that little was known about the way that anger interacted with other motivational factors for acts of self-harm.

Some of the studies into self-harm cite anger as one of a number of emotional states that self-harming behaviour tries to regulate but gives little information on the role of anger in terms of treatment for self-harm (Babiker & Arnold, 2001, Allen 2001, Conterio & Lader 1998, Turp, 2003). However the bulk of research into treating anger difficulties, in a more general sense unrelated to self-harm, tends to focus on how to manage the over expression of anger, by reducing the use of aggressive and abusive behaviours (Eckhardt & Deffenbacher, 1995, Edmondson and Conger, 1996, Kassonove & Tafrate, 2002, Novaco, 2001) providing little insight into the likely treatment for difficulties that may evolve due to the suppression of anger (Gilbert, 1999).

A difficulty lies in determining the various functions that self-harm may serve for an individual, as the literature is inconsistent in this respect. Another difficulty is that there are wide variations in the definition of self-harm, which makes it much harder to conduct focused literature searches and find clarification on treatment strategies.

The clients' perspectives appeared to have been largely absent and therefore important information might have been missed from the literature. Exploration into this area from a clients' perspective was important. Bringing information to light on the reasoning and meaning behind choosing to self-harm as opposed to finding other ways to express anger and emotional distress are the key aspects of this research.

Where research has looked into self-harm from the perspective of clients, this has sometimes been limited to self-report questionnaires (Arnold, 1995; Sansone & Sansone, 1999; Warm et al, 2002; Milligan & Andrews, 2005). This method often fails to capture levels of complexity and types of functions involved in self-harm, for example; self-harm as a self- preservative method as opposed to self-destructive methods (Arnold, 1995; NCCMH, 2004). Therefore interviews were chosen as the method used for this research. Participants who took part were given the opportunity to talk about their experiences of self-harm. This helped in exploring the meaning of self-harm for the individuals who took part.

This method made it possible to explore the types of behaviour and situational factors that might be present, the experiences prior to self-harming and how the experience of anger had influenced the subsequent self-harm. The aim was to examine how the experience of anger, if present, interacted with other factors and what effect this might have had on the method of self-harm, the notion of choice (the client subjectively feeling that they have or do not have the choice of whether or not to self-harm) and any other further possible effects of experiencing anger and the implications for therapy.

In recently published recommendations in National Collaborating Centre for Mental Health (Nice) guidelines for self-harm (British Psychological Society (BPS) & Royal College of Physicians (RCP), 2004) have emphasised the need to carry out qualitative studies that use methods of enquiry giving service users perspectives on the meaning of self-harm, therefore support the methodological considerations in the way this study was conceptualised.

CHAPTER 2: METHOD

1. METHODOLOGY:

1.1 RESEARCH DESIGN:

The study employed a cross-sectional, small sample design incorporating a qualitative methodology.

1.2 RATIONALE FOR A QUALITATIVE STUDY:

There is support for the view within the literature reviewed that anger may play a role in the experience of self-harm (Herman, 1992, Allen, 2001). However there appears to be limited researched data to support this view. In a recent paper where anger was cited as a factor in the experience of self-harm, the specific role that anger had was not fully explored (Milligan & Andrews's, 2005).

It appears that the self-harm data has also been largely limited to pre-designed questionnaires and the existing data appears to omit the experiences and understanding from the perspective of those who self-harm. Therefore the rationale for this study was to examine the subjective experience of clients who chose to self-harm with a focus on the presence or absence of anger within that experience.

Due to the nature of the enquiry a semi-structured interview was chosen in order to capture information that may not be obtainable from a pre-designed questionnaire, particularly where the complexity of emotions and meanings might be obscured by the limits on the specific questions asked (Robson, 1999; Smith, 1995). Using a qualitative research method may hopefully make it possible to explore the meanings and perceptions from the perspective of the participants (Ritchie & Lewis, 2004) and therefore enable the understanding sought within this research project.

1.3 PHILOSOPHICAL CONSIDERATIONS:

Qualitative psychology is concerned with human experience and with each person's perspective of those experiences (Ashworth in Smith, 1995). The phenomenological movement grew out of a desire to break away from the positivist position of externally

observable testing on a range of human thinking such as attention, perception, thought, and memory. Tests were devised around manipulating aspects of the environment in order to observe predicted responses to produce externally measurable and observable variables. In contrast, phenomenology sought to return to the things themselves as experienced. The phenomenon therefore became the thing itself as it appeared to the individual (Ashworth in Smith, 1995). Edmund Husserl (1859 – 1938) largely regarded as an early founder of phenomenology (Moran, 2000) established that human experience in general is not a matter of lawful response to variables that are assumed to be in operation. Rather, experience is a system of interrelated meanings, or a gestalt, bound up in the person's life-world (Ashworth in Smith, 1995; Moran, 2000).

Behaviourism and cognitivism have been regarded to share an underlying positivist position and determinism where human behaviour and experiences are to be regarded as an inevitable outcome of a set of variables (Ashworth, in Smith). The humanistic movement led in part by Abraham Maslow and Carl Rogers grew in order to counter this (Monte, 1991). The humanistic movement elevated the ideographic approach where the individual was studied as a unique case (Ashworth in Smith, 1995). Phenomenology has evolved over many years and IPA (interpretative phenomenological analysis) is but one of a number of qualitative approaches that seeks psychological meanings from the phenomenon as lived by the participant. Phenomenological analysis attempts to discern the psychological essence of the phenomenon from examining the lived examples within the context of participants lives (Giorgi & Giorgi in Smith, 1995).

1.4 METHODOLOGICAL CONSIDERATIONS:

In choosing a qualitative approach several options were considered. IPA (Interpretative Phenomenological Analysis) and grounded theory have a similar approach to data analysis and share common techniques in producing data. However IPA was specifically developed to gain insight into individuals' psychological worlds whereas grounded theory was originally developed to identify and explain contextualised social processes. Although more recent developments in grounded theory have allowed analysis to include experiential data it appears that the 'theory' created is from the researcher's perspective (Willig, 2001).

Discourse analysis was also considered because it explores psychological understanding of discourse between participant and researcher, and provides a way to think about the role of discourse in the construction of meanings (Phillips & Jorgensen, 2002).

However it seems to be more useful when exploring how people manage accountability and stake in everyday life settings rather than seeking to explore cognitive processes (Willig in Smith, 2003).

IPA (Interpretative Phenomenological Analysis) therefore seemed to offer a method that specifically addressed the individual's psychological world and seemed more suitable for the aims of this research study.

1.5 IPA (INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS):

The Interpretative Phenomenological Analysis (IPA) method analyses the meaning individuals attach to their experiences, and how they make sense of their personal and social world (Smith, 2003). IPA is especially useful where the concern of the study is to understand complex issues, novelty and the process of those experiences (Smith, 2003). Therefore IPA offered a methodology to meet the complexity of enquiry into the experience of self-harm and the role of anger within that experience.

The IPA method of data analysis seeks to explore the participants' view of the world by recognising the meanings they make about their experiences. It also recognises that the researcher's thoughts, perceptions and conceptions are also required to make sense of the participants' world. A process of interpretative activity is used and a thematic analysis of data which generates codes and then super-ordinate themes from the transcripts. Data is then processed from the particular in a single case to the more general once more data is analysed and from descriptions in the early stages to more interpretative meanings later (Willig, 2001; Smith, 2003).

A brief description of this process is as follows:

- Transcripts of the interviews are read several times to gain a general feel for the participants' views and feelings etc. Whilst reading through the text, notes are taken on interesting comments and sections of text etc and entered as codes anchored in the participants words in the left hand margins. The text is

then reread and emergent themes are identified using more interpretative accounts from the perspective of the analyst. These are noted in the right hand margin.

- Individual themes are then listed initially from the first interview. These are then subdivided into super-ordinate themes where interrelationships between the various themes have been identified.
- Subsequent interviews are then analysed in the same manner and organised into existing super-ordinate themes or where new ones emerge added to these.
- Finally shared themes across all cases are organised to make consistent and meaningful statements that acknowledges the participants' account of their experience grounded in their own words.

(Smith, 2003).

1.6 PERSONAL REFLECTIONS ON THE CONCEPTUAL PROCESSES OF THIS STUDY:

As several parts of the remaining chapter contain personal accounts towards reflexivity I have used the first person and highlighted this by the use of italics. I hope I have provided an adequate account of the way that my personal interests, values and ideas have shaped this research project. This may help to improve the evaluation of the data and provide a reflective description of the research process to readers (Banister et al, 1999; Willig, 2001).

The thoughts and feelings, which brought me to this research study, were borne out of a number of emerging experiences in my practice as a counselling psychologist. I have been working within the NHS for approximately four years and have worked in outpatient services providing therapy to those who have varying mental health difficulties. I specialise in working with people who have complex trauma difficulties including working with refugees and adults who have been abused in childhood. I mainly work from a cognitive behavioural therapy perspective and where cases require work on interpersonal difficulties integrate psychodynamic perspectives at the schematic level.

In June 2003 I became interested in working with people who had some anger difficulties in relation to other mental health difficulties. I thought that more men

presented with difficulties expressing anger by using aggression and violence whilst some of the women I worked with seemed to have difficulties related to feeling that they were unable to express anger at all. When thinking about doing my critical literature review as part of the requirements for my Post MSc Level qualification I decided I would look into the evidence for gender differences in anger. This was later revised and updated and included for part of this Doctoral research, which is included in Part D.

I also gained clinical experience of working individually and in co-working with a group of people who self-harmed and it was during this time at I began to ask questions about the significance of anger within self-harming behaviour. It seemed that some of difficulties being experienced that led to self-harm were due to the inability to express anger. The literature review (part D) gave me some ideas on why the some types of expression or inability to express anger may possibly lead some people to self-harm. However the focus had not been on self-harm itself, therefore understanding anger within self-harming behaviour became the focus that inspired this research project.

2. PARTICIPANTS:

2.1. Inclusion Criteria:

The inclusion criteria was that participants had used self-harming behaviour (as per the definition in literature review) within the past six weeks, were male or female, aged 18 or over.

2.2. Exclusion Criteria:

The exclusion criteria were that participants should not be actively psychotic or be receiving in-patient care for mental health problems. People who could not converse fluently in English were also excluded. The requirement to speak English fluently was made because of the need to explore complex emotional factors in self-harm in verbal discussion and that this might get lost through the process of translation.

Potential participants could ask for written information about any aspect of the study in a language of their choice to ensure proper informed consent. Of the nine

participants recruited no-one was excluded because of psychosis and they all met the criteria set. None of the participants recruited required any written translation in another language.

2.3. Sample Size:

IPA does not set a preferred number of participants for sample size, and is concerned only that it provides enough richness of data to examine similarities and differences between cases (Smith, 2003). The aim was to recruit 8-12 participants to give enough data for generalizability. Twelve potential people identified through colleagues in the mental health service were approached with three withdrawals and nine agreeing to be interviewed. Of the nine participants that were recruited for this study, only eight were used for analysis as unfortunately one of the tapes of the interviews became corrupted. The participant whose audio-tape became corrupted was not contacted for a re-interview as this would have breached the agreed ethical guidelines. It was also felt that it would be unfair to ask the participant to be interviewed again. A letter was sent to the ethical committee for guidance on this matter. After consultation the ethical committee agreed with the proposal to write a letter to the participant, thanking him for taking part and apologising for not being able to include his interview in the analysis.

3. PROCEDURE:

3.1 Recruitment:

In keeping with the choice of methodology, purposive sampling (Smith, 2003) was employed by choosing to recruit participants who had self-harmed within the previous six weeks. Participants were recruited via multi-disciplinary mental health professionals in Coventry Teaching Primary Care Trust. Service Managers were approached by telephone to discuss the study and were also sent a letter for distribution to mental health workers etc (please see appendix 1). Upon full ethical and managerial approval, local clinicians were provided with an information sheet about the study (please see appendix 2). They were asked to identify suitable potential participants based on the inclusion criteria. Clinicians were then asked to give potential participants an information sheet about the study along with a reply slip and stamped addressed envelope and a contact telephone number (please see appendix 3). Participants were asked to reply via this method or contact the researcher via

telephone if they were interested in taking part. Following contact with the researcher, they were given an opportunity to discuss the study and ask questions. If they agreed in taking part an appointment was then made to conduct the interview at the local agreed site sanctioned by Coventry Research Ethics Committee and at a time convenient to the participant. At the beginning of the appointment, the participant was asked to sign a consent form (please see appendix 4).

The process of recruitment had to be strictly adhered to in accordance with the ethical guidelines. Although this sometimes felt quite restrictive I was also reassured to know that my enquiries were being conducted in accordance with the concerns that had been raised. At this stage of the research I was lucky to have had the benefit of support from my fellow colleagues who were keen to help. The most difficult aspect of recruitment was in trying to keep within the six week time frame. Many colleagues had contact with people who had self-harmed in the past but by coming into contact with mental health services had reduced their self-harming behaviour putting them outside the time frame. Nevertheless by stipulating the six week period the participants who were recruited were actively self-harming some as recent as a few days before the interview. This gave me some reassurance that the accounts gained were capturing participants' recollections of some recent self-harm episodes.

3.2 Interviews:

The interview then proceeded and on average lasted between 45 minutes to 1hr 15 minutes. This was audio-taped. At the end of the interview participants were given the opportunity to ask questions and were provided with self-help material and national help lines. If appropriate they also had an option to request that I contact their preferred mental health worker if they wished and a consent form was prepared for this (please see appendix 5). Following this the participant had approximately a month after the interview to withdraw their consent for the data to be used. I then transcribed the interviews for analysis.

A semi-structured interview schedule was designed and used as a guide during the interviews process (see appendix 6). The semi-structured nature of the schedule allowed greater flexibility so that the researcher could follow the participants line of thought rather than sticking rigidly to a script. This helped in establishing a connection

with the participant and to explore any interesting areas and follow the concerns of the participants where further fruitful information might be gained (Smith, 1995; Smith, 2003). The researcher also completed a field notebook throughout the data collection period in order to record any therapist reflections of the process (for examiners only to remain within ethical guidelines).

I was pleased that all the interviews went well and was encouraged by the frankness and openness that participants displayed. I quickly realised after the first few interviews that participants desperately wanted to talk about their experiences of self-harm, especially without being subjected to prejudice about their behaviour. It seemed to me at the time, that they wanted the opportunity to let people know what it was like for them. I was therefore encouraged to feel that I had done the right thing by placing participants' views at the forefront of this research. The questions devised were only loosely followed so that participants were free to speak about their anger in self-harm experiences in any way that they wanted.

4TRANSCRIPTION:

Transcriptions were done in the order of the interviews and given a number to identify the participants (i.e. P1 for participant 1) and the letter W for the interviewer and the number one (i.e. W1) as there was only one interviewer. IPA does not require prosodic (speech rhythms) features of talk as is required by conversational analysis but does require all the words spoken to be seen including false starts, pauses, laughs and features that are worth recording (Smith, 2003). Engagement with the text and a process of interpretation was then followed according to the conventions of the IPA method as outlined in 1.3 above (Smith, 2003). As transcripts contain sensitive information they will only be made available to examiners (this follows the guidelines in ethical approval given by Coventry Research Ethics Committee).

Transcription takes a long time and can be quite a torturous process however it had its rewards in my being able to get closer to the words spoken in connection to the text. This helped me to gain a sense of the differences between different participants' accounts and yet map some of the similarities and links they had to one another. When I listened to the taped recordings it help remind me about the features that impressed

me at the time of the interviews. This became a useful way to start to develop a sense of the themes that eventually emerged.

5 THEMATIC ANALYSES:

5.1 Themes

Transcripts were read several times and descriptive notes made of interesting parts of the text were made in the left-hand margin. Emergent themes were then extracted from the sense that was made of what the participants said and recorded in the right-hand margin. Connections between the themes were made initially in chronological form. Once all the data from the transcripts had been scrutinised then the data was sorted according to analytical and theoretical ordering. The idea was to capture the important issues that emerged from each transcript using an iterative process between text and analysis then again overall the transcripts as a whole to complete the analysis.

This part of the process was very exciting and the most rewarding, I really began to feel that the research was worth all the months of uncertainty and negotiation between all the people involved. My main concern was to stay as close to the words of participants as possible but I was also aware that this would not be enough. The process of moving within and between scripts helped me build a picture that encapsulated all the routes and between all the stages in participants accounts. Whilst staying true to their accounts I also hoped that I would help readers make sense of what was being said by the interpretations I brought to the themes.

5.2 Analysis

Using the IPA method, data was scrutinised thoroughly by reading through the transcripts several times and highlighting interesting and significant passages and noting these into the left hand margins. Building themes was done by rereading through each transcript and from the highlighted data making a more psychological analysis of the data to construct themes and noting these into right hand margins. Super-ordinate themes were extracted once a list of the initial themes from first interview was divided. These were grouped according to related pieces of data that were prominent and strongly supported from within the transcripts. Subsequent interviews built on those themes or were changed through an iterative process of

analysis that highlighted differences as well as the common themes that emerged (Smith, 2003).

A paper trail account of the process follows:

From the first interview a list was drawn up of all of the themes (see appendix 7). The list was then subdivided into super-ordinate themes with a heading for each (please see appendix 8). From this initial list of themes and super-ordinate themes, new themes were added after each transcript was analysed (please see table 1). A table was then constructed to record all of the themes. As each interview was analysed the themes were recorded within the table within a previous theme or added when a new theme was discovered (please see table 1).

Theme descriptors used the original wording used by the participants as closely as possible such as 'release' with super-ordinate descriptors tending to be from the sense made of these themes e.g. 'Unbearable Mental Anguish'. Line numbers were linked to the emerging themes to anchor the data into the descriptive narrative used by the participants (please see Table 2).

After all the data was analysed interview by interview and added to the list of themes the data was then sorted and re-analysed across all the interviews. Only themes with enough evidence to support it from across all of the interviews were extracted and a new table was developed. A review and reorganisation of the super-ordinate themes was undertaken after consideration of the way these linked with each other. The ordering of data within the final table reflects the way that data was re-ordered and reorganised. A final table was drawn up once satisfied that the themes that were left had captured the essence of the participant's accounts of experiences (Table 2).

I was aware not to go too far when interpreting the themes that emerged as I wanted to reflect the concerns of participants as closely as possible. I have made attempts to use words that stay as close to the issues participants' raised yet are descriptive enough to help the reader understand the content and nature of the themes. I am aware that my interpretations and choice of themes may differ from others who might analyse the scripts. I hope that the participants who took part will recognise my attempts to portray their experiences fairly.

6. Improving the validity of data:

6.1 Constant comparison and deviant case analysis

Coded data from the transcripts was compared by moving from the singular case where emerging themes are compared for deviations, and then onto other cases and then back again when new cases were added. Going over transcripts this way helps to identify deviant cases and ensures that analysis is thorough (Willig, 2001; Silverman, 2000).

6.2 Paper Trail

In accordance with good practice in qualitative research a paper trail of all data concerned in the building of codes, themes and super-ordinate themes to analysis was kept. A field diary of impressions of the research process of each of the interviews was also kept (available to examiners only in accordance with ethical guidelines). An account of early ideas and conceptualisations in the continuing development of the research for tracking and building on reflexivity was contained within the field diary (Henwood & Pidgeon, 1992; Willig, 2001). As the field diary was only available to examiners and could not be included in the thesis I have included my personal reflections on the process in italics throughout this chapter.

6.3 Triangulation

For the purposes of triangulation and validation of findings (Ritchie & Lewis, 2004), a quarter of the interviews were reviewed by my research project supervisor. Comparisons were made then discussed as part of the process of selecting and sorting themes. Some of the named themes made by my supervisor were dropped as were some of my own themes where discussion led to agreement that little evidence was there to support them over a single case or over all of the cases.

Discussions between my supervisor and myself about some of the issues in the scripts helped me to decide how to name themes. By comparing each others themes in the early stages I was able to question whether any of the themes I had originally listed captured the essence of what was being said. This stopped me from being blinded by earlier conceptualisations that I might bring to the data too early and not be on the look out for alternative views from all participants' accounts. By keeping in mind

throughout that the names selected for themes were meant to project what was being said I felt that I would be keeping as true to the accounts as possible yet also hopefully bringing greater understanding.

6.4 Transparency

In accordance with qualitative methodology which requires transparency the process of analysis was walked through in this chapter above. This might enable the reader to scrutinise thoroughly every step that was taken and follow the process from beginning to end. This may help readers to see where and why choices were made and the reasoning behind them (Smith, 2003). The reflective paragraphs included in italics will hopefully enhance this process further.

7 ETHICAL CONSIDERATIONS:

7.1 CONFIDENTIALITY:

7.1.1 Data

Code numbers were used to identify individual participants and no references to actual names or details that would identify individual participants were disclosed. All data, written or audio taped was kept in a locked filing cabinet when not in use. On the first hearing of the audio material any identifying or personal information was erased immediately.

7.1.2 Transcriptions

Where personal or identifying information was used during the interview this was removed in the transcriptions and a row of XXXXXX was inserted. This was to indicate where information had been removed and to help with the flow of reading. Participants were notified that quotes taken from the transcriptions might be used in future published material with the removal of any personal details or identifying material. Participants were informed of this before consent was given and they were asked to indicate their consent to this on the consent form. They were also informed that after a period of five years all transcripts would be completely destroyed in accordance with ethical approval.

7.2 Authentication:

For the purposes of authentication of transcripts my supervisor listened to each of the tapes and authenticated the transcripts before the audio-tapes were destroyed in accordance with ethical approval granted. A form stating the authenticity of all the tapes was signed by my supervisor and is included in appendix (9).

7.3 Consent

Participants were given an information sheet containing information about the research and what they would be expected to do (please see appendix 3). They were given least 48 hours to consider taking part. Each of the points on the consent form was discussed before the interview began and before they signed the form (see appendix 4). The researcher, the researcher's academic supervisor, and examining body had access to any written data after personally identifying information was removed. Again participants were informed of this and asked to indicate their consent on the consent form. Participants were also informed that this was a voluntary study and that they could withdraw from the project at any time, without affecting their treatment within the mental health service.

7.4 Managing Distress

Participants were given the opportunity to stop the interview at any time. If they became distressed they were encouraged to ask if they wished to stop. The researcher also used clinically validated techniques and clinical judgement to monitor participants' level of distress. Where signs of distress were detected they were given an opportunity to take a break or leave the study. Participants were periodically checked during the interview as to whether they needed a break or wanted to stop. Only one participant actually stopped the interview and took a break. He was given time to consider whether he wished to continue or not and he chose to continue.

Consideration was also given where the researcher believed that a participant was particularly distressed or at risk. The researcher discussed the appropriate follow up with the participant and then agreed that either the participant or researcher would contact the appropriate supports (e.g. primary clinician, GP etc). This did not ensue and none of the participants required immediate contact or support from any mental health workers. There was also time after the interview for debriefing and participants

were given information about who to contact if they should feel distressed later, this included the contact details of their key worker if appropriate (see appendix 10).

7.5 Ethical Approval

Ethical approval was sought and granted in October 2004 from Coventry Research Ethics Committee and the Research and Development Department of Coventry Teaching PCT (Please see appendix 11). City University received a copy of this approval and also sanctioned ethical approval of the study (Please see appendix 12).

All research was carried out in accordance with sound Clinical Governance and Research Governance principles, Coventry Teaching PCT's policies and the Coventry Research Ethics Committee requirements. This study was guided by and conformed to NHS Research Governance Framework and COREC guidelines.

The Researcher also adhered to the Data Protection Act 1998 at all times and complied with the ethical and good practice guidelines of the British Psychological Society.

CHAPTER 3: ANALYSIS OF DATA

1: INTRODUCTION:

This chapter will walk through the development of themes and super-ordinate theme building as outlined in the methodology section previously. This will act as a record of the way the analysis was conducted and provide the basis for replicability. Each of the themes will be discussed in succession and a series of examples will show how the themes were built and were anchored in the words used by the participants. Italicised paragraphs are personal reflective accounts on my own experience of IPA which will be incorporated throughout this chapter.

2. PERSONAL FEATURES OF PARTICIPANTS:

Table 1 outlines the demographics of the participants in order to situate and contextualise the sample and to determine the relevance and applicability of the findings (Willig, 2001; Elliot et al, 1999).

Participant Number	Gender	Age	Sexuality	Marital Status	No of Children	Pseudonym
1	M	18	Hetero	Single	Nil	Ted
2	F	27	Hetero	Single	Nil	Marie
3	F	34	Hetero	Married	2	Katy
4	F	18	Hetero	Single	Nil	Leah
5	F	22	Hetero	Single	1	Louise
* 6	M	39	Hetero	Married	1	Not Transcribed
7	M	23	Hetero	Single	Nil	Larry
8	M	62	Hetero	Married	3	John
9	M	30	Hetero	Single		Dave

Table 3: Demographics of participants:

Out of the twelve participants whose names had been forwarded and then approached, nine agreed to be interviewed giving a response rate of 75%. Unfortunately one of the tapes became corrupted so eight were then subsequently transcribed for the research. As complete transcripts may contain sensitive material they are available only to examiners to comply with ethical approval.

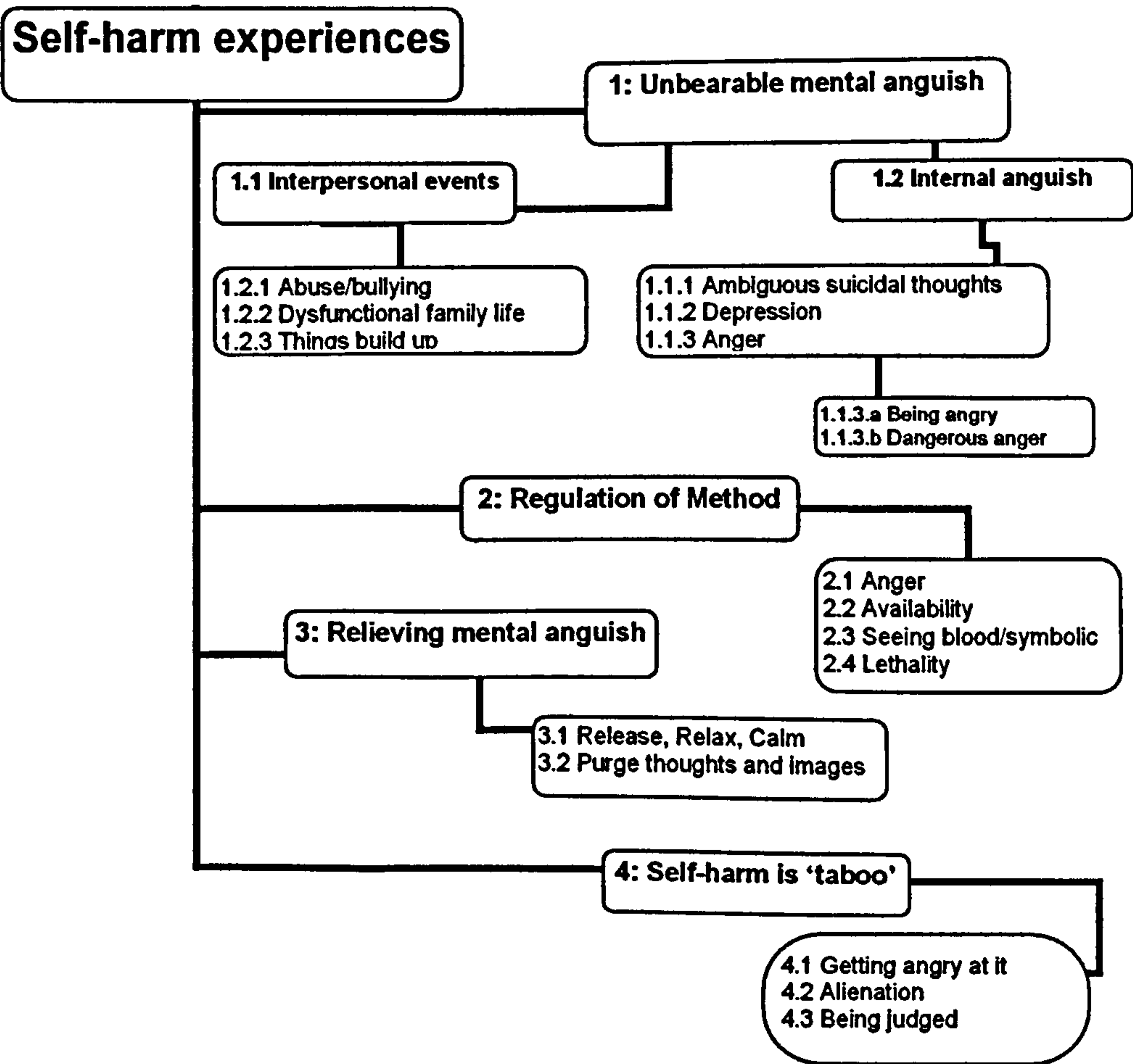
The identifier for each participant is the letter P followed by their position in the number of interviews conducted and is recorded on the transcripts. There is therefore no number six as the tape of this interview was lost as previously mentioned. Field notes were taken after each interview to record the nature of the process from the interviewer perspective and to help in the development of thematic analysis (for examiners only to comply with ethical approval).

3: DEVELOPING THE THEMES:

3.1 THEMES IDENTIFIED:

Five super-ordinate themes emerged from the data: i) Unbearable Mental Anguish, ii) Relieving Mental Anguish, iii) Regulation of Method, iv) Societal Taboo, & v) Impact of Taboo on self. The development of each of these will now be discussed. Table 4: Displays the structure and order of themes. Further details can be found in the list of tables.

Table 4: Themes for self-harm experiences:



Super-ordinate theme 1: ‘Unbearable mental anguish’:

The heading of ‘Unbearable Mental Anguish’ was listed as a super-ordinate theme because the individual themes seemed to be about the unbearable nature of the experiences that participants expressed that occurred just prior to self-harm.

The super-ordinate theme of ‘Unbearable Mental Anguish’ is divided into two sub-ordinate themes of ‘Interpersonal Events’ and ‘Inner Anguish’ to capture the external factors and internal experience of psychological pain that leads to self-harm. The themes contained within the ‘Interpersonal Events’ seem to capture the way that participants experience interpersonal conflict situations. This often precipitated the ‘Inner Anguish’ experienced therefore it seems important to examine this major theme first.

Theme 1.1 ‘Interpersonal Events’

The events just prior to self-harm described by the participants seem to have been experienced within the context of interpersonal conflict and appears to have led to the ‘unbearable mental anguish’ experienced. Three main themes were identified that contributed to the subordinate theme of ‘Interpersonal events’. Two sub-themes account for the different types of experience, namely ‘abuse and bullying’ experiences and ‘dysfunctional family life experiences’, whilst the third captures the process and impact of these experiences such that ‘things build up’.

1.1.1 ‘Abuse/Bullying’:

The theme of abuse and bullying experiences captured participants’ accounts of experiences they had encountered within interpersonal situations where conflicts arose. Some of those experiences occurred in the past usually in childhood where accounts of the memories of the abuse were being re-experienced in present day circumstances. For example the extract that follows describes the way that the participant experiences a flashback of the abuse she suffered in the past which leads to her feeling angry in the present.

‘my mum and dad hurting me, my ex partner/ stabbing me little sister. It’s like I see that in front / that flashbacks right in front of me/ and I don’t know

why I do but I think that it's happening there and then again/ so I try and grab her but she just disappears and that gets me wound up' Louise (line 285).

Louise 'gets wound up', a reflection of the anguish felt at experiencing such a violent image that leads to self-harm to restore a sense of calm. Not all of the participants reported experiencing flashbacks. In some cases it was the experience of being bullied in the past that had repercussions in the present. For example Larry describes the way that being 'taunted' at school because of his 'puppy fat', still sticks in his mind even having left school eight years previously.

When, when I was at school / I did go, have some puppy fat / and I was taunted at times with that / so I think that's stuck really, / a lot of the things have built up from school so, Larry (line 250)

This was not reported as an intruding memory or flashback as such, although it is possible that he had experienced them. It seemed more about the recollection of his bullying experiences.

Its been about eight years since I left school but its still something that sticks in my mind, like the puppy fat, going back even further because, I developed that in second and third year, so / but it still sticks, / a lot of my problems stem from that and I do get angry, / I do find it hard to talk about that sort of thing Larry (line 266)

Larry's accounts seem to reflect a damaged self-image from the 'taunting' he suffered at the hands of the bullies at school. He demonstrates that a lot of his problems, where he feels the necessity to self-harm, stem from the anger he still feels towards the way he was treated. In the interview just after he gave me this account he needed to take a break because just talking about it made him so angry.

In the examples above it is past memories of 'abuse and bullying' that create the distress and anguish experienced. However for some, abuse was still being experienced in present day life and self-harm was used to diffuse the anguish felt in the aftermath of conflictual exchanges. Ted describes living with his parents at home where his father's violence dominates the whole household and he describes how he experiences feeling helpless to change anything.

‘if I, because I’ve done it before, I’ve flipped off the handle at him, and he just ends up standing up and beating seven bells of shit out of me and / then goes and sits down having another drink, / and it’s just like what’s the point, it doesn’t give him any, f, self-satisfaction, it gives him self satisfaction when he get, when he sees me angry, / so I’ Ted (line 783)

Although Ted is angry there is a sense that it is defeated or thwarted by the level of his father’s strength and violence. The anguish experienced is only dissipated when he self-harms. The sense of defeat is demonstrated when he says ‘what’s the point’ in trying to stand up to him, he just ends up ‘beating’ me. Beating him is meant as in the physically sense yet used metaphorically he also appears beaten or defeated psychologically.

Participant’s descriptions of abusive experiences appeared to have led them to experience unbearable feelings of mostly anger but also a sense of defeat in Ted’s case. This might be an indicator of the presence of depression that he talks of in the sub-ordinate theme of depression.

Interpersonal circumstances leading to ‘unbearable mental anguish’ were not always of abuse or bullying and in some cases ‘dysfunctional family life’ also appeared to create circumstances where anguish was experienced.

1.1.2: ‘Dysfunctional family life’:

The sub-theme of ‘Dysfunctional family life’ contains examples of the way that participants have experienced life in general within their families. There may be little distinction between calling an abusive family life as dysfunctional. Family life however may contain dysfunctional elements without abuse occurring and so this theme was distinguished from the ‘abuse /bullying’ theme. Marie for example describes the stress she feels at seeing her mother suffer with depression.

Parents, / yeah ehm, because my mum’s suffering depression as well /, and it’s just frustrating to see her and having her tablets changed over and over again it’s, you know you think, oh well, you know why can’t they give her something that actually works or do something /, so ehm, I’m just sort of, friends as well, the lack of help their getting/. Marie (line 358)

She identifies with her mother's suffering and is clearly stressed by the way that her mother is not getting better. Her sense of frustration with the limits of help she and her mother have had with mental health services is represented throughout her interview.

Descriptions of the experience with parents are both interpersonal and relational in nature. Negative experiences with close family members also seemed to add to the mental anguish experienced. Dave for example talks about his relationship with his father.

'I was more scared of my Dad because he was really quiet /and he wasn't around a great deal, he'd be off working, when he was home it was kind of oh, s, shush, your Dad's watching TV, /he never seemed, he seemed really /discontented with everything/ I think one of, he took me, me and my brother to a, a football game once and I just, did, didn't enjoy it, my brother did'
Dave (line 616)

Dave appears to fear upsetting his father and the relationship appears to have been distant. He goes on to say further on in the transcript that it is only now as he is older that he is beginning to feel that he has some closeness with him.

On the whole participants appear to lack support from the parent/s that they talk about. Marie is also clearly concerned for her mother and this seems to add to the distress she experiences. The lack of support may add to the anguish experienced when faced with difficult interpersonal situations leading to self-harm.

1.1.3 'Things build up':

This sub-theme captures the way that participants described how everyday life stressors built up and they experienced the need to self-harm to relieve the unbearable crescendo of feelings. There are less specific events leading to self-harm spoken about by participants and the non-specific nature of 'things' suggests that there may be a lack of ability to deal with more minor events leading them to build up. In the example following Marie expresses the non-specific nature of experiences that build up over a few weeks requiring her to self-harm.

Ehm, I could have ehm, a time where a lot of things build up, a lot of things have happened over a space of a couple of weeks and then it will get to the point where it needs to come out, so in that situation I would sort of just get a knife, I just cut my arm /, try and, sometimes I, I try and cut myself and it's only like a little cut and you just feel as if something your heads saying no that's not deep enough, / so it's like try again, see if you can do it this time and ehm, sometimes I can and sometimes I can't but yeah. Marie (line 199)

What seems important in Marie's account is her sense of 'things building up' and reaching breaking point where it 'needs to come out' and her self-harm stops this build up. In the next example Ted also describes how in the past his father's remarks would 'get too much' and he needed to self-harm but that he 'lets it go in one ear an out the other now' to prevent that.

'just let whatever dad says go in one ear and out the other, / just my way of starting to deal with things, whereas before I'd just listen to it and take it to heart and it would all just build up and build up and then one day he'd just say something stupid and then, it'd just get too much and you'd just go upstairs and try slash yourself up or something/' Ted (line 183)

This however seems a bit more specific in that he is describing being criticised and of that building up over a period of time. The build up of things would 'get too much' and Ted describes how he would try to 'slash' him-self up to alleviate the mental anguish experienced. John describes the way that things for him 'build up' out of nowhere. Where he could be 'happy and joking' one minute and then 'get agitated' and the easiest way for him to let it go was to self-harm, again this seems less specific.

'I don't know it seems to build, you, you can be fine and you could be happy and joking and all of a sudden you, I seem to get agitated, I get ins, irritable, I get hot, I get sweaty, start feel scratching and then from there, you actually have too release it and let it go, its like a kettle boiling / you know if you don't let it go, and probably self-harm is the easiest way to let it go' John (line 152)

'Self-harm is the easiest way to let it go' for John as his agitation and irritability boil up and he has to release it.

In all of these accounts the build up of 'things' gets unbearable like John's 'kettle boiling' and the self-harm is used to restore things to a more bearable state.

In all of the accounts described by participants self-harm was used to extinguish the 'unbearable mental anguish' experienced arising from the 'interpersonal events' of abuse/bullying, dysfunctional family life, and a build up of things that could not be contained.

1.2 'Inner Anguish'

While 'interpersonal events' described the external circumstances leading to self-harm, 'inner anguish' describes the internal feelings that are experienced. Three main sub-themes were identified in terms of the way that participant's experienced 'inner anguish'. These were 'Depression', 'Ambiguous Suicidal thoughts' and 'Anger'. Anger was sub-divided into two further sub-themes as 'being angry' and 'dangerous anger'. Each will be described in turn.

1.2.1 'Depression':

The 'depression' theme was developed to capture expressions about hopelessness as well as statements from participants about feeling low and depressed. Some of the examples do not use the term depression explicitly in the accounts but statements such as 'what's the point' seemed to indicate a sense of defeat and hopelessness that are akin to depression.

Ted for example uses the expression 'what's the point' indicating a sense of hopelessness and defeat after 'dwelling' on the argument he had with his parents and girlfriend.

'I just sat in my room dwelling on, dwelling to myself, thinking, what's the point, what's the point no-one wants me, everyone's having a go at me/, the three main people in my life at the time were just all screaming and having a go at me because it's like, just some petty little thing that I did, and like I just saw the plug socket and put a fork in there and held onto it for while' Ted (line 262)

'Everyone was having a go', 'no-one wants me' were dwelt on, the sense of defeat again when he says 'what' the point' all before he self-harms to takes away the 'unbearable mental anguish' he experiences. Although he does not state that he is depressed as such this appears to be evident.

Dave does describe his experience using the word depression when being on his own at home becomes 'unbearable' for him. The unbearable nature of the depression he describes often precipitates episodes of self-harm for him.

'As I say it's not something I think about when I'm out and about during the day. It's when I get home / you're kind of on your own for a while and then you kind of just get really depressed and this, its, that, that's usually what happens but it does become kind of routine'. Dave (line 164)

Ted and Dave share the sense of being on their own and Dave explicitly states he is depressed whereas Ted appears to feel he is unwanted and expresses feelings of hopelessness by the use of 'what's the point' to indicate his distress.

Larry also did not expressly state that he was depressed but like Ted the words used to describe his state indicate expressions of affect that correspond with depression. For example Larry's sense of worthlessness and the term 'empty' was used that seemed to indicate just how low he was prior to harming himself.

'Phew, I felt, empty, worthless / that everything that I was doing was going wrong, / that I shouldn't be here / so' Larry (line 73)

So this theme seemed to capture the way that being low, down or depressed were experienced prior to self-harm. However in contrast Leah expressed that being 'too low' prevented self-harm, she was to explain subsequently that her lethargy meant she couldn't sum up the energy to do anything;

'I haven't felt, a lot of the time I think I, I mean this week's been really hard, (mhm) but I've actually harmed less this week and I put that down to the fact that a lot of the time, I was, too, too down to, to harm myself.' Leah (line 586)

On the whole when participants talked of feeling low and or gave statements of hopelessness this was sometimes linked to self-poisoning acts of self-harm and

or ambiguous suicidal thoughts. However there were also examples as Dave's above where self-injury (cutting) was used.

1.2.2 'Ambiguous suicidal thoughts':

The theme of 'ambiguous suicidal thoughts' seemed to capture the way that participants had 'ambiguity' in relation to killing themselves (self-destruction) and harming themselves (self-preservation).

Leah when talking about taking some tablets isn't sure about what might happen. For her the prospect of possible terminal damage to her organs is a known possibility but she is prepared to 'leave that in the hands of the god's'.

'Ehm, /just, just sort of, you'd, if you take them and just, you don't quite know quite what's going to happen, / you don't know whether you're going to be okay or, / whether your liver could fail or that your kidneys could shrivel up and you don't quite know, /and, /somehow you're sort of leaving it in the, in the hands of the gods somehow its, I guess its /'Leah (line 481)

The laissez-faire attitude towards the risk she takes seemed to indicate the way that she was uncertain as to whether this was a self-destructive act or not. As with the next example, again when Larry was asked whether he was trying to kill himself or not he was unsure whether his self-poisoning episodes were self-preservative or self-destructive.

'I don't know it, its just to block out things, /and on top of medication or drink, / I've drank so much that I'd pass out and knowing that I took the medication, as well which is a big /, no, no, so /but I would, I made a mistake once of doing it but then when I got well I thought I could keep using it which I did drinking too much, / making sure I had, took my tablets before I went out and then just drank enough so that I could pass out' Larry (line 82)

When Leah was pressed further about whether the means of self-harm by self-poisoning was suicide or self-harm she went onto say that her intention was to knock herself out, but that she wouldn't be 'particularly be bothered if she did die'.

'it is to harm, sometimes, it might just knock you out for a while and sometimes that, that's what you want, / but at the same time usually if you do

it, you wouldn't be particularly bothered if you were to die, the thought of that, /but the primary intention is not to do it, its Leah (line 505)

It seemed that captured in this theme participants were sometimes engaged in the experience of suicidal thinking and that there could be a fine dividing line between self-harming behaviour and suicidal behaviour on some occasions. The example of ambiguity is expressed by the vagueness of intent from Leah where she says 'you wouldn't be particularly bothered if you were to die'. Another expression of ambiguity was in terms of the lethality of the behaviour at the time. Dave toys with moving his 'slicing' to 'stabbing'.

'instead of slashing you'd be thinking, you sometimes kind of, you get you kind of, heckles up a bit and think about, just, instead of slicing, just actually just stabbing, / just to see what'd happen, and then thinking about the aftermath of that and then I begin to think it through I think, family are going to find me /no, so I've kind of ma, that's stopping me from any kind of, that'd be more' Dave (line 185)

It is the move from 'slicing' to 'stabbing' imagined by Dave that changes the self-harm act from one of self-preservation to contemplation of self-destruction. Toying with the idea between these two positions is evident, before deciding that the aftermath of suicide would mean that his family would find him and so this stops him. The impulse to self-destruct therefore seems to revert back to self-preservation.

1.2.3 'Anger':

In the final sub-theme of 'internal anguish' anger was divided into two further sub-themes to capture two of the major responses given by participants. 'Being angry' was mostly expressed as being experienced towards others within interpersonal contexts either from memories of past experiences or from the way that they were experienced as they happened. In some of the participants accounts anger was expressed as being experienced towards self. In the theme of 'dangerous anger' reported by all of the participants this seemed to be mostly about the anger they felt towards those whom they were angry with. It appeared that participant's anger having been aroused was felt to be too 'dangerous', possibly as a result of the reports that anger was being associated with aggression and violence. As a result participants felt that they needed to

divert the anger away from the person they were angry with. It also seemed that participants felt unable to express the anger due to the levels of 'danger' in it they felt and in turn used self-harm to alleviate the 'mental anguish' they experienced.

1.2.3.a 'Being Angry':

'Being angry' accounts consisted of descriptions of anger affect being experienced in relation to interpersonal conflict situations. Many of the examples appeared to be in relation to experiencing abuse or unacceptable behaviour from others either in the past or in more recent circumstances. This contributed to the 'inner anguish' experienced that necessitated self-harm.

In the first example Louise describes the way that memories of past abuse is replayed in her mind in the present and that the anger she feels towards the person who abused her is so powerful that she needs to hit the wall to dissipate the anger affect.

'It's funny when you do it /. It's like / it's like someone's actually standing there. It's like the person that you hate at the time is actually standing there in front of you, or the object your angry with is standing there in front of you so you just see red and you start laying in to the wall. Louise (line 252)

The person she hates and is angry with is imagined to be standing in front of her, 'seeing red' indicates the level of the anger (rage) and acts as a trigger for her self-harming act of 'hitting the wall'.

In contrast Marie talks about an incident where she is out with friends and someone who attends the same group as Marie and her friends confronts her as to why Marie won't talk to her;

'she just wouldn't drop it and it just, and she then she says oh, you your making me feel uncomfortable with my other friends, and I says, well okay, I'll, I'll move, laughs, so I went over to the opposite side and she says no, no you're still making me feel uncomfortable so I thought, well sod it then I'll go, and I could feel the anger coming up (mhm), so I sort of got up, she sort of, I was going to throw a drink at her, thought no, and just stormed out.' Marie (line 436)

Marie goes on to report that after she storms out she goes onto,

I just stormed out, sort of pushed the door really hard, laughs, (mhm) I'm surprised I didn't break the glass and then just walked over to my friend's car (mhm), and saw the wall and sort of took it out on the wall. Marie (line 453)

The strength of her anger is 'taken out on the wall' by punching it really hard, which is similar to the expression of anger reported by Louise. Marie also avoids taking her anger out on the person she was angry with at the time of the conflict by walking away and later 'hitting the wall'. Louise on the other-hand has the memory of a past event, this is something she cannot walk away from so she also 'hits the wall' to relieve her of the anger she experiences.

In the next example Ted frequently relates the difficulties he has at home living with a violent father and copes with the anger he feels towards him by banging his head to stay calm.

he was all like, you're pathetic, you're never going to get anywhere, and all like this and so I just walked out into the kitchen, and just started smashing my head off the cupboard, he was like, damage any of the cupboards I'll make you pay for them, I was like, fuck it, I'm going outside, just stayed outside until I knew he'd gone to bed and then just went back in. Ted (line 840)

The description of life at home given by Ted is frequently punctuated with his father's violence towards different members of the family. Ted appears to get caught up in exchanges with his father on a frequent basis where self-harm for him is reported to take many forms and acts as a diffuser of the anger and distress he experiences.

All of the participants talked of the anger at others arising in the context of interpersonal situations either past or present, which links back to the subordinate theme of 1.1 'interpersonal events'. Abuse and dysfunctional family life experiences were frequently reported. Also difficulties with people outside of the family were also spoken of in relation to what triggered the anger initially.

A major concern expressed by participants was to direct the anger away from those who they were angry with. This appears to be connected to the way that anger is perceived by participants to include physical and verbal acts of aggression. Ted makes it clear that he stops his anger for fear of retaliation in the form of a physical attack by his father whereas some of the participants were concerned not to harm the other person. Marie for example when questioned further about her anger spoke about the aggressive urges she redirects for fear of consequences.

‘I think I’ve always, gone off the extreme (mhm) even at school/ if someone bullied me, then, they’d only bully me for so many weeks (mhm) and it’ll all build up (mhm) and then I’ll just explode, and, I would actually, grab them, (mm), physically grab them (mhm) and on some occasions I would actually grab them by the neck,’ Marie (line 650)

Then later she states;

‘ think I just think of maybe what would happen if I did do that (mhm), they could, if I’d have, if I’d have hit that girl, she could have phoned the police (mhm) and got me arrested / I sort of think of those things now’ Marie (line 680)

This concern is linked with the theme of ‘dangerous anger’ that will be explored further on in this section.

So far the theme of ‘being angry’ has been in relation to being angry with others. However not all participants experienced anger just with others but also at themselves. The strength of this anger was then taken directly out on themselves by self-harm. Dave’s description of anger sums up best what the experience of being angry at self was like for him.

‘Well I’m just annoyed at myself / I can’t help thinking I’ve, I can’t shake the feeling that I’ve failed, / or I’ve messed up, /, and it’s more, I’m absolutely seething when I’m doing it, but I’m really angry at myself.’ Dave (line 471)

He expresses a lot of negativity and blame towards himself in the words ‘I’ve failed, messed up’, and he is seething at himself and blaming himself for things that went wrong.

The descriptions of anger experiences in the accounts above are all in the context of interpersonal situations. This appears to provoke self-harm whether the anger is experienced towards others or self at the time. Memories of similar 'interpersonal events' can also lead to powerful anger affect and generates the 'unbearable mental anguish' that leads to self-harm.

1.2.3.b'Dangerous anger':

The 'inner anguish' state of 'being angry' within the context of 'interpersonal events' seems to be of such magnitude that participants speak of aggressive and violent acts being envisaged and fears about retaliation, consequences and of not harming those they feel angry with were expressed therefore the theme of 'dangerous anger' was developed.

Larry for example seems to equate the strength of his anger as requiring expression by hitting and as he would never do that to another person the option is therefore to harm him-self or destroy his own property.

'Not really, no I wouldn't there is something that stops me from think, even thinking, contemplating hitting someone, I wouldn't, so hence why I do it on myself and why I take it out on my property so apart from them' **Larry** (line 347)

When participants talked of 'being angry' with others this seemed to be related to the experience of abuse or perceived unacceptable behaviour from others in 'interpersonal events' situations. Leah for example talks about her Dad being angry with her for spilling tea and of her being angry with him back but that she 'couldn't express the anger she felt' towards him so ended up 'hitting herself'.

'my Dad was really angry and cross, and he says oh XX it's all over the, oh Christ you've made a right mess there haven't you, and I felt like I just wanted to say, its not my fault its because of, you know, this side effect, but and then I just thought, its, but then I couldn't take it up with him because I, that I couldn't sort of, couldn't express that anger (mhm) because of the lies and the and all that so, I sort of took it up with myself and that was the last time I, I hit myself.' **Leah** (line 819)

Earlier in the interview Leah stated that hitting herself consisted of her either head-butting or hitting different parts of her body with her fists. As her difficulties had been kept from her family she was unable to explain why her hands had shaken. The anger she experienced therefore could not be expressed for fear that this would expose her secret. Keeping her self-harm and other difficulties secret therefore led to further self-harm.

Katy also spoke of family situations creating a dilemma in terms of expressing her anger. She describes how intrusive memories of past abuse in childhood and of being raped as an adult came back frequently. She also talked about how it felt for her in having a young family and how this meant that it was difficult for her to contain the anger and rage she felt when the images she constantly experienced occurred. This was on top of having to cope with what seemed to be being described as the relatively harmless irritations of her children's behaviour from time to time.

Yeah, I'm scared that I'm going to hurt someone /, eh, its coming, its hanging there somewhere really going to hurt someone, I can feel it / that's why I don't allow them to come out the kid's room really but there not at risk, I wouldn't hit them, I don't know, /, I don't know what would happen if I lost it, /. Katy (line 289)

Katy therefore cannot express the rage she feels towards the intruding abusive experiences of the past whilst in this situation. The situational context places restraints on her ability to express the rage that is held inside and subsequently this leads to self-harm to relieve the 'inner anguish' she experiences.

Participants experience of 'inner anguish' and of 'being angry' at self or others due to past or present interpersonal events required this to be expressed in the form of self-harm. Self-harm seemed to be more preferable than the envisaged lack of control over the aggression and violence occurring within them-selves that seemed anticipated from participants. The thought of unwanted retaliation or other consequences and or the harm to others prevented unleashing this type of 'dangerous anger'.

Super-ordinate theme 2 'Regulation of Method':

The method participants used to self-harm were wide and varied therefore just listing the various methods was avoided. In examining the transcripts it appeared that each of the participants talked of a number of different methods they had used both currently and in the past. It also seemed that different methods were being used for different situations. The theme of 'regulation of method' was developed to capture the way that each of the methods of self-harm appeared to be being regulated. These were narrowed down into four main themes, availability; anger; seeing blood /symbolic, and lethality.

Availability seemed to capture the sense of the way participants talked about using what was 'around at the time', or carrying the 'tools of the trade' with them in order to carry out self-harm.

For example Ted appears to be swayed into using his mother's pills that were on the side partly because he was too lazy to go into the kitchen for a knife and partly because cutting himself would have 'made a mess'.

2.1 'Availability':

'No, it depends, (no), no,/ that all depends on like what's around you at the time / cause like personally the only reason I took an overdose was because there was pills on the side, / and there was quite a large amount of pills on the side, and so I thought, things were getting to me, Dad was having a go at me, and then he went upstairs to bed and I thought, I might as well, couldn't be arsed to go into the kitchen and get a knife, and make a mess, so I took an overdose', Ted (line 250)

Whereas Marie used to carry a knife with her but stopped that. She described how now she also carried her 'tools of the trade' around with her so that she could cut herself whenever she felt she had to. But mainly she cuts her-self at home.

'mainly it sort of all builds up and I'll go home and sort of try and forget it but sort of comes back / so it's mainly done at home, so I have my own little piece of equipment as me and XXXXXX call it. /, our little tools of the trade, ehm, yeah usually just a knife, blade, ehm, /but eh, /I have in the past actually carried a, a knife with me / ehm, but I sort of stopped doing that --so, no, laughs, do it at home don't do it anywhere else'. Marie (line 210)

Ted talks about why the method chosen at that particular time comes down to the convenience of what is to hand whilst Marie has her tools with her for convenience.

Participants may also have a preferred way of self-harming but it also seems that in the absence or removal of that method then they will use what is available. Thus they describe something opportunistic about their self-harm. This is captured in the following example where Katy explains that after a recent visit in hospital they took her method of self-harm away and she described substituting her method of self-harm with something else.

‘So I was in there and everyone was saying oh well she can’t self-harm now. Believe me you can find a lot of things in there you can self-harm with’.

When asked what types of things, she replied,

‘Right, coke tins, / eh, it depends on how jagged your wardrobes are/, you eh, the lighter stop, what else is there, there’s loads of things inside the hospital /, I can’t think of them all, they’ve all changed now, they’ve all got this new hospital, so, / it’s all changed so I don’t know how safe they are because I’ve not been in’. Katy (line 133)

The removal of the means to self-harm when entering hospital still doesn’t appear to stop Katy. She still finds other means of cutting herself with anything sharp she can find. This seems to indicate a powerful sense of urgency and necessity when looking for an alternative way to cut her-self to relieve the ‘unbearable mental anguish’ experienced.

The theme of ‘availability’ sheds light onto the way that participant’s choices of method can be influenced by factors of convenience, choice and limitations being imposed. Participants have also described how resourceful they are where those limits have been imposed. This seems to indicate that a sense of urgency and necessity to self-harm to relieve the mental anguish they experience, takes hold.

2.2‘Anger’:

There were many examples of the way that anger seemed to play a role in the use of methods of self-harm involving physical force against self. Earlier in the

theme of 'being angry' Louise and Marie described hitting a wall when they experienced anger and Ted also described hitting his head against the wall when he experienced anger. Looking at table 3, participants reports of methods used in relation to experiencing anger were as follows, Louise, Marie and Dave talk of hitting walls, whilst Leah and Larry talk of hitting themselves on the body, and Ted head-butting a wall. Only Katy and John do not report hitting themselves when experiencing anger, throughout their transcripts they only report on two methods for their self-harm, that is cutting and self-poisoning.

Hitting oneself by the use of physical force by punching walls or head-butting walls and hitting a part of the body seems different to cutting oneself.

Participants do not appear to talk about why they do this as opposed to another method except to say that they get angry. Dave and Leah talk about head-butting as something they used to do, with Dave suggesting that it was something he grew out of. He also talks about the angrier he gets, the more likely he is to use physical force against himself in the form of punching his face and punching doors and walls.

'I've, it's something, it's not a lot (mhm) but in the past, I've done, I used to, Mum said, I used to, kind of smack my head of the wall when I was a kid quite a bit' Dave (line 318)

'Ehm, but yeah I've punched, I've punched hole in flipping doors and hit walls in the past (mhm), I, I don't know but it seems the angrier I get (mhm) the more chance there is of me, punching me in the face, quite hard as well.' Dave (line 328)

The image of this is very uncomfortable to comprehend and suggests extreme violence being enacted from the degree of anger felt. Yet cutting one-self provides an equally disturbing and violent image to envisage.

Going through all the transcripts Ted, Marie, Larry, Louise, and Dave report throughout to have hit walls and other objects when angry. The descriptions are all similar to the example above. Dave, Leah and Larry have also reported hitting themselves on different parts of the body, Dave hits his face, Larry hits his stomach and Leah hits her arms and legs.

In Larry's case it appears that hitting his stomach is directly linked with the anger he feels about being overweight, hence targeting this area.

I do tend to whack my stomach a lot (mm) so, I do hit so hard that it does hurt. **W1: Yeah and can you tell me a bit about what triggers that off?** Its, I'm a bit overweight anyway, I do want to do things like go to the gym and eat healthy and I do sometimes do that but I've never been as big as I am (mhm) I don't like it, so. **Larry (line 169)**

There seems to be a link between Larry's feelings of being overweight to hitting his stomach whilst Dave and Leah report no direct link to the areas of the body they hit.

Overall there appears to be a need to use physical force when anger is being discussed by participants. There does not seem to be any reasons given as to why hitting is used as opposed to cutting or self-poisoning for example when discussed. The common denominator in all of the participants accounts where hitting has been discussed as the method used is 'being angry'.

2.3'Seeing Blood/Symbolic':

Within the super-ordinate theme of regulation of method seeing blood was a significant regulator of the method chosen at the time. Some of the participant's accounts talked about the symbolic meaning for them in seeing their own blood. The following extracts describe the manner in which blood is symbolically being used. Louise describes the wish to wipe away her past like the way she wipes away her blood, so perhaps she can feel that she has dealt with it.

/It's like my past innit. You cut yourself / and it's like you see the blood coming down and you wipe it away and it's gone. / That's how I want it to be with my past. **Louise (line 522)**

This suggests that symbolically seeing blood is experienced as having the power to take away the past. Other participants also emphasised that needing to see blood was important and Dave even made pictures from it.

‘so, and then I’ve got a, I don’t know to be honest, I, when I started doing it I started bleeding onto paper / and making pictures out of it, which sounds kind of odd, so I’ve got a booklet full of pictures which are pretty much scab’s / so next I’d be looking at these things and they dry like a river bed and crack /, and ehm, I made a ton of those but after a while I just packed that in’ Dave (line 135)

Participants may be influenced by the ease and convenience of a particular method at the time. Generally cutting is the most frequently used method of self-harm reported by all of the participants. This suggests that there may be other psychological factors present when a person uses physical force in response to experiencing ‘anger’ as opposed to other forms of ‘mental anguish’ where cutting or overdosing is preferred.

2.4‘Lethality’:

The sub-theme of ‘lethality’ is used to capture the way that participants talked about the method of self-poisoning as a more lethal form of self-harm. Nearly all of the participants talked about overdosing by the use of tablets with or without alcohol as a method when thinking about the suicidal thoughts that they had. The word suicide was used to distinguish the use of the method of self-poisoning as distinct from self-harm as in the following example. John describes how when he had enough he tried to kill himself by taking sleeping tablets and a bottle of vodka.

‘Uh, I had enough I tried some suicide ehm, (mhm) I always thought when it come, I would be in control I would make no mistakes cause I read about other people, oh well if you’re going to do it you’ll do it right. (Okay) you know, you either walk out under a train, but that’s to messy I wouldn’t (mm) so I saved up a lot of sleeping tablets (mhm) and I took about thirty five, which I thought was more than enough, plus a bottle of vodka’, John (line 284)

He makes it clear that the use of self-poisoning by taking tablets and vodka was supposed to end his life. This was meant to be ‘lethal’ but unfortunately he goes onto say he miscalculated by keeping the tablets for too long and being sick bringing the tablets up again.

The idea that taking tablets is a 'lethal' method for ending life was also expressed by Katy who really wants to die at times but 'hasn't got the bottle to do it'.

'The feeling of wanting to die has been there (mm) but I've had no bottle to do it / so if I could be left alone I was okay', **Katy** (line 30)

If she could be left alone she might do it and she describes how being watched over prevents her from carrying this out.

The tablets are another self-harm way, that's how I (yeah) self-harm as well, but I was going to take all these tablets and X walked in and caught me, (aha) as usual, and he took the lot off me, now X in, X my partner, huh, (mhm) he, he's the one that's got the medication now, (yeah), he has to keep giving it to me (okay) at certain times so, I don't know **Katy** (line 38)

Taking tablets therefore could be 'lethal' and warrants her partner to take control of the medication she takes. 'Lethal' and 'more drastic' ways of self-harming are also confirmed by Larry as overdosing. Larry also talks about a serious attempt he had made to end his life when he tried to hang himself and expressed this as 'throttling' himself.

I did yeah, / yes it was a better way from what I was doing and how I was feeling, / it was either that or, / actually trying more drastic ways, / and one of the more drastic ways of me self-harming, like, like putting myself / to the overdoses and the throttling, / its actually, the actual strong ones might be actual suicidal ones I'd want to end my life / with so **Larry** (line 96)

Larry is clearly equating the 'strong and drastic' methods of self-harm with his experiences of trying to end his life. All of the participant accounts confirm that they felt that overdosing, by taking tablets and or alcohol was a more lethal method of self-harm and therefore the expression used was suicide. Other lethal methods were also described as suicide.

The 'lethality' theme has some overlap with the theme of 'ambiguous suicidal thoughts' described earlier when Katy describes how she has not had the bottle to take enough tablets to end her life. John, Katy and Larry described self-poisoning acts of self-harm as being a 'lethal' method that carried the risk and had the potential to end their lives.

Looking at the super-ordinate theme of 'regulation of method, when participants described 'availability' they were concerned with convenience, choice and limitation on the method used. Where 'anger' experiences occurred there was evidence to suggest that the use of physical force seemed important. Cutting is the most frequently used method reported and the symbolic meaning attached to 'seeing/blood' was important. Self-poisoning acts of self-harm were seen as 'more drastic' and lethal and seemed to be used whenever a person was contemplating ending their life. There was some overlap with the theme of 'ambiguous suicidal thoughts' where there might be ambiguity from participants in not being sure about ending their lives. Therefore it seems that the method being used can be indicative of the experienced emotion attached to it, such as 'anger', or 'wanting to die' or that the method has some symbolic meaning attached to it such as 'seeing blood' or the circumstantial restraints of 'availability' is in operation.

Super-ordinate theme 3: 'Relieving Mental Anguish':

All of the participants talked about the way that self-harming brought a sense of relief from the 'unbearable mental anguish' from distressing events or memories of distressing events experienced. There were two main ways that relief was experienced by the participants reflected in the sub-themes below. 'Release, Relax and Calm' was developed to capture the essence of relief experienced, while 'Purge thoughts and images' captures the way that participants expressed getting rid of the unpleasant and distressing thoughts and images.

3.1 'Release, Relax and Calm'

Each participant had different ways of describing the relief they experienced after self-harm. Sometimes this was related to the particular experience of mental anguish being talked about at the time.

Larry for example is talking about the way in which he hits his stomach to release the anger he feels towards himself because he feels overweight.

'I suppose at the time I'm, I don't really know, I don't think it really helps, / but at the time I just I'm doing it, I'm thinking, it does release something any way, / it releases a bit of tension, /, so releases a bit of stress and the anger /but then when I think, it doesn't look quite normal to do it /, and that I end up having a sore stomach / so' Larry (line 308)

The self-harm acts as a way to 'release' the stress, tension and anger that Larry cannot bear any longer. Leah on the other hand is talking about the way that cutting and seeing the blood is calming because then she knows that she is alive. This seems related to the way that she frequently feels 'empty' and 'hollow' described in parts of the transcript.

'I've thought about this quite a lot about why, why there's that need for blood and, I think there's lot's of reasons really I've, I think a lot of it is the fact that when you see blood you, you know that you're alive, you know that that's running through you, and, and that /yeah, sorry, ehm, / I just find it, really calming just to see it' Leah (line 192)

This was also related to the way that the tension she felt 'built up and up' and 'just boils up' requiring self-harm to calm things down for her again.

I just, it sort of just boils up in you, it, sort of feel this tension, in you it sort of builds up and up and up' Leah (line 208)

In the transcripts all of the participants use the terms of release, relax and or calm seemed to describe the experience after self-harm is carried out. This also seemed connected to a belief that self-harm was something useful and preferable to what was expressed as the 'unbearable' levels of 'mental anguish' being experienced. There is a sense of the level of distress not being able to be contained unless the person self-harms.

3.2 'Purge thoughts and images':

The theme of 'purge thoughts and images' was developed in response to the way that participants appeared to need to rid themselves and purge the distressing thoughts and images that created 'unbearable mental anguish' for them. They appear to purge the disturbing nature of them by the use of self-harm.

Louise describes her experience of having a flashback after watching a television programme.

'Erm, I was watching telly (mhm). I was watching telly and there was this programme (yeah) about gypsies and caravans and things like that / and then it's like, I could see it in front of me/ W1: so this was thoughts? No it's like, it was like, it's a flash back (yeah) of something. Oh man'. Louise (line 459)

The images referred to, are of sexual abuse, where she wanted to kill 'him' she then goes on to cut her arms and her legs to get rid of the disturbing image described as follows,

'Yeah, It's like when you get a video innit and the video player gets stuck and you try and smack it and it just won't move. It gets stuck on one picture. It was like that.' Louise (line 491)

The flashback is described as a mental image that 'gets stuck' which appears to be so disturbing causing the 'unbearable mental anguish' being expressed that Louise cuts herself to 'purge' her-self or rid her-self of the image that causes the distress.

In contrast Marie after describing the experience of being low and getting lower from thought about things that happened in the past uses self-harm to 'block out these thoughts'.

'Ehm, ---usually it's, if it's sort of rubbing or scratching it's, it's sort of things are sort of deep down that come up occasionally (mhm), and it's sort of, sort of feels like, if I can get this pain then it will, that will give me something to think about and block out these, these thoughts (ok), ehm, cutting is a quick fix thing I think it's, (ok) it's a quick' Marie (line 327)

The pain she feels from self-harm acts as a way to displace the psychological distress that she cannot bear. Thinking about the pain from cutting herself relieves her of the psychological pain she experiences, giving her a 'quick fix'.

In the examples above there are descriptions of the desired affect sought by the participants, such as a sense of calm, being relaxed or at peace after using self-

harm. Linked to this is the experience of distressing thoughts and images that require purging to alleviate the 'unbearable mental anguish' and restore the sense of calm and relaxation that is desired. From other accounts self-harm also seems to help them relieve the tension, anger, agitation and irritability they experience. It seems that participants know that they can get this sense of calm and peace from self-harm and there is no mention of other ways to alleviate distress being spoken about.

Super-ordinate theme 4: 'SELF-HARM IS TABOO':

This super-ordinate theme is concerned with the way that participants describe their experience of others reactions to them when they self-harmed. The interpersonal context included both professionals and family alike. The super-ordinate theme of 'self-harm is taboo' seemed to capture the way that participants spoke of the sense of censure and discomfort received when they tried to speak about their self-harm to others. It also captured the way that participants spoke about the reactions when faced with the evidence of self-harm in the form of scars from cuts or overdosing etc.

This theme is divided into three sub-themes, the first two sub-themes of 'getting angry' and 'being judged' are concerned with the way participants describe negative reactions about their self-harm behaviour whereas the third sub-theme is concerned with the impact of that experience creating a sense of becoming 'alienated' as a result of their self-harming behaviour.

4.1 'Getting angry':

In general responses received by participants were reported as being largely negative and often seemed to evoke anger that prohibited them from feeling that they could talk about their self-harm. In the following example Leah having gone to the local health centre to see a doctor after she had cut herself experienced the doctor acting in an aggressive manner towards her.

Okay, ehm, a while ago I went to see a doctor at the health centre and I found his reaction very negative, / I thought his tone was really aggressive ehm, he was just, started saying why did you do that, why on earth did you do that, that's really silly, you shouldn't do that and personally I found that very

harmful, / and I think maybe if he'd understood a bit more and knew a bit more about it, then my experience would have been different. Leah (line 59)

It is clear that the doctor's reaction to Leah really distresses her she goes on to say how this added to her distress and in turn fed into suicidal thinking when she says she 'just wanted to end it really'

'I just, I just wanted to go out, I just wanted to run out the room, and ehm, / just wanted it to, to end really, Leah (line 112)

Although subsequently she goes on to describe how she later was able to see that it may have been his inexperience that caused his negative reaction, at the time the impact of his reaction was to provoke suicidal thoughts in her.

In contrast Marie gets angry her-self when she recalls the way that a chance remark about self-harm and suicide is made during a conversation taking place within a service users meeting.

'we were just talking about the crisis service and ehm, and mentioning about suicides and ehm, one person said I've actually, I've committed suicide, I've tried to commit suicide and I also self-harm, and someone just turned round and said, it's just attention seeking (mm), and I just thought, I just thought, just answered back like, well it's people like you that makes people like us, not want to go out to get the help, because, we know, that you're going to get people like you saying, oh, we are attention seeking' Marie (line 145)

In the exchange that is recalled the remark about 'attention seeking' is seized upon by Marie and she retorts that it is just this kind of remark that prevents her and others like her going for help. Marie clearly feels angry at this remark and was seen to be angry during the interview when she recalled the incident. Ted on the other hand talks about the way that his family have reacted towards his self-harm.

'I went to the fridge in the kitchen and got a can of beer and just sat down drinking that, took a couple of pills, took a couple more, finished a coup, the can off, took a couple more /, felt a bit woozy, went too sleep, didn't think I was going to wake up man, woke up with a killer hangover, / and then parent's saw the wrappers and stuff on the floor in the morning and just started 'scitzing' at me saying ah your crazy, trying to kill yourself in the family home, and you bring shame to us and all this, and that just,' Ted (line 531)

Ted in his despair takes pills and beer and doesn't expect to wake up, but when he does he is faced with anger (scitizing) from his parents. He experienced his parent's angry reaction as indicative of more concern being shown towards the shame that the family would experience if he had succeeded than any concern being shown for him.

In all of the examples of 'getting angry' the negativity about self-harm is evident. Lack of experience and appropriate responses to participants when self-harming or even talking about self-harm was described adding to the sense that 'self-harm is taboo'.

4.2: 'Being judged':

Another prominent concern for participants was a sense that they did not want to be judged by anyone. Dave was concerned about how his family might react if they found out he was self-harming adding to the sense of the 'taboo' nature of the behaviour with the thoughts that he might be seen as 'weird' and even more 'strange'.

'I wouldn't like some unwelcome attention / in a very negative way, and as far as my friends and family, God knows how my family would react, laughs / because I've touched on the subject with my family before in regards to other people and they have thought it was really weird / went yeah that's flipping weird that is, so, they already think I'm strange, laughs, so that on top, I thought nah, that would just be really un uncomfortable for me/ and'
Dave (line 89)

'Unwelcome attention' is anticipated from previous tentative attempts at trying to gauge his family's response to self-harm. Being seen as 'weird' would not be helpful and he mentions that they already appear to think that they think he is 'strange'. It appears that where family might be being considered as a source of comfort he cannot trust the reaction he might face.

Ted also seemed to have concerns about being judged and that people would say something about it.

'if I cut myself on my wrists, people are going to notice and then they can say something,/ so if I do it down on, on my ankles or something it's still going to bleed enough, and it's still going to make me feel better, so I do it down there and it's covered up, so no-one will see and no-one know any different, so no-one will judge you, an make you feel even worse, cause when people judge you it's just like, everyone's looking at you and thinking that you're a weirdo and that you're a downfall to society or something/ , so / that's why I usually hide the scars' Ted (line 235)

Ted and Dave make it explicit that they do not want others to see the scars for fear of 'being judged' in a negative way. Other participants also covered up their scars but did not explicitly state that it was to prevent being judged but hiding the scars seemed to be important to them just the same.

1)'arms, legs, just anywhere; anywhere where no one can see it (Okay, where you can cover it up)yeah anywhere I can cover it up by putting a jumper on or a pair of trousers or a long T-shirt or whatever, where no-one can see it'. Louise (line 237)

2)'Ehm, in the winter I tend to cut on my arms cause, it's easier to cover, (okay) ehm, during the summer it tends to move to slightly more concealed areas, laugh.W1: Where in part, can you tell me where in particular or? Ehm generally legs or stomach area' Leah (line 147)

Hiding scars for fear of disapproval and strong negative reactions from others was a prime concern in participants' accounts. Whether explicitly stated or not participants seemed to be uncomfortable with others seeing their scars from cutting episodes of self-harm. This adding to a sense of self-harm being thought of as a 'taboo' subject by the way that others might react.

4.3 'Alienated':

This theme was developed to capture the essence of the way that participants felt as a result of negative reactions and judgment experiences. From the sub-themes of 'getting angry' and 'being judged' participants expressed the negativity they had received. It also seemed that there was a sense that the subject of self-harm was difficult for people and professionals to talk about. The way that participants talked about the lack of supportive and appropriate responses seemed like a form of rejection to participants. The rejection experienced seemed to 'alienate' participants hence this became the title of this theme.

Louise describes her experience with counsellors in the past where she has felt that they have backed off from her when she broaches the subject of her self-harm.

‘Laughs, they just treat you different, its like if you say if, its like I’ve had some counsellors say like they’ve been alright and then when I start going into my self-harm they just like, they like brush it aside and then they just like go onto the previous bit that I’ve already just been over, they don’t like going into detail, and they just, they just back off you /, and back off like what you really need’. Louise (line 94)

When pressed further to explain why she did not feel that she got support she explained that once when the subject of self-harm was introduced by Louise a counsellor had walked out on her.

‘I’m trying to think, I had one counsellor walk out, (walk out), yeah walk out on me, (oh, and what happened after that then, just that’s it), just never saw her again W1: oh, okay, and where were you seeing her then or I was seeing her at the school, (oh, right, okay), she was the school counsellor and she walked out, because I was telling her about self-harm, (right) so she walked out. Got up and left.’ Louise (line 107)

The lack of compassion experienced when the counsellor walked out on her left Louise experiencing being ‘palmed off’ and unsupported.

‘You feel worse, makes you feel more like, crap, makes you feel like you’re mad, (right) because you do it and then they just palm you off, onto other people and then they palm you off onto somebody else, its just goes round in circles and you’re never get nowhere (right) and you’re still self-harming, you’re still doing it’ Louise (line 159)

Louise’s experiences have left her feeling rejection from the people she has sought help from. The lack of experience in knowing how to respond appropriately seems to be something that Louise had experienced on a number of occasions.

In contrast to this Dave talks about the anticipated rejection response from potential future partners on seeing his scars from his self-harm.

‘and I’ve thought about it with someone else, what’s that on your arm, you know (mm), what’s that on your leg, (mm) ehm, and their going to be kind of freaked by that (mm). (So is it) it wouldn’t freak me out cause (mm) I don’t know, I’d have to, I’d get to know someone first, before I get into that anyway’ Dave (line 442)

‘Their going to be freaked by that’ is the anticipated response and he seems unable to envisage any compassionate response as an alternative. This links in with the theme of ‘being judged’ where participants show their concerns at others seeing their where they have cut themselves.

The experience of others disapproval and that talking to others was difficult led some participants to experience a sense of isolation adding to an ‘alienating’ experience.

/ alone, would be the word that springs to mind, as if you’ve got no-one to talk too, /, as if no-one is willing to listen, so you just /try an /I don’t know, it kind of evokes a picture in my mind of like a turtle, where you kind of shrink yourself up into a little ball and conceal yourself from everyone’ Ted (line 94)

Ted’s picture of withdrawal and of experiencing having no-one to talk to or listen to him adds to the sense of isolation and ‘alienation’ he feels. Not talking about it and not being listened too are prominent themes in participants accounts when they try to talk about self-harm.

Participant’s experiences of receiving lack of approval, support or the right to talk about it seemed to create a climate of ‘alienation’. The experience of ‘alienation’ adding to the sense that ‘self-harm is taboo’

It seemed that there was a general air of negativity experienced by participants towards them in encounters with others adding to the powerful sense that self-harm is highly disapproved of and little understood. Strong and negative reactions (anger) were reported to having been evoked. In turn this appears to influence the way that participants’ felt that they needed to hide their activities of self-harm and the evidence of their behaviour (i.e. scars), for fear of disapproval. It seemed that they were also left with a sense of having become ‘alienated’ from others as a consequence.

5: 'LINKING THEMES':

All the themes discussed have distinct qualities and also share some overlapping concerns. Each of the themes sought to capture the essence of participants concerns when they described their experiences of self-harm. Within those experiences anger themes were a feature of the way participants experienced anger within them-selves and also received anger from others within the overall experience of self-harm.

In looking at the themes it appears that there are multiple pathways to self-harm. Also, in reading over the accounts of all of the participants' experiences it seems that each participant can use several different pathways towards self-harm. The diagram below demonstrates these pathways to show how the themes extracted from the participants could be linked together. At the start 'interpersonal events' precipitate the experience of 'unbearable mental anguish' and 'internal anguish' experiences. 'Self-harm is taboo' is also fed into the 'internal anguish' experiences from the theme 'alienated' and towards the 'interpersonal events theme' from 'getting angry' and 'being judged' sub-themes. This is then followed by the 'regulation of the methods' theme that distinguishes the form that self-harming takes before the experiences of 'relieving the mental anguish' occurs.

The following diagram represents the described experiences of the eight participants who took part in this research project and are representative of the way in which they spoke about their experiences and not intended to be a comprehensive representation of all pathways that may be experienced by others who may self-harm. The diagram has been split between anger experiences and all other experiences to reflect the interest in the role of anger within these experiences. The model maps the route of anger from the precipitating interpersonal events that trigger anger, through to the emotional experience of anger and finally to the behaviour in the form of self-harm that releases it.

Table 5:

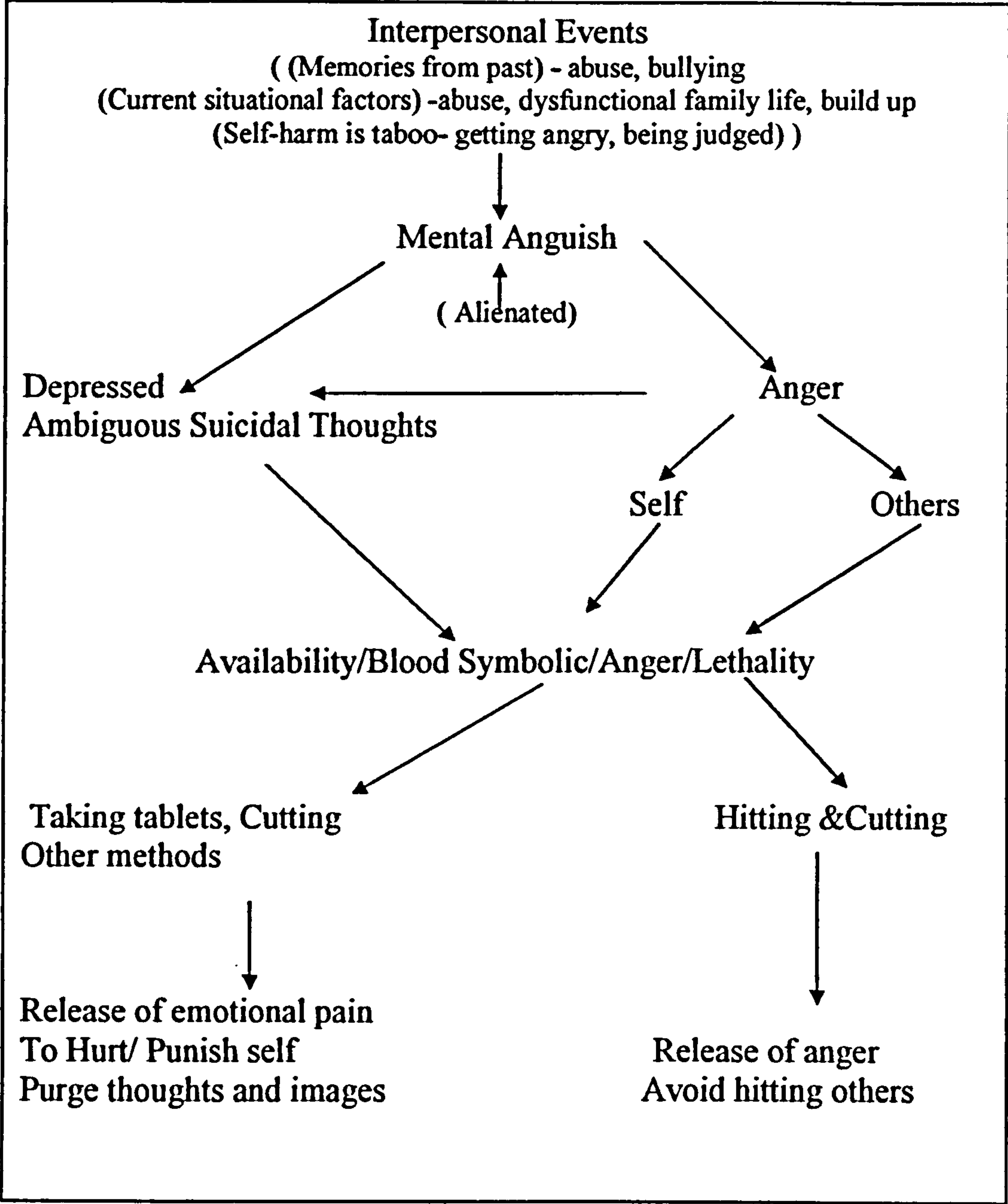


Diagram of various pathways of self-harming behaviour 2006:

By tracing the pathway of an individual’s experience of self-harm it may be possible to devise a number of therapeutic interventions towards the three key points (events, emotions and behaviour). For example, during interpersonal conflict where anger is experienced individuals may need to understand their anger in relation to the perception they may be using at the time. I.e., does the current situation warrant getting angry? Has the past coloured the view on the

present situation? This could be a matter of helping to separate the influence of past events from the present situation thus reducing or alleviating anger altogether. Separating anger experience from anger expression may also be helpful. For example if anger is experienced it may be that individuals could be taught how to express their anger in more appropriate and effective ways such as learning to use more assertive means of expression. Beliefs that anger equals aggression and or violence may therefore be usefully challenged and enable those who find it hard to express themselves. If anger is directed into appropriate and effective expression then this may in turn help to reduce the need for self-harming behaviour and some of the accompanying feelings of hopelessness and suicidal thinking (please chapter 4, section 6 for further discussion).

CHAPTER 4: DISCUSSION

1: INTRODUCTION:

The discussion will examine the results from the analysis, firstly in relation to that of the role of anger in self-harm and secondly in relation to self-harm behaviour in general. Each area will be examined against the existing literature and then the discussion will go on to examine the limitations of the study and methodology used. Clinical implications and areas of further research will follow and finally the conclusions.

2: A BRIEF OVERVIEW AND SUMMARY OF RESULTS:

The research question ‘understanding the role of anger in self-harm’ was approached by examining anger in the wider context of self-harm. A summary of the themes for anger will be highlighted first, in order to orientate the reader to the main focus of the study before discussing the anger themes from the analysis against the current literature on anger and self-harm.

Anger in the super-ordinate theme of ‘unbearable mental anguish’:

Two main themes were identified within the super-ordinate theme of ‘unbearable mental anguish’ and sub-theme of ‘internal anguish’ that specifically address the role of anger in self-harming behaviour. These were ‘being angry’ and ‘dangerous anger’.

Anger in the super-ordinate theme of ‘regulation of method’:

Participants commonly reported that when they experienced anger reaching a point of unbearable proportion various methods of self-harm were used to alleviate their mental distress. One method was emphasised in the participants’ accounts in connection with being angry and this was described as hitting self on various parts of their bodies.

Anger in the super-ordinate theme of ‘relieving mental anguish’:

Every participant described their use of self-harm as a way to alleviate unbearable mental distress. Within accounts on anger participants also described using various methods of self-harm to restore a sense of peace and calm. They also said that they used self-harm as a way to block out any unwanted thoughts or images experienced.

Anger in the super-ordinate theme of ‘self-harm is taboo’:

The taboo nature of self-harm and negativity associated with the responses participants received set up a vicious cycle of anger. The sub-theme of ‘getting angry’ consisted largely of the angry responses that participants received from others and how this appeared to result in their own anger in return.

Summary:

From participants reports anger’s role in self-harm appears to have more significance than the current literature appears to specify. In particular there appears to be a direct link between the experience of anger and participants self-harm behaviour that has not been highlighted before.

The antecedent factor that most commonly preceded participants’ anger was interpersonal conflict. Abuse, bullying and general conflict within interpersonal spheres and a sense of not coping when things built up produced the feelings of anger that participants reported to experience.

The experience of anger either at self or others appears to be associated with the perceived expectation from participants that their expressions of anger will include aggression and or violence. They universally expressed concern not to harm others with their expressions of anger. However they also stated that the strength of anger experienced was unbearable and therefore had to be released. All of the participants stated that they directed their anger towards

self in the form of self-harm. Only then could they restore a sense of peace and calm. Anger therefore seemed to be the key affect experienced before participants self-harmed and this may be an important factor when considering therapeutic intervention when working with others who self-harm.

The discussion will now compare these main themes for anger against the current literature introduced in chapter 1.

3: COMPARING ANGER THEMES WITH EXISTING LITERATURE:

By looking at the major anger themes, participants' accounts highlighted interpersonal conflict to be the major preceding cause of their self-harm. Many forms of unacceptable abuse and other behaviour towards participants were reported. Interpersonal conflict situations in particular seemed to give rise to all of the incidences where anger was experienced before participants self-harmed. Participants also reported that they became angry when they perceived violations against their personal integrity from comments and other exchanges made in everyday non-abusive or less abusive circumstances. Therefore it seems that anger was the initial response experienced by participants. This point seems to be missing within the literature reviewed.

3.1 (a) 'Being angry'

'Being angry' appears to become unbearable to the point where participants perceive that they need to self-harm. The unbearable nature of the anger experience seems to be linked to the intensity of memories of previous violations even where relative minor violations occur in more recent episodes. Therefore for most of the participants it was recollections of abuse suffered in the past that appears to have acted as a trigger for the anger experienced. However these were not all of the same magnitude and were not in similar circumstances therefore looking at these separately seemed important.

Memories of childhood sexual abuse coupled with domestic violence and rape experiences appeared to have produced extremely disturbing intrusive memories and flashbacks in two of the participants' accounts. The disturbing nature and strength of emotions appear to produce high levels of anger (rage). It appears impossible for the participants to contain it within themselves and self-harm was reported to be used as a way to release this.

Traumatic symptoms seemed to be present in the form of flashbacks and disturbing memories and the pattern of behaviour described by participants corresponds with the type of complex form of PTSD found in those who have suffered childhood abuse (Van der Kolk et al, 1996; Chu, 1998; Herman, 1992; Foa, 1998). Participants recounted behaviour corresponds with Van der Kolk's, (1998) assertion that those who suffer from self-harm and other disorders will spend a lot of time organising their lives around repetitive patterns of reliving and warding off traumatic memories. This statement seems very similar in essence to participants' recollections. The distinction between here and now anger provoking situations and past memories being provoked at these times may hold the key as to why participants felt unable to express the rage they experienced. It is possible that the intensity of the anger partly belonged to past events more than the current events warranted. This may be an important distinction when determining therapeutic intervention.

Anger is not reported to be a central feature of PTSD with the emotional focus being largely on anxiety and fear. However in literature that encompasses complex PTSD related to childhood abuse issues, affect regulation takes centre stage when seen in conjunction with self-harming behaviour. Anger whilst being acknowledged to exist indirectly as a symptom of complex forms of PTSD did not appear to be identified as being directly linked with self-harming behaviour. The literature seemed to emphasise the inability to regulate affect as the main reason for self-harm

(Fonagy et al, 2004; Linehan, 1993; Kennerley, 2004; Briere, 2002), however types of affect were not distinctly specified.

Participants also spoke of the physical and verbal abuse experienced from parents as something that triggered their anger response. In Hefferan & Cloitre's (2000) study comparing a PTSD and borderline personality group with a PTSD only group found that verbal and physical abuse by the mother may increase the likelihood of the development of borderline personality disorder. There may be similar findings in this research study, where one of the participant talks of his father's violence and verbal abuse as a trigger for the intense anger he experienced. However unlike Hefferan & Cloitre's (2000) study he was angry with his father perhaps this raises the possibility that emotional abuse from either parent may be a contributory factor.

This theme was primarily concerned with anger arising in interpersonal situations and so far the discussion has looked at participants' anger at others in the context of abuse situations either past or present. However another aspect of anger and self-harm was reported as arising in everyday interpersonal contexts where participants found people's comments triggering anger. Participants' sensitivity to the perceived verbal violations seemed to be at the centre of the anger response leading to self-harm. It is possible that self-harm may have followed due to the presence of poor interpersonal skills and affect regulation skills (Linehan, 1993).

Getting angry however may also be due to the perceptions becoming corrupted from years of abuse whereby the remark that is made or minor criticism becomes magnified in the person's mind. Cognitions may then become distorted whereby the remark or criticism becomes linked to painful emotions from past abuses or violations. This would therefore have a similar affect to the intrusions of traumatic memories, but instead of a fear

response this activates an anger response (Le Doux, 2004; Kennerley, 2005; Dalgleish & Power, 2004).

Where disturbing memories were less traumatic and originating in less abusive contexts there appeared to be more rumination attached to the thoughts occurring from participants accounts. Negative appraisal and ruminations were identified with maintaining PTSD symptoms and may act as internal mental triggers for unwanted memories of past events (Ehlers & Clark, 2005). This may also help to explain why some of the participants stated that they wanted to rid themselves of unwanted thoughts by self-harming.

There was one further aspect that was captured in the theme of 'being angry' and this was in relation to the way that participants expressed being angry at themselves. In one example the 'seething' anger experienced by a participant towards himself seemed to be the trigger for his self-harming behaviour. This aspect may be related to the ideas of inhibited aggression, and self-punitive thoughts in the development of depression put forward by (Gilbert, 1999). In the participant's account he has 'messed up and failed' warranting the angry response to himself. The negative appraisal of himself seems close to low self-esteem issues and may be linked to the development of depression symptoms and para-suicidal thoughts contained in the transcript (Fennell, 2004; Hunter & O'Connor, 2003). The literature that links anger as a factor in the development of depression appears to be sparse but the analysis findings seem to concur with this idea.

The examples of 'being angry' are varied and appear in different situational contexts but all have an interpersonal component to them. There appears to be evidence that the provocations for anger may be a relevant area of investigation to establish the cognitive appraisals being used. The need to look at the ability to regulate the affect of anger arising from poorly

developed interpersonal skills and regulation of affect and the possible development of reactive aggression also seem to be important factors.

3.1 (b) 'Dangerous Anger'

This theme was used to encapsulate the way that participants described their own anger as being 'dangerous' and therefore had not to be unleashed for fear of harming others. This concern was expressed by all the participants and this seemed to be a prime consideration that participants gave for self-harm being a better alternative.

The sense of danger came in expressions where anger seemed equated with physical forms of aggression and violence being envisaged (hitting) therefore the re-direction of this 'dangerous anger' went into self-harm. There also appeared to be an awareness of the other person's right not to tolerate the anger in the form of aggression and or violent acts in statements of 'not wanting to hurt others' which were frequently expressed. There were also statements about the possibility of consequences and retaliation being expressed by participants.

Everett & Gallop, (2001) identified intense anger as symptomatic of abuse survivors and anger expression identified within two distinct patterns of coping. That is, suppressed anger leading to depression, or overly expressed anger leading to alienation and isolation from others. Linehan (1993) also has observational data that similarly identifies suppression of anger with depression and suicidal thoughts and fears attached to past incidences of overly expressed anger.

Participants' accounts seem largely to concur with the idea of suppressing anger and there was some indication of past incidences where they had lost control of the anger they experienced.

The literature on anger tends to focus on treating inappropriate displays of anger such as aggressive and violent acts (anger-out) (Kassinove & Tafrate, 2003). Whereas participants had difficulties when holding onto the anger experienced (anger-in) in that they reported to have experienced this as both unbearable and requiring them to turn that anger towards themselves in the form of self-harm. Very little seems to be written about treating this aspect of anger experience and the literature tends to concentrate on discouraging negative anger-out expression by the use of assertiveness skills, cognitive restructuring and relaxation techniques which have proved to be effective in these types of cases but might not be so helpful when trying to help those who self-harm (Kassinove & Tafrate, 2003).

There is some evidence to suggest negative and contra-indicatory results for relaxation techniques on some women who repeatedly self-harm (Huband & Tantom, 2004). However cognitive restructuring and assertiveness skills may have some benefit if anger was reduced as a result of reconstructing thoughts and appropriate expression of anger learnt to replace the need for self-harm.

Participants appear to have endured abusive behaviour from others and the lack of positive ways to handle anger being displayed towards participants may reinforce the idea that anger equals aggression and violence and therefore 'being angry' is 'dangerous'. This therefore seems to affect their ability to find appropriate and effective expression and in turn leads to self-harm.

In the literature on anger, anger expression is often discussed in relation to gender differences and cultural differences being shown (Kring, 2000). In this study participants were equally divided between males and females taking part and all used self-harm as a method of coping with the unbearable level of emotions experienced. In the literature on self-harm,

anger did not appear to be studied independently from other factors. This might be problematic in that it may overlook the significance of anger in the overall aetiology of self-harming behaviour.

For example, if inhibited aggression and self-punishing thoughts are associated with higher rates of depression, and, anger and resentment are the key affects in the development of depression (Gilbert, 1999, Gilbert & Gilbert, 2003) then the distinction between anger and depression might become hard to make. This might explain why there is such ambiguity between self-harm and suicide in the participants' accounts. Feelings of hopelessness might be more akin with thoughts of suicide and anger with self-harm for example. This may also fit with the oscillation of affect between anger and depression that is similar to the polarisation of affect in Linehan's (1993) contributions on borderline personality disorder.

If suppression or keeping anger in leads to depression, self-harm might be seen as a safety valve for the expression of anger experienced and possibly lowering the need to feel depressed. By taking some control by self-harming this might lead to a reduction of the feelings of hopelessness over the events precipitating anger. Therefore a self-preservative form of self-harm has been chosen (Babiker & Arnold, 2001). Brown et al's (2002) study also supports this idea in that self-harm was reported to be linked with expressing anger to regain normal feelings and distraction. Suicide on the other hand was reported to be linked with the perception that this would lessen the burden for others.

Social ranking theory was also thought to be a factor in inhibiting expression of anger (Gilbert, 1999) with speculation that this may act as a constraint when anger is experienced towards those of higher social ranking but less constrained towards those of lower social ranking. This pattern was identified in connection to domestic violence and childhood abuse

situations and identified as a possible factor in the development of poor interpersonal skills in these areas (Herman, 1992). This may also account for the way that participants in this study were unable to envisage expression of anger except by aggressive and violent means and also from the fear of retaliation expressed by some. Most participants gave examples of abuse/bullying as triggers for the anger they experienced. Some experienced this in current situations and some were directly linked with past events being experienced as intruding memories.

Herman (1992) highlighted that where survivors of abuse are faced with confrontation in interpersonal contexts they direct the aggression experienced at them-selves and this is consistent with participants' accounts. Van der Kolk et al's, (1996) study also found that participants who had suffered interpersonal abuse before the age of 14 developed difficulties in modulating anger, including modulating aggression against self and others and engaged in self-destructive and suicidal behaviours. Again this is consistent with the findings of this study.

Overall this theme has linked the fears about expressing anger to participants' reports of their perceptions that anger equals violence and or aggression. This in turn results in fears over possible retaliation from others and or alienation. The levels of anger experienced may be linked to past abuse or violation more than the present situation warrants and therefore may also be a factor in deciding to suppress anger. Suppression of anger may therefore lead to self-harm as a form of self-preservative action. However it may also lead to depression and possible self-destructive forms of self-harm. There is some evidence in participants' accounts that they alternate between these two positions at times.

Perceptions about anger may need to be challenged as well as helping participants' to express anger more appropriately. This may prevent the

secondary effects of self-harm and depression occurring. There is evidence that memories may also require intervention by possible restructuring and understanding the links to present day experience. This might help alleviate the distress and anger that builds up into unbearable proportions.

In the next section the factors that control the method of self-harm chosen will be discussed.

3.2 'Anger' in 'regulation of method:'

Anger was a distinct theme in the super-ordinate theme of regulation of method. In participants' accounts it seems that there was a lot of evidence that anger was linked with the need to express it by the use of physical force against oneself. This behaviour was most typically reported to be in the form of hitting self by head-banging/butting, punching walls, or hitting face, arms legs stomach by participants. Participants also used cutting as a method of self-harm when angry however this was not mentioned as often in the accounts. This type of self-harming behaviour does not appear to be linked specifically with anger in the literature therefore this highlights a potential discrepancy.

Of the literature reviewed direct descriptive references to hitting one-self was not prominent. However, acting out behaviour was highlighted in Parker et al's (1998) study and head-banging was mentioned as one of a number of those behaviours. In this study several participants highlighted that anger, either at themselves or at others, was experienced just prior to banging their heads. This was off walls typically and or on other hard surfaces. Hitting self was also by punching or throwing self at walls and also punching ones own body.

It was difficult to find any theoretical understanding for this type of behaviour but Iwaniec, (2000) looked at the effects of childhood emotional

abuse on children where they were emotionally stunted and saw head-banging behaviour as a marker of emotional disturbance. She also saw head-banging as a form of self-harm occurring when the child was distressed and angry. Insecure attachment patterns in childhood were discussed as a contributory factor. It is possible that childhood patterns continue into adulthood and further discussion on attachment issues will follow when comparing theory with the findings.

Authors have reflected that acts of self-directed aggression after feeling anger are carried out but none of the literature on adults have highlighted the significance of hitting self or linked this method of self-harm with anger. They have also reflected on the possibility that the anger felt towards another is expressed towards oneself as a safer or more acceptable option (Allen, 2001; Babiker & Arnold, 2001) and this was confirmed by participants and was an aspect already discussed.

To speculate it may be that the experience of anger produces an urge to lash out but this is inhibited therefore is redirected to self as part of the impulsion to act. In turn this gets rid of the anger and therefore restores a sense of equilibrium. This might be linked to biological reactivity such as anger producing adrenaline for action, and pain in the form of self-inflicted injury producing enkephalin. The enkephalin produces a pleasurable feeling therefore is connected to the perception of a restoration of calm and the way out of dealing with built up anger. The next section will discuss this more fully.

3.3 'Anger' in 'relieving the mental anguish':

Within the theme of relieving mental anguish, anger was one of a number of emotions that was reported to have been experienced as unbearable. All participants gave examples of becoming angry before using self-harm as a way to release the unbearable-ness of the way they felt.

The super-ordinate theme of relieving mental anguish encompasses the way that participants talked of the after-effects of self-harm. Self-harm seems to have bestowed a powerful calming effect for participants and restored a sense of 'normality' to them. For some self-harm was also used to divert and block psychologically painful thoughts, images and or emotions. Two main themes were developed to capture participants accounts, that of 'release, calm and relax' and 'purging thoughts and images'.

3.3.1 'Release, relax, calm'

Participants' accounts were full of references made to the beneficial effects of self-harm and were expressed in terms of releasing tension, of being relaxed or having a calming effect after self-harm was used. This also seemed connected to a belief that self-harm was something useful and preferable to what was expressed as the 'unbearable' levels of 'mental anguish' being experienced. There is a sense of the level of distress not being able to be contained unless the person self-harms. Huband & Tantum, (2004) speculated that dissociation may be a factor that helps the person to reach a euphoric state in order that they can then cut them-self. The state of euphoria therefore not only enables self-harm but becomes a preferred state with further benefit once cutting produces biological relief (in the form of natural opiates released) from the pain.

The repetitive nature of participants self-harming behaviour is prominent throughout the transcripts and this seemed to indicate an addictive quality in the accounts. As mentioned a link was made between the biological production of enkephalin after cutting is released to ward off the ensuing physiological pain. The pleasurable effect of this is akin to taking opium or heroin and thus is thought to play a part in the repeated acts of self-harm where cutting is concerned (Kennerley, 2004; Favazia, 1992).

3.3.2 'Purges thoughts and images'

This theme was an alternative one given by participants on the benefits of self-harming. This seems to be linked with participants accounts of 'abuse/bullying' where memories of abuse/bullying is experienced in the form of flashbacks, intrusive memories or ruminations on events from the past. The unbearable nature of the thoughts and images were purged by the use of self-harm and as above to restore a sense of peace and calm.

Various self-harm methods may be chosen but alternative ways of expression of their 'unbearable mental anguish' did not appear to be even contemplated. It seems therefore that once the benefits of self-harm are experienced this becomes an almost automatic response when reading through participants accounts. This may be as a result of the addictive component in the production of naturally occurring opiates and the effectiveness seen from the point of view of participants in restoring peace and calming effects (Kennerley, 2004; Favazia, 1992). Alternatively self-harm may also be seen as the only choice where the lack of or absence of 'mentalization' skills or regulation of affect skills preside in those who have had insecure attachment patterns in childhood (Linehan, 1992; Fonagy et al, 2004).

3.4 'Getting angry' at the taboo:

The super-ordinate theme of 'self-harm' is taboo' was developed to capture participants' accounts of the way that they experienced other peoples' reactions to their self-harm and in turn their anger and sense of alienation at this.

'Getting angry' encapsulated the experience of how others would become angry towards participants self-harming behaviour. It also captured participants' anger in return to the negativity and hostility received and of this ultimately leading to further mental anguish where self-harming behaviour

sometimes increased as a result. Participants seemed to focus on the way that friends' family and professionals appear to have let them down. This perception seemed to be linked with the reception of their self-harming behaviour as deviant and warranting anger and hostility. This reinforced a sense of 'taboo' in relation to self-harm within participants' accounts and this was also given as a reason to hide their behaviour.

Lack of understanding and inappropriate responses to participants from family, friends and by some professionals when they had self-harmed or even tried to talk about self-harm was described. The negative responses from others may have arisen from concern, horror at the self-harm act itself, whether, self-injury or self-poisoning, lack of experience and feelings of helplessness and hopelessness engendered in the person. The angry reactions received appear to cause great distress to participants. This may be in part to the perception from participants that this is reminiscent of some of the abusive behaviour they have already experienced. Participants may also be sensitive to remarks or criticisms that are reminiscent of painful emotions from past abuses or violations (Kennerley, 2005).

Participants suggested alternative and more helpful ways in which to respond to their self-harm. Such as them being allowed to talk about their self-harm and being listened to. It seems that given the opportunity to speak about things may have the power to alleviate some of the distress being experienced. Babiker & Arnold (2001) advocate the use of acceptance, understanding, compassion and respect when listening and taking seriously what is being said.

In terms of encounters with professional they also highlight the many ways in which accepted practise and limitations on mental health services can interfere with the way that professionals are allowed to work with people who self-harm. Thus it was reported that getting access to professionals who could give them time to talk was difficult. Responses by professionals varied and

shouting and getting angry was seen as the most damaging by participants. The perception that there was a general lack of care, of punishment and condemnation at times by professionals were key features in the participants' accounts.

In general friends, family and professionals were perceived to have given little care and to have been condemning of their self-harm. Punishing attitudes and behaviour were also reported to have been experienced. These experiences can therefore make it difficult for people who self-harm to ask for help and or talk about their difficulties. 'Lack of care' may repeat internalised attachment patterns where participants re-experience behaviour reminiscent of poor parenting and painful affect. Likewise 'punishment and condemnation' may be linked to abuse/bullying issues and low self-esteem issues (Allen, 2001; Fonagy et al, 2004; Van der Kolk, 1996; Fennell, 2004).

Therapeutic work may need to include addressing all the people involved with an individual, to provide information, education and promote understanding of self-harm. Good practise guidelines could be developed for professionals whilst, consulting close family members where appropriate may be helpful.

All of the anger themes are interrelated but it was important to understand each of these areas separately to build a fuller understanding of the role of anger in self-harm behaviour. Whilst the literature does not highlight anger's role in self-harm separately it has provided comprehensive information and theory on self-harm. This study has provided data that suggests that anger is a prime emotion in the aetiology of self-harming behaviour. There are a number of key areas where consideration of anger's role is important and may need to be highlighted in formulations when working with individuals who self-harm.

4. Summary of general self-harm themes:

This section will look at the general themes that capture further aspects of self-harm and provide a backdrop for the anger experiences already discussed. Whilst these areas were not intended to be the focus of the study nevertheless they provide important information about self-harming behaviour.

Two remaining themes were left after anger in the Super-ordinate theme of 'Internal anguish'. These are Depression and Ambiguous suicidal thoughts. There were also a number of regulating factors other than anger in the super-ordinate theme of 'Regulation of method'. These were Availability, Seeing blood/symbolic, and Lethality. Finally in the super-ordinate theme of Self-harm is taboo, there were two themes other than that of 'Getting angry at it' and these were, Alienation and Being judged.

Depression:

Participants spoke of the depression experienced usually in the aftermath of interpersonal conflict situations and when they were on their own. Being depressed appears to be linked to feelings of hopelessness and worthlessness and general negativity towards self. Low self-esteem and poor interpersonal skills were identified as contributing to greater mental anguish in the face of interpersonal conflict and general life stressors.

Ambiguous suicidal thoughts:

Ambiguous suicidal thoughts were discussed in relation to the way that all the participants had spoken of the difference between suicidal behaviour and self-harm. Whilst they were clear about the distinction in terms of their intent and the lethality of the method chosen there was some evidence that the demarcation between suicide and self-harm became blurred.

Other regulators of self-harm:

The method of self-harm used seemed to be regulated by a number of factors. From participants accounts the availability of a method could determine what was used at any time, particularly when the preferred method was not available. Multiple methods could be used by any person for different purposes at different times and seeing blood seemed to hold symbolic meanings for some participants. Participants spoke about the lethality of the method used determining whether an act was a suicide or self-harm.

Other themes in 'self-harm is taboo':

Finally the taboo nature of self-harm also encompassed the negative reactions of others and the sense that they would be judged. The impact from the experience of negativity surrounding their self-harm behaviour was expressed in terms of the alienation participants felt as a result.

4.1 'Internal Anguish'

4.1.1 'Depression'

This theme captured participants experiences that corresponded to feelings encountered when depressed. Explicit use of the term depression was not always made but rather the terms used corresponded to statements similar to those when depressed. Experiencing hopelessness, worthlessness and negativity towards self a major preoccupation usually occurring in the aftermath of interpersonal conflict situations and when participants were on their own.

The evidence from this study that participants experienced depression concurs with the findings of Haw et al's (2001) study where 70% of the participants who self-harmed were found to report depression. Low self-esteem seems evident from participants' self-critical statements and may also be a contributory factor in the development of depression that

corresponds with the literature on self-critical and perfectionistic thinking involved in depression (Fennell, 1999; Fennell, 2004).

The majority of participants spoke of abusive childhood backgrounds with a few exceptions. The exceptions were those who reported bullying who appeared to have more self-critical statements possibly as a result of a damaged sense of self from the bullying. Social perfectionism described as 'excessive expectations' that others have of us are associated with greater hopelessness and greater suicidal ideation (Sidley, 1998; Hunter & O'Conner, 2003). It is possible that where children are brought with abusive and or critical caregivers there is a tendency to develop perfectionistic thinking styles and this may be a feature of participants' poor interpersonal skills. If participants have low self-esteem and have poor interpersonal skills this may be contributory in them experiencing being overwhelmed and overcome with 'unbearable mental anguish' when encountering interpersonal conflict and general life stressors.

4.1.2 'Ambiguous Suicidal thoughts'

This theme captured the ambiguity that participants experienced in respect of their self-harming behaviour. Cutting was a method that all the participants typically engaged in and mostly discussed as self-harming behaviour. Suicide was discussed by all the participants as distinct from self-harm and involved the use of more lethal methods of behaviour such as taking overdoses of tablets with or without alcohol and or other extreme forms of self-harm such as hanging for example. Participants whilst making distinctions between the two seemed more uncertain when questioned further about their 'intention' to die in relation to some self-harming behaviours.

Self-injurious forms of self-harm were distinguishable from suicidal behaviour in Babiker & Arnold's (2001) view in that the former was

thought to be motivated by a desire to live and cope with unbearable mental anguish (self-preservation) whereas the latter is seen as a desire to end life to avoid and or escape from unbearable mental anguish (self-destruction). Therefore the intentionality of the purpose of the behaviour also seemed to be an important distinction made however with the added view that suicidal intent can be subject to ambivalent and competing emotions making it difficult to clearly distinguish the extent of the 'intent' present when a person contemplates self-harm or suicide Babiker & Arnold (2001).

The dividing line between those behaviours from participants' perspective also seemed to be extremely thin at times when examining the thoughts expressed about accidental death. Self-destructive (suicidal) impulses were sometimes contemplated at times of great 'internal anguish' moving participants to contemplate the use of more lethal forms of self-harm. This typically was the ingestion of tablets and or alcohol. The question of how much was enough to kill seemed to dominate participants' accounts with failed suicide attempts being used as a yardstick measure. Participants seem to have worked out what was safe enough. This then became a desirable form of self-harm (not suicide) where there is benefit derived from the semi-conscious states induced. However this potentially harmful behaviour could increase the risk of accidental death. The person may miscalculate the amount that is safe or the risk can come from the longer term damage to internal organs after ingestion of potentially harmful substances over long periods of time.

Another aspect to this type of behaviour is the divorced nature of participants thoughts in the form of what seemed like a detached thinking process around the 'intention' to carry out suicidal behaviour. This seemed like a form of dissociative risk taking. The ambiguity is expressed when participants discuss the experiences of harming oneself with thoughts about what it would be like to take it a bit further and accidentally killing oneself

in the process. The fuzziness of intent may be due to the taboo nature of suicide and a desire not to own the decision to take ones own life therefore accidental death would seem more acceptable. Likewise to own up to wishing to take ones own life where negative reactions may be anticipated from another person may be experienced as difficult. There is ample evidence from the analysis that all the participants had difficulties with others reactions to their self-harming behaviour within the super-ordinate theme of 'self-harm is taboo' to be discussed later. Within the interview process itself it is likely that participants also brought with them the expectation of negativity from previous experiences to bear in relation to the way they spoke about their self-harming behaviour.

4.2 'Regulation of method'

This super-ordinate theme captures the way that participants spoke about how the methods of self-harm used seemed to be influenced by various regulatory factors. The psychological processing of affect seemed to be closely connected to the method of self-harm used in different situational and psychological contexts.

The behaviours listed in the literature review were comprehensive (Conterio & Lader, 1998, Smith et al, 1998, Gardner, 2001, Allen, 2001). Although listing behaviours was not part of the research enquiry, this was an area that participants discussed during the interviews. The comprehensive accounts and list of methods used by some authors sometimes failed to highlight the variance of methods used by any single person and of the factors that might account for that variance. During the analysis it became clear that all the participants had used different methods over the duration of the period from when they first self-harmed to the most recent episodes. Four main factors were identified as regulators within the participants accounts and were listed under the following themes; Anger, Availability, Seeing blood / symbolic and Lethality. Anger was discussed earlier.

4.2.1 'Availability'

This theme is linked to participant's reports of the way that the circumstances at the time of self-harm could restrict or enhance availability and access to a preferred method. Therefore the method of choice such as cutting may not be possible and another method to hand is chosen instead (for example tablets etc). Some participants' spoke of taking their cutting equipment around with them but sometimes this may be taken from them when entering hospital for example therefore they would have to improvise and look for other ways to harm themselves.

This is not an area that was typically discussed within the literature reviewed and discussion around methods of self-harm seem to give the impression that a single preferred method is used by any one person when in fact multiple methods may be chosen by that person. Some methods may be for one purpose where others for other purposes. This applies to both the entire period when the person started self-harming or within more recent episodes. Babiker & Arnold (2001) have linked methods of self-harm to functions but participants accounts of their behaviour did not to fit as neatly into these functions. There appeared to be much more fluidity between methods chosen. As discussed earlier in the theme of ambiguous thoughts participants although clear that suicidal behaviour was distinct from self-harm sometimes ingested tablets (normally associated with suicide) but by stopping short of taking a lethal dose this was then turned into a method of self-harm.

4.2.2 'Seeing Blood/symbolic'

This theme was developed from the way that the symbolic meaning attached to the need to see blood was expressed by a few of the participants. This fits in with many of the accounts from the current literature available (Babiker & Arnold, 2001; Favazia, 1992; Kennerley, 2004). The symbolism is captured by a participants' account where the wiping away of her blood

represented the wiping away of her traumatic and distressing past. For another participant seeing the blood was a way to reconnect back to the world and meant that she was alive. This account is reminiscent of the way that Smith et al, (1998) describe self-harm as a means of connection with the world again after becoming dissociated. It is thought that the dissociated state occurs when feelings of emotional pain, shame, humiliation reverts to anger but cannot be expressed outwardly. It is also thought that the anger experienced is directed towards self by the use of self-harm and also becomes a means to reconnect to the world afterwards. Every participant talked of having used cutting as a method, not exclusively but as the most typical form of self-harm. They also chose self-poisoning just as often but for them this was seen as suicidal behaviour by participants and driven by feelings of hopelessness and of depression as discussed earlier. Therefore cutting may represent a self-preservative form of self-harm as discussed by Babiker & Arnold, (2001).

4.2.3 'Lethality'

This theme represents the expressions by participants about the role of lethality of the method chosen as a marker of more suicidal (self-destructive) self-harm episodes. This is linked with the theme of 'Ambiguous Suicidal Thoughts' previously discussed. The most important issue for participants was the way in which they described the taking of tablets, with or without the use of alcohol as suicide as distinct from the use of other methods of self-harm. This seemed to be related to the way in which taking tablets and or alcohol was seen as potentially more dangerous to participants. Some variations on other more lethal forms of self-harm were expressed by participant where hanging had been used and stabbing had been contemplated. Therefore the issue of lethality seems to be an important one for participants in that for them this is what distinguishes self-preservative from self-destructive forms of self-harm behaviours.

4.3 'Self-Harm is taboo'

This super-ordinate theme was developed to capture the essence of participants' accounts on the way that they experienced other peoples' reactions to their self-harm and in turn their sense of alienation. The sub-themes of 'getting angry' and 'being judged' was concerned with the way participants describe negative reactions about their self-harm behaviour whereas the third sub-theme was concerned with the impact of that experience creating a sense of becoming 'alienated' as a result of their self-harming behaviour. The theme of 'getting angry' was discussed earlier.

4.3.1 'Being Judged'

This theme captures the participants accounts of behaviour that they engaged in to prevent them from feeling judged. The secrecy surrounding their self-harming behaviour and hiding the scars were prominent themes in these accounts. This added to the sense that self-harm was a taboo.

The secrecy of self-harm seems to be engaged in to prevent the perceived further conflict they may face as was described above in the theme of 'getting angry'. They also appear to not want to be seen as different, 'weird' in some way so it was important for them to hide the behaviour so that self-harm is always carried out alone and out of the sight of anyone else. The scars that are left from cutting are also hidden under clothing that covers arms for example or the cutting is done in places on the body where it would be covered up anyway. These seem like self-preservative forms of behaviour designed to hide things away from the scrutiny of others for fear of rejection and or further conflict. However this can also lead to a lack of awareness from close family members, friends and some professionals who could help if they were able to do this with adequate resources for training and or knowledge about how to respond to those who self-harm (Babiker & Arnold, 2001).

4.3.2 'Alienated'

This theme captures the type of mental anguish experienced as a result of the impact of the negative reactions from others about their self-harming behaviour, the anger that is experienced by participants in return and the way that they felt they were 'being judged' brought about the sense of being alienated.

The lack of supportive and appropriate responses to their self-harming behaviour from family, friends and professionals all added to a sense of rejection in participants' accounts. 'Being judged' and hiding their self-harm also further alienating them from others. Feelings of isolation, loneliness and rejection were expressed as was the sense that they had no-one to talk to and no-one to listen to them leaving them with more 'unbearable mental anguish' leading to further self-harm or possible suicidal behaviour.

Participants may already struggle with low self-esteem and shame may be a feature of this, particularly where issues of childhood abuse and bullying have been experienced (Gilbert & Andrews, 1998). The self-punishing nature of self-harm may be the expression of anger, rage and despair taken out on self as a reflection of the sense of alienation they receive and in turn feel towards their own bodies (Gilbert & Andrews, 1998). Self-harm when seen in this context therefore seems a useful way to punish self for all of the failings they perceive they have.

Participants accounts of the nature of the taboo surrounding self-harm highlights the types of experience encountered that contribute further to their self-harm. This cycle of experience may need to be appreciated when working therapeutically with someone who self-harms. Interventions may have to address the contribution of the individual's network of existing relationships to

the difficulties encountered, such as, interpersonal skills training, joint therapy sessions with partners, and education on self-harm to others.

5. Comparing findings with current theories:

There were four main theories discussed in the literature review, psychodynamic theory, DBT (dialectical behaviour therapy) theory, CBT (cognitive behaviour therapy) theory and biological theory. Each of these areas will now be discussed against the findings on anger and other major points above.

5.1 Psychodynamic theory:

Within psychodynamic theory, attachment theory was prominent within the literature on self-harm. Poor ability to mentalize effectively was argued to be the primary reason for the inability to manage unbearable emotional states such as rage, despair, anxiety, loneliness and the sensation of numbness (Allen, 2001; Fonagy et al, 2004). In relation to self-harm, the development of insecure attachment patterns in childhood is held to be responsible for the inability to mentalize effectively. Traumatic early experiences and neglect also have a significant impact on the ability to mentalize and is thought to be an important factor in the development of personality disorders (Bateman & Fonagy, 2004).

Participants in the study all reported forms of abuse occurring in childhood, two participants reported sexual abuse, by stepfathers, two reported severe physical abuse by parents, and four bullying by children they attended school with. Therefore half of the participants give evidence of abuse by caregivers that may signal the likelihood of having insecure attachments whilst it is more uncertain whether insecure attachment with caregivers had been an issue for the rest.

However interpersonal difficulties and the inability to regulate affect were reported by all of the participants. These factors might represent evidence of insecure attachment patterns but without measures actually being taken for this it is difficult to be certain whether this is the case. Another discrepancy with the theory is the way that self-harm is encompassed within a personality disorder perspective and again it is uncertain whether any of the participants could be diagnosed with a personality disorder.

The literature on attachment theory and self-harm does provide comprehensive material on how to help clients regulate their affects. The method consists of identification, modulating and expressing affects (Fonagy et al, 2004). This method could therefore be applied therapeutically where appropriate regardless of the actual diagnosis. As participants identified anger as a major affect experienced this method could be helpful.

Modulating the anger experienced by reinterpreting the meaning attached to a situation or event may be beneficial, particularly where early experiences predispose a person to use particular interpretations and not consider alternatives. There were many examples of the way that participants struggled to contain the anger experienced towards others and self. Reinterpreting the meaning might lessen the level of anger and other affects present thus preventing self-harm. Learning to distinguish between experiencing anger and more effective ways of communicating the anger felt by appropriate means can also be usefully employed. Participants were concerned not to harm others with their anger. The interpretation that anger is dangerous thus could be usefully challenged. Help can also be given on effective and appropriate expressions of anger, possibly by learning to regulate anger affects or applying interpersonal skills. Employing this method to increase mentalization skills may lessen the 'unbearable' nature of the anger experienced and reduce the need to self-harm.

5.2 DBT (dialectical behavioural therapy):

This method was specifically designed to target people diagnosed with borderline personality disorder and or suicidal behaviours. As mentioned previously participants may not meet the diagnosis of borderline personality disorder. However they all mentioned occasions where they had had suicidal thoughts.

This therapy combines standard cognitive behaviour therapy with dialectics (the bringing together of opposites), i.e. all good versus all bad. Treatment focuses on helping patients to develop better emotional regulation, interpersonal effectiveness, distress tolerance, mindfulness and self-management skills (Linehan, 1992). These skills are designed to help the person towards better self acceptance, and to focus on what is happening in the moment. When this is achieved this will enable the person to counter any preset perceptions based in past experiences. This seems similar in some ways to the mentalization skills described in the attachment theory perspective above, however the method of achieving this differs. The awareness of emotion has to be acknowledged then learning to tolerate the distress used as an alternative to self-harm. Negative thoughts and perceptions are also challenged and reconstructed. This may reduce or eradicate the distress and again lessen the need to self-harm.

In terms of anger and depression these two emotions might be seen as polar opposite affects in the cycle of self-harm. Ambiguity between self-harm and suicide was discussed earlier (in section 3.1b). Feelings of hopelessness were seen as being possibly linked to suicide and anger with self-harm. Oscillations between the two affects were also thought to mirror polarised thinking in terms of all good and all bad type of positions. Linehan (1993) states that there are a group of individuals diagnosed with borderline personality that would meet the criteria for depression. This group have also been found to have difficulties with expressing anger, preferring to remain passive and submissive. There was

some indication that this follows from earlier encounters where over-expression of anger had taken place. Linehan (1993) states, that in almost all of the cases in this group, individual's had fear and anxiety about anger expression. Their concern was thought to be fear of losing control and that even minor expression of anger would bring retaliation from the person they directed their anger towards.

There is evidence from participants' accounts that corresponds with the fear about anger expression. There is also some corresponding evidence that depression was a factor in some of the participants' accounts in and around the times they had thoughts about suicide. Linehan's (1993) account is from her observations about women who attend a clinic for para-suicidal borderline patients. This research therefore may provide enough evidence to back up the observations or provide a starting point for further research.

5.3 CBT (cognitive behaviour therapy):

Kennerley's (2004) model for self-harm is not tied to any pre-set diagnosis and therefore this makes it more encompassing of all those who self-harm and of the participants from this study. The model includes the distinct phases of thought that may be present in the process of self-harm. This usefully provides opportunities to challenge the possible cognitions present at the various times in the cycle. The model also includes the effects of the presence of distressing memories and the biological effects after self-harm has been carried out.

In the previous two models the cognitions (thoughts and perceptions) were also being challenged but within different conceptual frameworks.

Interpersonal factors were given prominence in terms of the development of difficulties and therapeutic interventions were directed at these factors.

Challenging perceptions therefore was aimed at regulating affects to reduce self-harm. This model in contrast seeks to provide understanding of the

repetitious nature of self-harm and the cycle of negative thoughts that drive self-injurious behaviour.

For participants their mental anguish arose within interpersonal conflict situations and the anger experienced as a result of that was redirected towards self. This seems to concur with Kennerley's (2004) model. Participants' accounts of negative thoughts seem to be about the belief that their anger is too dangerous to unleash, that it entails expressions of violence and aggression and there is no other way to express anger. The beliefs surrounding the experience of anger therefore may need to be addressed and Kennerley (2004) also gives an example of how this might be done. Participants' accounts also provided evidence that memories of past abuse and violations were contributory to the anger experienced which also complies with the model so there may be links with the belief system of the individual that contributes to the mental anguish experienced at these times.

The model may also be useful when considering depression and the suicidal thoughts that participants expressed. Participants talked about the feelings of worthlessness and hopelessness they experienced and these were classified as expressions of depression. This seemed to occur in the aftermath of interpersonal conflict situation and when the person was alone. Therefore the model would also seem to fit this scenario.

Two further useful points on the model include the feelings of elation experienced from self-harm when the body produces endorphins that blocks physical pain which was reported by participants and will be talked about in the next section. Secondly the inclusion of distressing memories activated by triggers is also included. These may provide further possible routes in the maintenance cycle of self-harm. Participants had varying degrees of response to memories of the past. Rage and anger was commonly reported and seemed

to be difficult for participants to contain. Yet fears of unleashing anger on others was also present, the answer for participants seemed to be self-harm.

In the model developed at the end of the analysis (chapter 3) the various routes were mapped of the ways in which participants reported their routes towards self-harm. This highlighted that there was no single set pathway for self-harm but rather multiple pathways. It appears that Kennerley's model provides a complimentary fit to those pathways. The model however does not in itself appear to address the interpersonal difficulties, childhood abuse factors, post-traumatic stress symptoms, or personality issues that might be associated with people who self-harm and that appear in the participants accounts. Perhaps there might be a need to expand the model to take these areas on board.

5.4 Biological theory:

Biological theory relating to self-harm rests on the production of neurotransmitters into the body at crucial times of the self-harm cycle. When a person cuts or injures them self the brain activates the neurotransmission of enkephalin. This produces a pleasant effect and suppresses the pain and the experiencing of this pleasant effect is thought to be the reason for the repetition of self-harm (Favazzia, 1992; Kennerley, 2004). Participants accounts all talked of the peace and calm being restored after self-harm. Therefore there seems to be an expected benefit from self-harm that is similar to the pleasant effect talked about in the literature.

Participants also emphasised the importance of past memories in the cycle of their self-harming behaviour. The literature highlighted the importance of emotional and declarative memories. These types of memory are stored and retrieved in parallel and their activities are joined into conscious experience but we do not have direct access to emotional memory only to the consequences such as how we feel or behave (Le Doux, (1994).

Participants highlighted the impact of past emotional memories on present day circumstances in producing unbearable levels of anger which led to self-harm. Helping to regulate anger may require understanding and reprocessing of past memories to alleviate the levels of anger experienced. Work in the field of PTSD may provide a useful means of addressing these difficulties.

Earlier in the section on the theme of 'being angry' the presence of post-trauma distress was discussed in relation to PTSD and anger. The distinction between here and now anger provoking situations and past memories being provoked was discussed and it was speculated that the intensity of the anger partly belonged to past events more than the current events warranted and that this may be a contributing factor in participants' suppression of anger. The awareness of the intensity of anger not being warranted yet the lack of interpersonal skills or the ability to regulate affect may require direct reprocessing of memories.

Kennerley, (2005) incorporated the understanding of memory processes into a schematic formulation for therapeutic practice working with people who experienced childhood abuse. The programme contains interventions for self-harm but it was specifically developed to take all aspects of childhood abuse into account. Therefore this may be a useful approach to take where both self-harm is present and childhood abuse has occurred.

Finally being angry produces adrenaline and this factor was discussed in relation to the impulsion to hit or lash out being directed at self in the form of self-harm, however there did not appear to be evidence that could directly support this idea within the self-harm literature reviewed in chapter 1.

6. SUMMARY OF THEORETIC CONTRIBUTION:

The existing theories on self-harm do not appear to distinguish clearly between the different emotional states (affect) involved. This makes it difficult to know what impact a particular affect may have on the development and maintenance of self-harm. Anger whilst mentioned seems to be considered less important than this study's findings would indicate.

For example this study revealed that in every case interpersonal conflict situations gave rise to all the cases where anger was experienced before participants self-harmed. Anger also seemed to be the initial emotion experienced and this factor does not appear to be highlighted within any of the literature.

The intensity of the anger experienced was found to be linked to memories of past abuse and violations and would indicate a need to explore the reasons for this further. In some cases this was linked to the experience of intrusive memories due to the symptoms of post-traumatic stress. For others it was simply memories being activated during current conflictual situations and for some the ruminations about past events triggering anger towards self.

Therefore whilst current theory recognises the possibility that post-traumatic symptoms may be present it is less clear about the impact of different types of memory being activated in and around the time of self-harm. Also the literature does not directly link anger with activated memories but usually to fear or anxiety responses. Again this raises another possible area for further investigation.

From the study's findings anger having been activated posed a further problem in that this was seen as potentially dangerous. It appears that anger was associated with aggression and violence and concern was shown not to unleash this on others. There was some indication that there was fear of the consequences however the emphasis was concern for others and on not

expressing the anger experienced. It appears that it was the suppression of anger that built up and made the experience become unbearable. Self-harm (self-injury) was seen as a way to alleviate this state.

Both Linehan, (1992) and Kennerley, (2004) propose challenging the negative beliefs associated to the idea that anger is dangerous therefore requires suppression which would be helpful here. The use of assertiveness or developing better interpersonal skills highlighted by the authors may also alleviate the need to suppress anger therefore potentially reducing the need to self-harm.

There was evidence that suppressing anger also had the potential to lead to depression and possible suicidal forms of self-harm in the study. The key factors for this appeared to be the presence of hopelessness and or worthlessness at the time. An oscillation between anger and depression was also noted. There are similarities expressed within Linehan's (1992) theory focussing on a group of women who expressed fears about anger. However this study highlights the need to examine this aspect further to identify the nature of the relationship between anger and depression and the function of anger within the overall context of self-harming behaviour and its links with suicidal behaviour in the aetiology of depression. Particularly as men were included in stating concern about expressing anger and anger at self seemed to be implicated in suicidal thinking.

Although cutting self was highlighted as the most commonly used method of self-harm it appears that when anger was experienced towards others the self-harm method immediately chosen was hitting self with some force. This was in the form of banging head off walls, punching walls or punching self. This could be followed by further self-harm using different methods according to the emotional factors present at that time. Sometimes hitting self appeared to be a function of body dissatisfaction so the area on the body became the target.

Hitting self is not a method of self-harm specifically linked with anger in the literature therefore this highlights the need to study the reason for this method of self-harm further. Speculation that anger linked to the production of adrenaline may produce an urge to lash out that is re-directed at self was put forward to account for this. However it appears that there is a lack of any further evidence in the literature that would confirm this at present.

Pain having been inflicted produces the calming effect of enkephalin thus reduces adrenaline and restores calm and reduces the build up of anger.

Whilst this study had a focus on the role of anger in self-harm, other aspects of self-harming behaviour were examined which also reveal further interesting findings that extend beyond the current literature on self-harm. This study reveals that ambiguous thoughts between some forms of self-harm as self-preservative (self-injury) or self-destructive (suicidal) are present. Babiker & Arnold, (2001) had already argued that intent could be subject to competing thoughts and emotions and they also set out different methods for different functions of self-harm.

However the determining factors for participants were not so clear. The same method for example could contain both self-preservative function and self-destructive function. The lethality of the method could change with the extent of the intent moving between lethal and non-lethal doses of tablets for example or cutting to stabbing contemplated by participants. It was speculated that the fuzziness around the intent was used so that participants could psychologically distance themselves from admitting to suicidal thoughts. This is an aspect that participants may have been unwilling to admit to in a climate where self-harm and suicide may be subject to taboo attitudes and hostility. This is another potential area for further investigation.

Table 5 outlines the various pathways that anger affect is contributory not only in self-harming behaviour but of the context that it arises and the methods chosen.

7. REFLECTION ON THE METHODOLOGY AND LIMITATIONS:

7.1 Reflections on the use of IPA:

The choice of IPA as a qualitative method was chosen primarily because of the desire to explore the subjective experience of participants' accounts of self-harm. Particularly because the emphasis had been on finding the meanings and perceptions that participants could offer about their self-harming behaviour (Smith, 2003). The focus on the emotion of anger and the role that this had within self-harming behaviour was facilitated by the way IPA puts the emphasis on experience from the viewpoint of the participants. Therefore the data generated connected the emotion of anger experienced and memories of past experiences within the context of current interpersonal situations. The connectivity between these factors has been possible by studying what is being expressed by individual participants against what is expressed collectively (Smith, 2003). This process ensured that variations were also highlighted as well as the common themes that bound the experiences together. This has been useful in defining the results in terms of clinical implications and highlighting the areas for future research.

Criticism of IPA has focused on language in that the data collected is largely about the way that participants talk about an experience as opposed to the actual experience and that it does not attend to the way that language can also shape experience (Willig, 2001). Yet the subjective accounts expressed were how participants made meaning from their experiences and this was an important focus for this study. Perceptions however distorted from reality were also avenues to be understood in gauging how this affected participants' experiences. Whilst the use of discourse analysis was

considered its emphasis was on the importance of accountability and stake in conversation therefore this method did not offer the opportunity to address questions about subjective experiences (Willig, 2001). Whereas the research objective was not to address conversation as such but to gain insights into the role of anger during self-harm episodes from the perspective of participants. IPA adopts a more flexible approach in seeking to address the reality of never being able to directly experience participants' worlds with recognition of the researcher's perspective being used to construct further meaning of the phenomenon under examination (Smith, 2003). Credibility can also be enhanced in that the IPA method also made it possible for my-self as the researcher to be open to the emergence of unforeseen themes. This provides opportunities for further comparison and therefore did not limit the researcher to pre-constructed ideas.

7.2 Reflections on the design:

The size of the sample was subject to restrictions of time, homogeneity and availability, nevertheless a sufficient number took part for the type of study under investigation using IPA. The factor of time played an important role in that participants were recruited on the basis that they had self-harmed within the previous six weeks. Therefore the homogeneity of the group partly rested on self-harm occurring within a time frame. This was an important issue in the design when investigating retrospective accounts of a persons self-harming behaviour. Memory is subject to distortions over time even within a six week period (Baddeley, 2002). However this aspect had to be weighed against the practicalities of access to participants and time constraints for the studies completion. Six weeks was therefore chosen as a compromise between the optimum allowable time for memory deterioration and limits in the time available for recruitment, availability of participants and the interview process to be completed before the six week time frame expired.

The homogeneity of the group was also determined by the subject under investigation that of self-harm. No other restrictions were made.

Demographics of participants (table 2) highlight that equal numbers of females and males were recruited but this was not intentional and recruiting relied upon the random forwarding of participants from colleagues working within outpatient mental health services. A weakness in the design may be that participants were not screened for pre-existing disorders which would have enhanced homogeneity further. However the field of self-harm itself is not restricted to any particular disorder so that the sample may actually be more representative. Future research designs may make use of comparisons between different diagnostic groups who self-harm.

Although not instructed to do so one or two of the colleagues who forwarded participants had read the title where anger was mentioned and actively sought out those who they thought had anger issues. Again participants themselves were also informed of anger in the title on the consent forms and information sheets so that they knew anger was under investigation. Due to the self-selecting bias in recruitment these factors may potentially weaken the transferability of findings to other cases where anger may not be an issue. Despite this there was considerable consistency across the participants' accounts to maybe counter this concern.

7.3 Reflections on Credibility:

The research question was rewarded with generous and rich data in the many themes generated. Participants' accounts were constantly compared with each of the others as part of the analytic process (Ritchie & Lewis, 2004). Where differences were found these were highlighted in the analysis to further understanding of the aspect being analysed.

Supervision was used as part of triangulating the data processed as explained in chapter 2 (Henwood & Pidgeon, 1992). This helped to clarify and

highlight any discrepancies with a view to further the analytic process and to check any biases or blind spots in the themes being developed.

In terms of personal reflexivity (Willis, 2001) the researcher is mindful to state here that an integrative approach is adopted as is reflective of the underpinnings in the philosophical stance of counselling psychology. Counselling psychology elevates a humanistic concern with delivering practice that emphasises respect for individuals as separate and unique (Wolfe & Dryden, 1998). The framework adopted is largely cognitive behavioural with psychodynamic understanding incorporated at the schematic level and as a response to the demands of working with complex interpersonal issues where an object /relational base may be required. The researcher has worked in NHS outpatient departments for approximately four years and during this time has worked with people who self-harm. They also had a range of disorders such as PTSD, borderline personality disorder, depression, and the researcher also worked with those who have suffered childhood abuse, hence the interest in this field of enquiry. To acknowledge the impact of the interpersonal nature of the process of interviews a field notes diary was kept to record the reflections and reactions to participants accounts (available for examiners only). Extracts of personal reflections are contained in chapter 2.

Transparency of the analytic process was maintained in order that the reader can draw comparisons in the data and construction of themes can be scrutinised thoroughly thus enabling checking of the researcher's conclusions for replicability (Elliot, 1999). A balance was sought between the voice of participants and the interpretations used in the development of themes. The limit of space meant that examples used were not exhaustive. However a table (table 3) was constructed with line numbers to further examples in the transcripts for a more comprehensive coverage if required.

The use of supervision and expert and non-expert readers of the write up ensured that the quotations used illustrated a coherent and representative account of participants' views and understandings ensuring the importance of fit (Henwood & Pidgeon, 1992). Rigor of the study was enhanced by the use of supervision which audited the paper trail from transcripts to write-up (Elliot, 1999).

7.4 Limitations of the study:

The number of participants might limit how far findings can be representative. However the depth and breadth of data generated may help readers to understand the multiple contexts that need to be taken into account when trying to help those who self-harm. The sample recruited were all willing to be interviewed about their self-harming behaviour and participants' were aware of the focus on anger before the interview. Therefore the focus on anger may have been influential in choosing to take part or declining. Whether anger would be as prominent in the accounts if not highlighted cannot now be determined. Therefore results need to be seen with these factors in mind.

Participants were not screened or assessed for any psychological symptoms prior to interview. This may have highlighted the presence of clinical symptoms that could be used further to distinguish the differences in participants' accounts. The literature reviewed in chapter 1 seemed to suggest that there might be a lack of consensus on the links between clinical diagnosis and self-harming behaviour. For example borderline personality disorder may not be the only diagnosis. If screening had been included it may have contributed towards identification of specific clinical diagnosis to different types of self-harming behaviour.

8. Clinical Implications:

Findings on anger's role in self-harm has highlighted it as a major affect with distinct implications for treatment. For example by highlighting anger's role it has been possible to see that current perceptions could potentially be coloured by the appearance of past memories and distort present day reality. The distinction between types of memory being activated may need to be made before deciding on appropriate interventions. Based on clinical experience tackling this area possibly by cognitive restructuring of past memories, possibly exposure and or re-experiencing techniques in the cases of post-traumatic stress symptoms and helping to develop better interpersonal skills might alleviate some of these difficulties (Linehan, 1993; Kennerley, 2004; Cloitre et al, 2006).

The findings also highlighted participants' perception that anger was dangerous and this has pinpointed another potential area for therapeutic intervention. By helping to find better ways of expressing anger or to alleviate the intensity of anger response in the first instance may help to reduce the levels of build up of suppressed anger and possibly in turn alleviate self-harm.

The following sections will explore these factors in more detail and discuss clinical implications further:

8.1 Childhood abuse/bullying and anger:

Anger that arose in relation to the experience of intrusive memories and flashbacks of sexual abuse was demonstrated to be so strong that the rage felt became so 'unbearable' that self-harm was required to restore calm. The accounts of intrusive memories indicate the possibility of post-traumatic stress symptoms and anger here may need to be treated as a result of the re-experiencing process. Treatment for self-harm therefore may have to consider that anger produces such distress that in order to reduce self-harming behaviour anger requires attention. The use of intrusive memory reprocessing

techniques may be helpful and although the reduction of fear and anxiety are emphasised it might also be possible to tackle anger through similar reprocessing methods (Arntz & Weertman, 1999). In addition, addressing the emotion specific appraisal that produces anger might enhance a better outcome than treatment that focuses appraisals on fear alone (Dalgleish & Power, 2004).

Anger also arose in memories of past non- sexual childhood abuse and bullying and present day abuse experiences. Affect regulation seemed to be compromised. The lack of regulation of anger may therefore be treated by Linehan's (1993) dialectical behaviour therapy where learning to tolerate distress and regulate emotions may be helpful. As most of the anger experienced seemed to arise in the context of interpersonal conflict situations, addressing this by the use of interpersonal problem solving techniques may also help (Linehan, 1993). However as was also highlighted addressing corrupted perceptions from years of abuse would address anger by helping to re-appraise magnified remarks or criticisms that were linked to painful emotions from past abuses or violations (Le Doux, 2004; Kennerley, 2005; Dalgleish & Power, 2004).

In conjunction with the paragraph above participants also expressed becoming angry at them self and this seemed linked to low self-esteem issues or self-blame issues (Fennel, 2004; Gilbert, 1999; Gilbert & Andrews, 1998). Low self-esteem is a likely outcome where abuse and bullying have occurred in childhood (Kennerley et al, 1998). Recovery therefore may need to address these issues as a step towards minimising the anger at self and in turn the need to self-harm. Therapeutic practise using Kennerley's self-help workbook in conjunction with the programme developed for working with survivors of childhood abuse has been useful (Kennerley et al, 1998; Kennerley, 2005 respectively). Approaches that incorporate anger and self-

esteem issues as part of a holistic treatment approach may be useful (Kennerley, 2005; Cloitre, 2006).

8.2 Anger expression:

Difficulties with anger expression were highlighted and the redirection of anger meant that participants self-harmed. General anger literature does not address this issue however Linehan (1993) approaches the under-expression of anger by combining exposure to anger arousal and angry behaviour with training in expressive control. This has the advantage of minimising the belief that anger will lead to loss of control and that controlled expressions of anger will not lead to rejection. The therapeutic skills involved in this may be prohibitive to some however and the comprehensive techniques of DBT may require considerable training. DBT also has the disadvantage of being a treatment seen as specifically for those with a borderline personality disorder diagnosis although its application could be adapted for others with similar difficulties.

Finding an intervention that can address the antecedent factors involved in the experience of anger and that can combine the controlled expression of anger may help. Cummins, (2006) looks at what is described as first order change and second order change in tackling anger difficulties. First order change looks at controlling anger expression whereas second order change looks at the construction of an alternative view where anger does not even have to be experienced. It may be helpful to see this as a similar process to the cognitive reprocessing of trauma memories discussed earlier where anger is tackled by addressing the appraisals being made at the cognitive level (Dalglish & Power, 2004).

8.3 Breaking the taboo

Participants made it clear that the attitude displayed towards their self-harm was prohibitive and prevented opportunities for them to express their thoughts

and emotions. This appeared to increase the alienation felt which could lead to further self-harm. Training for all mental health and other health workers in helpful and supportive responses to those who self-harm would help.

However it may also be useful for therapy to help those who self-harm to give consideration on why others might find this behaviour difficult and remove some of the restricted perceptions and the resultant alienation experienced. Sensitive handling of the behaviour with acceptance and tolerance whilst encouraging alternative behaviour would seem the best approach. Tackling wider prejudice and misunderstanding could be directed towards educational settings and wider community settings.

9. Avenues for future research:

This was a qualitative study that aimed to provide rich and detailed data on the role of anger in self-harm in the absence of previous research data on this subject. The details revealed that anger may have an important role in the levels of affect being experienced leading to self-harm. Future studies that questioned participants on a larger scale about anger may be able to confirm its applicability across the wider population of those who self-harm.

There is theoretical data on the inability to regulate affect being cited as a prime factor in self-harming behaviour but little in the way of research evidence has been collated to confirm or deny this. Therefore not only does affect regulation need to be researched but the individual components of affect could be studied to establish how much anger, depression, or anxiety and other secondary emotions contribute to the unbearable nature of the distress experienced. Therapeutic interventions therefore could be directed at the origins of those affects.

Findings from this study showed anger was a major affect in participants self-harm and speculated that intervention could be directed at the cognitive appraisals that gave rise to anger. For example; beliefs that reside in past

schemas based on memories of past abuse may be effectively challenged by acknowledging the source of belief yet looking at alternative explanations in present day circumstances. Kennerley (2004) gives a good example of how this might be done.

This might alleviate anger and in turn may lead to a reduction in unbearable affect overall, thus reduce self-harm behaviour. Therefore studies that focussed on this aspect on larger cohorts could help to establish what affects are important and what types of interventions work with each specific affect. As yet the literature appears to have no clear consensus on treatment. This may be because the individuals that self-harm seem to have such varied antecedent backgrounds and diagnostic difficulties (Herman, 1998; Kennerley, 2004). The largest bodies of work on self-harm can be seen as divided between borderline personality disorder and complex post-traumatic stress presentations (Linehan, 1993; Briere, 2002). Therefore a broader view with research that is less restricted to diagnosis and looks at self-harm behaviour as an expression of distress due to varied underlying difficulties may be more helpful in future. Equally the inclusion of pre-screening tools to distinguish between clinical diagnoses or rule this factor out may be helpful. Pre-screening tools may include, TSI (Trauma Symptom Inventory), (Briere, 1995); MMI –III, (Millon Multi-Axial Inventory 111), (Millon, 2006) and BSI (Brief Symptom Inventory), (Derogatis, 1993) for example.

Existing literature has emphasised childhood abuse to be a major factor in the development of disorders where self-harm features (Linehan, 1993; Bateman & Fonagy, 2004; Kennerley, 2004). Three of the participant's reports from this study were distinct from familial forms of childhood abuse in that they cited bullying experiences (distinct from other forms of abuse because this usually occurred in school). It was their reports of bullying that were linked with the development of their self-harming behaviour. This highlights a need to compile data on those who self-harm and discover the range of childhood

antecedents that are contributory as well as more recent contributory factors (such as domestic violence or rape, for example).

The analysis revealed possible links between depression and anger. This aspect was also highlighted by Gilbert (1999) in the literature. However, it appeared from the rest of the literature reviewed in chapter 1 that little emphasis was placed on the link between anger and depression in self-harming behaviour. This is with the exception of Linehan (1993, p16) who reports on her clinical work with para-suicidal patients diagnosed with borderline personality. This may be an important area to research further. It may be useful to study people who have a diagnosis of depression and who self-harm about their anger experiences. The implications of the links between anger and depression in para-suicidal behaviour were also highlighted in this study and could be an adjunct area that would warrant further investigation. Again this could be done by studying those who have histories of para-suicidal behaviour about aspects of depression and anger experience in their self-harming behaviour.

Finally investigations that study the affects of reactions to people self-harming and of the subsequent impact of this on further self-harm behaviour would be helpful. This was an important factor highlighted by participants in the study. The negative reactive affect especially of anger was highlighted and studies that focussed on the benefits of alternative reactions could provide useful guidance to mental health and related practitioners. This could be done by disseminating information to front line workers about the impact of negative responses for those who self-harm.

10. Conclusions:

This study's aim was to understand the role of anger in self-harm and the analysis findings suggest that anger may play a significant role in self-harm. NICE (NCCMH, 2004) guidelines emphasised the need to carry out qualitative studies where the perspectives and views on the meaning of self-harm from

participants' views were paramount. This study also complied with these objectives.

Participants' accounts provide evidence that anger is a significant factor in the experience of mental anguish, which once affect has become unbearable leads to self-harm. Accounts also provide evidence that childhood abuse (not necessarily sexual) as well as bullying experiences encountered in childhood are the primary antecedent factors involved in the development of self-harm behaviour for participants. Therefore it is important to look further than the traumatic nature of sexual abuse and look at emotional abuse, physical abuse and neglect factors more closely. This may highlight more clearly the exact components involved in the development of self-harming behaviour in adults from the childhood developmental and antecedent perspective.

Post-traumatic re-experiencing was a factor in some of the participants' accounts. Recurrence of traumatic memory experiences gave rise to rage/anger and participants diffused this by self-harming. Others appeared to have damaged self-esteem and ruminated about past events occurring in childhood. This seemed similar to the intrusive memories of PTSD but without the life threatening aspect of trauma attached and again anger was the major affect experienced. Ongoing everyday events also elicited anger and this appears to be associated with a lack of interpersonal skills specifically when involved with conflict situations. Participants avoided expressing the anger they experienced towards others as the perception of their own anger was that it was too dangerous to unleash hence their need to self-harm instead. It was a major concern not to harm others that was expressed as well as minor references to possible consequences in the shape of retaliation or punishment.

Methods directed at affect regulation and interpersonal skills were discussed (p121-122). As were looking at altering the perception or appraisals that led to anger to lessen the anger affect and reduce the need to self-harm (p123).

Anger's relationship with depression was also discussed and in particular with regards to ambiguity between self-preservative and self-destructive acts of self-harm (p116). The oscillations between anger and depression a possible factor in the ambiguous thoughts expressed.

As participants expressed using multiple forms of self-harm in different situations for different purposes this needs to be taken into account when constructing ideas for therapeutic intervention. Cutting was referred to as the most common form of self-harm used by all participants however they did not use this exclusively. Hitting self was a method often spoken of in conjunction with being angry. The significance of this was linked with possible infantile expressions of rage (Iwaniec, 2000), and self-directed aggression. Suicidal or self-destructive self-harm was signified by participants as associated with more lethal forms of self-harm. Most typically this was self-poisoning by ingestion of tablets and or alcohol. Over simplified approaches to self-harm therefore are to be avoided. Broader formulations may need to be compiled to understand the complex and ambiguous psychological processes involved in any individual who self-harms.

Participants' accounts of the taboo nature of self-harm created situations where participants had received anger and in turn made them angry. The implications were that of increasing self-harm behaviour. Efforts to tackle prejudice and encourage understanding for those who came into contact with people who self-harm were therefore discussed. Also helping people who self-harm to understand why they receive hostile reactions and reduce perceived alienation was also discussed. Doing this within a supportive and accepting therapeutic relationship was seen as a possible way to reduce further self-harm.

Overall, understanding anger's role in self-harm may become a central part of any therapeutic plan or intervention. Therefore interventions for anger where appropriate could be as follows: The use of breathing techniques to keep

person calm and in control of their anger, followed by separating any assumptions from any appraisals based on past experience from present day experience, dealing effectively and appropriately with the current situation or conflict, possibly by the use of assertiveness skills and attending to issues from the past during therapy. These steps in part or whole may become an integral part of developing good working practice in helping those who self-harm reduce their self-harming behaviour.

Consideration of the implications for training for those who work with people who self-harm may need to take note that not all of those who self-harm may have difficulties with anger. The small sample scale of this study prevents any generalisability of the findings at this stage. This should therefore be borne in mind before applying any of the interventions mentioned above. However where it has been shown that anger is a feature of someone's self-harming behaviour it may be of benefit to consider the pathways of the individuals self-harm as is illustrated on page 85 (analysis section) to determine which type of interventions might be appropriate for use with a specific client. Training therapists to become familiar with the importance of affect regulation skills, interpersonal skills and challenging faulty appraisals may benefit the work they do with those who self-harm regardless of whether clients have issues with anger (Linehan, 1993; Cloitre, 2003).

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Table 1								
Unsorted themes								
Participant Number	P1	P2	P3	P4	P5	P7	P8	P9
Names	Ted	Marie	Katy	Leah	Louise	Larry	John	Dave
<u>Relieving Mental Anguish</u>	Line numbers							
Way to look after self	98							
Release	189		92			311	184	
Relaxes/Calming self	870		93	199	388		402	415
Blocks thoughts		330				82		
Brings you out of trance		273						
Sorting it myself		820	16					
Instead of crying			442					
Emotional pain to physical pain				524				
Gets rid of images					491			
Wipes away past					522			
Urge for suicide not so strong							313	
More acceptable							713	
<u>The taboo nature of self-harm</u>								
Asking about self-harm is unexpected	35							
Sensitive subject	147			28				47
People get angry about it	165			61			227	
Lack of compassion	181	148		89			619	444
Family feel shame and anger	536		255		981		309	92
Being judged	239				237			77
Shame	223			147	241		727	59
Isolation	94		630	437				
Alienation	97	95		112	176		225	95
Withdrawal	67	150						
Despair	133			96				
Being wound up	70							
Unable to respond		44			107			
Attention seeking		52						33
Frustration		122						
Anger		129						
<u>Regulating the method</u>								
Availability	250	212	133	316		151	177	
Cutting is quicker / easier way	216						232	
Impulsivity	293					118		
Anger	446	186		296	356	291	145	329
Pain stays		181						
Cutting makes you feel something		264		194				
Cutting is a release			260					
Hitting is safer when angry				309				
hitting head =headache				341				
practicalities				467	202			

Abuse					340			
Either that or more drastic ways						97		
Repetition / not feeling it							821	409
Easy and painless								214
Lethality	633		38	481	982	99	288	
<u>Unbearable Mental Anguish</u>								
Brooding/Rumination	262					151		125
Depression	406		164	588				166
Feeling trapped	566		185					
Rejection	632							
Ambiguous suicidal thoughts	676	351	144	481	947	65	680	185
Things build up		199				130	155	334
Memories from past		338	640		230	250	373	
Negative sense of self		725						
Stress		839						
Hard on self		853				212	579	
Tension builds up				208				
Learned Habit				854				
Empty/ Worthless						73		
Being in physical pain							363	
Relationship breakdown								257
Anger	436	453	362	274	285	291	194	471
Abuse	784		356	776	340		352	607
Dysfunctional family life	890	358	67		335		545	640
Humiliation	977							
Not being able to express anger	772		284	823	888	342		
Getting hassle		407				471		
Flashback					276			

Table 2

Table of themes used in analysis:

Table used for final analysis

Themes	Psuedonyms	Participant Number							
		1	2	3	4	5	7	8	9
		Ted	Marie	Katy	Leah	Louise	Larry	John	Dave
Unbearable Mental Anguish	Line numbers in transcripts								
Abuse/Bullying		783	650	266	776	285	250	352	607
Dysfunctional family life		500	358	67				462	616
Things build up		183	199				130	152	334
Depression		262		164	586		73		164
Ambiguous suicidal thoughts		672	349	144	481	947	82	680	185
Anger									
Being angry		840	436	362	802	252	397	545	471
Dangerous anger		890	638	289	819	888	347	194	482
Regulating the method									
Availability		250	210	133	316		151	177	
Anger		446	186	372	296	304	188	145	328
Seeing blood / symbolic					194	522		513	135
Lethality		633		30	505	973	96	284	
Relieving Mental Anguish									
Release, Relax and Calm		870		92	192	388	308	184	415
Purge thoughts and images			327			491	82		
Self-harm is taboo									
Getting angry at it		536	145	255	59	981		227	
Being judged		235	52		147	237			89
Alienation		94	95		112	159		225	442

Part C:

CLIENT STUDY:

**TITLE: The use of imaginal exposure within a CBT framework
in processing traumatic memories:**

FOREWORD:

As this case study represents an individual case and examines some of the specific processes involved during therapy I have used the first person throughout. This is to reflect the ideographic nature of presenting a case study and of my individual reflections on some of the therapeutic processes involved.

INTRODUCTION:

This case study looks at the relationship between anger and self-harm within a Complex PTSD (post-traumatic stress disorder) presentation. This may be of interest to those studying PTSD, self-harm and cases where interpersonal relationship difficulties are presented.

My approach and choice of guiding theory when working with this case was built on the developing principles of Complex PTSD (post-traumatic stress disorder) material, which are informed by the principles of a Cognitive Behavioural Therapy Perspective (Yule et al, 1999; Kennerley, et al, 1998; Kennerly, 2000). In particular I will be referring to material that takes in both trauma and relational aspects to this client's difficulties (Arntz & Wertman, 1999), which specifically address the more complex aspects to the case arising from childhood events.

The use of a Cognitive Behavioural Perspective was chosen after being partly informed by the appraisal of the recent literature on Cognitive procedures in the treatment of PTSD, which incorporated schematic representations that closely resembled the presentation of difficulties discussed and displayed by the client, specifically anger and fear (Dalglish in Yule, 1999; Dalglish & Power, 2004;). From the beginning the client found the use of diagrams helpful and used guided discovery questions well during assessment sessions (Padesky & Greenberger, 1995). This gave me some confidence that the client would respond well to a cognitive behavioural, based treatment. More recently guidelines have been published that recommend the use of trauma-focused cognitive behavioural therapy for those with PTSD diagnosis (NICE, 2005).

The Referral:

I received the referral for Jane within the PTSD service of the Psychological Services Team at Coventry PCT (Primary Care Trust) NHS (National Health Service) by the client's GP in May 2004. The referral stated that Jane experienced flashbacks and nightmares as a consequence of being held up with

a shotgun during an armed raid on the public house that Jane had been working in one evening.

At the time of referral Jane was twenty-seven years old, unemployed, and living with her female partner.

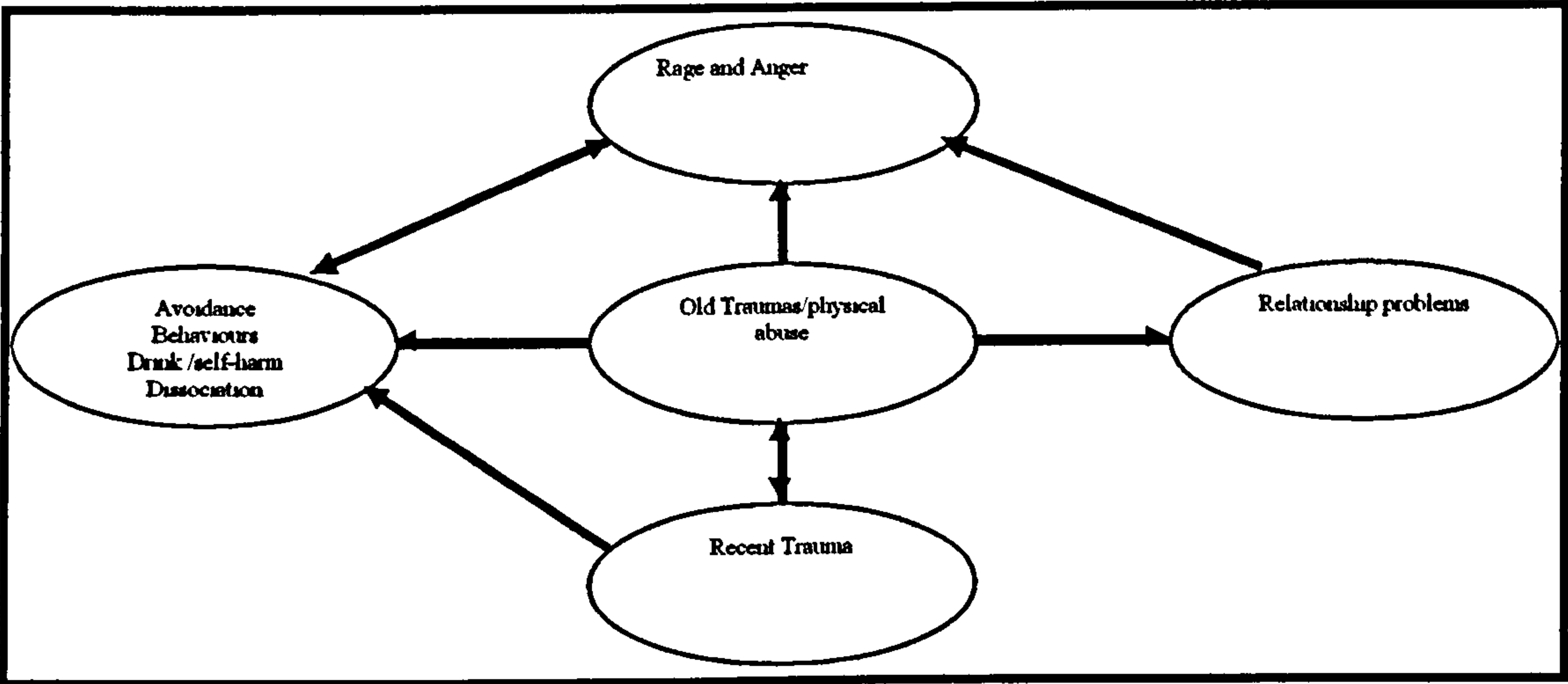
First Session:

The first session focused on the level of anxiety Jane constantly felt and she reported suffering a number of panic attacks. She also exhibited hyper-vigilance over noises, and seeing things in shadows and the belief that she was under constant threat from the masked raiders who had held her up at gunpoint whilst at work. She was very disturbed about not being able to see the faces of the men who threatened her and this became a significant point a little time later during therapy. She did not leave the house very often and she only travelled by car between where she lived and where other family members lived. She talked briefly about not being able to trust people and that relationships were difficult for her.

I understood from this session that Jane was exhibiting features of PTSD and that the initial focus from Jane had been on the masked raid event that she had survived. Hyper-vigilance, sleeplessness, nightmares, high anxiety leading to panic attacks and avoidance behaviour were all reported and correspond with the symptoms of PTSD (Yule et al, 1999), and the experience of the threat of death and subsequent response of fear and helplessness in Jane's case also correspond with the diagnosis of PTSD (DSM-IV-TR, 2000).

I used three sessions in total to fully assess Jane's difficulties and develop a formulation with her. The diagram below is the full version of the difficulties we discussed over the whole of the course of therapy. The self-harm and dissociative components were added when these were discovered later. By using a simple diagram with Jane I wanted to help her understand the links between the recent trauma event, and past trauma events and the other difficulties she had shared with me. Shared formulations devised in therapy are a way of bringing the client on board in the therapeutic process and to build a

collaborative approach between client and therapist (Butler, 1998; Beck, 1995). This diagram was a simple way to hold together quite complex and separate difficulties but in a way that the client could both conceptualise easily and be able to refer to (Butler, 2003). Please see diagram below:



It became evident from the initial formulation that Jane had difficulties with a recent trauma event (the robbery at the pub) and that previous familial childhood traumas and other relational aspects further complicated this.

Therapeutic Contract:

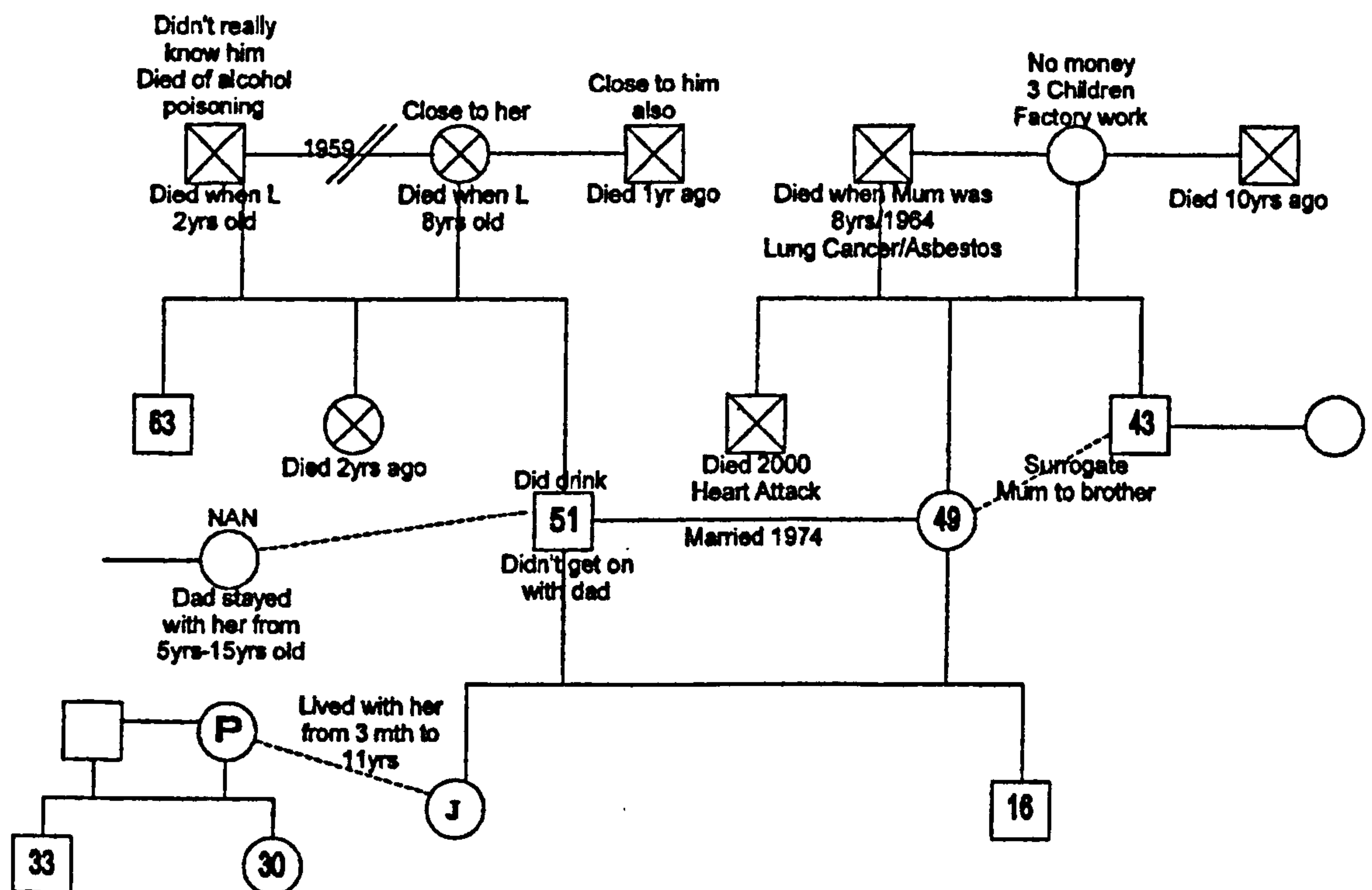
Within the Psychological Therapy Service at Coventry PCT a single event trauma (Type 1 Trauma, Yule et al, 1999; a single traumatic event) would be permitted to take a maximum of 20 weekly held sessions with an hour to an hour and a half in time. For complex cases (those with multiple and varying traumas and or other issues) no time limit has been set and this is worked out on an individual basis.

An initial contract was agreed between Jane and my self that we would have six sessions of therapy and then review the situation at that time. We agreed to begin work looking at the aspects of the recent trauma as Jane felt that this gave her the most concern. It was understood that the treatment plan would

undoubtedly change when other aspects became clearer (Butler, 2003; Padesky & Greenberger, 1995).

Genogram:

The following genogram was drawn from information that Jane shared with me in the initial stages of therapy:



Jane focused on the relationship she had with her mother whilst exploring the family structure from the Genogram. She reported that her mother made demands of her, telling her what to do, what to wear, do errands etc despite the fact that she was 27yrs old and lived independently from her. She also described not feeling 'loved or of really being wanted' and 'of never getting anything right'.

Jane also revealed that she struggled against the belief that 'If I try I might fail' and we examined this using the downward arrow technique (Hawton et al, 1999). Jane felt that if she failed, people would think she was stupid, waste of space, and would laugh at her and that then she would feel like a failure, she

concluded that 'if I don't try I won't fail'. This led Jane to give up on a lot of things that she was good or reasonably good at because she felt she would never get things right.

In recognising that interpersonal difficulties can infiltrate the therapeutic relationship I spoke to Jane about the work in therapy and the homework assignments that she was being asked to complete and whether she felt I might be critical of her (Wills & Sanders, 2000). She confessed that she had thought this and although she could rationalise against the thought she still found it difficult when she was at home not to get into the 'if I don't try I won't fail' habit. Bearing this in mind I devised experimental challenging around the core belief to counteract Jane's reluctance to try to do things for fear of failure (Hawton et al, 1999). She was asked to record how often she got things right in the course of a week and then we revised the assumptions she held that she was a failure and that others would laugh at her. However as you will see later in the text this difficulty was very intrinsically woven into schemata that became the focus of working with childhood trauma (Arnz & Weertman, 1999) and this led to my discovery of the way that existing mental representations can impede recovery from PTSD symptoms (Dalglish & Power, 2004).

MAIN ISSUES OF THERAPY

Sessions 1-6;

Preparation Period:

At the beginning of therapy for PTSD (Post-Traumatic Stress Disorder) using the Prolonged Exposure Treatment protocol it is recommended to start with education about PTSD Symptoms, and instruction on breathing retraining (Zoellner et al, in Wilson et al, 2004). Information was given to Jane during the assessment period on PTSD symptoms and she was also given hand written instructions on the use of a breathing exercise (see appendix 13). Information about PTSD was discussed thoroughly in relation to Jane's reported symptoms. By gaining an understanding of the development of PTSD patients can have some of their fears dispelled (such as I felt like I was going mad or crazy) and

also gain information on how to begin tackling their symptoms (Herbert & Wetmore, 1999)

In Jane's case she exhibited hyper-vigilance and startle responses within the session often jumping at noises from doors banging etc and looking around her. The use of relaxation exercises at the start of therapy was used during the sessions to help Jane to feel more relaxed (Herbert & Wetmore, 1999) (see appendix 14). She was also encouraged to use the breathing and relaxation exercises at home to alleviate some of the stress responses she was experiencing. Her concentration was poor at this stage, which is also a feature of PTSD symptomatology (Yule et al, 1999) so I took care to have everything we discussed on PTSD and the other exercises written down for her to refer to at home and for her to refer to in the initial stages of therapy.

Jane was also asked to keep simple diary sheets to record some of her thoughts and feelings particularly around the times when she experienced panic and fears and felt that she was under threat (see appendix 15). This revealed that Jane was experiencing flashbacks, intrusive thoughts related to armed raid incident, triggered by everyday situations, (i.e. watching TV, letting dog out in garden at night, window cleaner appearing etc), she also became highly anxious when out in her car or in a shop etc, displaying symptoms of panic and she also recorded having a nightmare. There were two days recorded as being angry all day, wanting to be left alone and feeling in despair about displaying her mood to others. It seemed that she was unable to complete the sections at the end of the diary sheets because of the negativity she felt and she missed the scheduled session due that week because she was still feeling low.

In the next session we discussed the issue of anger, which provoked a flood of responses to both current situational factors at home and from events that happened in the past. Prior to the dates in the diary sheets where Jane had become angry and withdrawn an argument broke out over a trivial domestic chore that Jane had not completed to her partner's satisfaction leaving Jane feeling undermined and furious. Jane believed that her partner was being overly fastidious and very critical, who also needed things done 'just so'.

During the discussion I commented to Jane that she seemed a whole lot angrier than just about the incident that kicked off this row. Key features in her dialogue were feeling undermined, undervalued, criticised, and very angry more like rage in the way that she described her feelings. She confessed that she hit herself by banging her head against the wall when she got angry and that she had done this at other times in the past. I described my understanding of the behaviour as a form of self-harm, which Jane protested against saying she only did this occasionally and that it was not serious. This protest I took to be as, a reluctance to acknowledge her use of self-harm or the use of the word self-harm as a description of her behaviour. After some discussion Jane admitted that she was uncomfortable with admitting that she harmed herself in this way as it fed into the feelings explored earlier in the text in that of being a failure and that linked to this was a sense of shame and of the need for secrecy. This issue was addressed in therapy but I do not have room for discussion here (please see Gilbert & Andrews, 1998).

Self-harming behaviour is often a feature of the difficulties of adults that have endured childhood abuse. Interpersonal difficulties are often a result of never being able to resolve issues arising from the abuse and or other behaviours that a person experiences (Kennerley, in Bennett-Levy et al, 2004). Jane had endured abuse and emotional neglect in childhood and was exposed to extreme forms of abusive behaviour between her parents when they were in conflict with each other. This meant she had never learnt to resolve differences without envisaging shouting, screaming and violence. I was not aware till much later that there was a traumatic incident attached to this information, which I will return to later in the text. Anger was something she experienced as being dangerous and leading to extreme forms of abandonment so she had developed the strategy of trying to hide her anger from the view of others no matter how provoked. This led to a build up of rage whereby she redirected the anger against herself by the use of self-harm and dissociation (Kennerley, in Bennett-Levy et al, 2004).

Van der Kolk et al's, (1996) study comparing community participants with clinical participants for a relationship between PTSD, Somatization Disorder, and Dissociative disorders found that participants who had suffered interpersonal abuse at or before the age of 14 developed significantly more dissociative problems as well as difficulties with modulating anger, including aggression against self and others. Dissociation is thought to serve as a coping mechanism when a person has been exposed to trauma event/s and although can serve as a protective mechanism from the initial trauma event/s can also become problematic with information processing activities and in treating traumatic memories (Van Der Kolk et al, 1996; Herman 2000; Kennerley, in Bennett-Levy et al, 2004).

Review:

At this stage I was now more aware that some of Jane's coping strategies originated in earlier trauma events. Taking this into consideration I discussed this with Jane and devised the next stage of therapy with her. Jane still wanted to concentrate on the presence of distressing flashbacks and intrusive memories of the attack she experienced. I also felt that concentrating on this experience to be a priority, so we agreed to work for the next six weeks on helping Jane alleviate the anxiety and distress felt surrounding this event.

Sessions 6-12;

Following the procedures within a cognitive behavioural therapy framework I discussed the use of reliving with cognitive restructuring with Jane (Ehlers & Clark, 2000). This would include asking Jane to write down a narrative of the events about the masked raid, to investigate the 'hotspots' and begin cognitive restructuring the trauma memories (Grey et al, 2002). Her initial reaction to this proposal was to be extremely anxious about one aspect in particular, that of seeing the masks. I directed her into grading the task into three attempts per time stopping at distressing material, use of breathing exercise to control her anxiety and continuing past the previous point and then stopping again when distressed. She was asked to do this as homework where I would explore with her in the therapy session aspects of distress and other cognitive work. By grading it this way I had hoped that this would help her overcome her fears

about tackling the memories. Unfortunately she still indicated that she didn't feel able to carry out the task.

It was at this point that once again I went over the reasons for bringing memories back into her thoughts (Grey et al, 2002) Jane explained that although she understood the rationale behind the exercise she did not believe that she could survive the panic she would feel at recalling this aspect of the event. In particular she believed that she wouldn't survive the fears once they were raised in this way as she felt she had survived purely because she had become good at blocking them out. She felt that she needed to keep things the way they were in order to function reasonably well. At this time I decided with Jane to leave the homework task for the time being so that we could explore the issue further.

Afterwards I reflected on what had happened and felt that at some level I had missed something fundamental about what Jane had told me so far. She appeared to have been able to tell me quite a bit about the events surrounding the masked raid so I did not think she would have had any reason not to want to carry out the task as suggested. She appeared to become more agitated when she spoke about the masks and so I resolved to discuss this with her in the next session. I also took note of the maladaptive use of suppressing thoughts that Jane had been using (Ehlers & Clark, 2000) and that somehow this was especially linked to the masks.

In the next session I asked Jane if it was ok to discuss things about the masks, she visibly froze and became anxious. Although I did not want to force the issue and cause distress I felt that it was important to explore this aspect and I explained this to her. I said that I would go very slowly and help her to relax and explained that I needed to know more about why she found this aspect so difficult. She did not seem aware of any reason herself at this time and remained focused on the threat.

I took note of the way that this aspect of the masks was something visually disturbing and at first she was only able to tell me that it was not seeing their faces (the raiders) that worried her. She elaborated that they might be out there

and she would not know who they were and that they could come and get her and as she did not know their faces she felt even more scared that they would get her. We discussed each of the aspects extensively and I tried restructuring the cognitions (Ehlers & Clark, 2000) by carefully challenged the assumptions that they would come after her but she still had difficulties in relation to not being able to see their faces.

In exploring the aspect of not being able to see their faces I remembered that previous emotional laden memories may sometimes be linked in memory to the recent trauma but be buried out of awareness (Dalgleish & Power, 2004). I tested this out with Jane by asking her to recall whether she could remember another time in her life where 'not being able to see faces' had been difficult for her. She was able to tell me about a time in her teens when a male friend of the family had sent sexually explicit letters to her accusing Jane of being 'dirty and promiscuous'. Jane's mother instead of being supportive gave her a hard time and she remembers being blamed for the subsequent breakdown of the man in questions, marriage. Jane was fourteen years old at the time and remembered feeling deeply ashamed even although she had never done anything wrong.

The 'hidden aspect' is what most distressed her about this previous event, as she had never had any involvement with the man and yet he could say all these things about her. It was as though he could see her and make comments about her that could get her into trouble that resonated with not seeing the faces of the men who attacked her during the raid. She has had a deep distrust of men since. In exploring this with Jane she gained a deeper understanding of the way she interpreted the 'not seeing' aspect and gained some relief about this. Later in the work she decided of her own account to directly confront the fears she had by agreeing to take part in painting masks on children's faces at a charity event.

Review2:

In helping Jane to uncover her discomfort over the masks she recalled earlier events that had caused her great distress but she was initially very reluctant to

explore this further. I then had to temporarily suspend the intended imaginal exposure with cognitive restructuring techniques (Ehlers & Clark, 2000). I realised that I was now working with more than one level of memory and had decided to slow things down a bit to allow some of the relational aspects to be worked on. With hindsight I question whether I should have persevered with the exposure tasks to directly challenge her fears yet I also reason that by altering the course I gained a substantial amount of trust from Jane who at a later stage was able to divulge the details of earlier traumatic events.

The literature available does not cover this type of complex presentation where a Type I Trauma event is preceded by earlier unresolved Type II events (Yule, 1999). Usually the examples are of one or the other types, not both together. Although we had agreed to embark on tackling the Type I event initially but it seemed that the complications of previous events now required attention.

Sessions 13-20;

We approached these indirectly at first where Jane was able to talk over some of her feelings towards her parents and of the difficulties she felt she had as a result. I reviewed some of the literature in this area and found evidence to suggest that previous emotional laden memories can play a part in the way re-experiencing of memories is understood (Dalgleish & Power, 2004). After a number of sessions where I felt we had explored things sufficiently I asked Jane if she had any specific memories that still bothered her. She indicated that she had one in particular that still upset her a lot. She gave me an initial brief description about an event that occurred in childhood.

Because the memory event appeared to be associated with highly charged and complex emotional reactions occurring in childhood I felt that it was important to find a suitable method to process not only the fear response but any other types of emotions that may be present. I was aware of a possible method that combined imagery with re-scripting as part of a technique for working with childhood memories (Arntz & Wertman, 1999). This technique was specifically designed to work at a schematic level to process not only fear responses but other emotional responses from childhood that have had a lasting

impact on the perceptions used by the person in adulthood. Jane's level of emotional response about this event seemed would benefit from using this model.

I discussed using the technique as a way to relieve some of the distress Jane felt and to help her understand the significance it had in other areas of her life. She agreed to try it out and I stressed that she could stop at anytime she felt uncomfortable or distressed. I also said that I may step in and help her if she looked to be upset or distressed and I would ask her to check that she was ok. I took time to explain the procedure so that Jane felt able to take part in the process and to make sure she gave her full consent. To make things easier I said that we could use a tape recorder to tape the exercise so that Jane could use this at home to listen to privately. Exposure could then be reinforced without the need for Jane to write things down or to talk into a tape on her own which she had seemed reluctant to do. She agreed and Jane was given a copy of the taped recording at the end of the session. Jane gave me permission to use a copy of the taped recording of this session for use in this case study.

To begin the procedure Jane was then asked to remember the scene and look at what was happening from the perspective of a bystander (full technique explained in Arntz & Weertman, 1998). Jane agreed and the following is a ten-minute extract of that exercise which I have transcribed as follows:

The events unfold as follows: the previous evening a huge row broke out between Jane's parents with violent exchanges between them both. At one point where Jane, her brother and mother had barricaded themselves in the bedroom, Jane was asked by her mother to get help by climbing out of the bedroom window. Jane managed to get herself onto a ledge on the roof but could go no further. She became hysterical as she called for help. Neighbours came round, got her down off the roof and she stayed with them overnight. The following morning Jane found out that her mother had left the marriage taking Jane's brother with her but leaving Jane behind without telling her that she had left.

When Jane returned home the following morning she went upstairs initially to get ready for school, Dad was still downstairs; she came down later to find her father still drunk from the previous evening,

J = Jane

M = myself

() interruptions from myself

[] interruptions from Jane

----- Pauses in speech

1). M: Can we do it now from the bystander, if you think about looking at it, and take yourself, from that morning you were about to say, from that morning we got up, I got up for school okay, [right] so what I want you say is okay, you're the bystander and that what you're doing is you're looking at Jane, right, so [and Dad] right so yeah, right ehm, or whatever you see, and talk us through what happens, yeah

2). J: Okay, so Jane was up getting ready for school and Dad was downstairs still drinking from the night before, (mhm), and was completely off his face, (mhm) and, Jane came down to make breakfast, or something like that (mhm) and maybe, I said something to my dad like you've got to stop this, its ridiculous you know, okay and he was being arsy and telling me to fuck off and stuff, so, I got upset and was crying because he was speaking to me, (you've gone back into yourself again), oh, so Jane got upset and was crying because Dad was speaking to her very negatively (he was swearing at her and) he was swearing at her and Dad was saying that her Mum was a whore and then Dad said there's a letter on the table. So Jane read it and it said you'll find me in the garage, and Jane got upset.

Jane reverted into talking in a childlike voice

3). M: Who was the letter written by?

4). J: Dad, (aha), and Dad said they were everywhere, I looked around, Jane looked around and there were letters all over the house which Dad had wrote (mhm) saying you'll find me in the garage. They were all the same (mhm) Jane got a bit hysterical, and they argued and Dad was just, he didn't know who he was to be honest because he was that drugged up (mhm) and drunk, and then Jane went upstairs to her bedroom and was crying and slammed her bedroom door. So then Dad came up, put his fist through the bedroom door, and then he put his fists into Jane's face. Smashed it up (okay) so Jane went to school with her smashed up face, and then I told one of the teachers about what had happened and she, Jane then spoke to a school counsellor, who then phoned the police, and was taken away by social services.

Jane talks in quite a detached way almost as if she felt no emotions whatsoever, noting this I wanted Jane to recognise the impact this event had emotionally for her but without traumatising her further. Using the bystander routine would enable her to be able to take a stand back from the event yet recognise both what she had had to endure and the way the adults in her life behaved towards her as well as acknowledge her needs and to ask for those needs to be met (Arntz & Wertman, 1999).

5). M: Okay, right, now as the bystander okay I'm going to take you through the sequence again, okay, but now the bystander can actually do something about it [yeah] okay, so you would want the bystander to protect you, yeah [yeah] so if you then do the sequence of events but this time changing, so that the bystander intervenes, between yourself and your Dad and what he does. Can you do it that way?

6). J: No because if it were any other way I just would not have been there.

7). M: Yeah I know, but for the purposes of the exercise, laughs, [laughs]

8). J: Oh, so I've got to go through that again (yeah) and say, then the bystander come in and punched Dad in the face and knocked him out.

9). M: If that's what Jane would want him to do or her to do yeah that's fair enough, if you want that to happen, you choose what you want the bystander to do. We'll do this several times, you know, we can change it again. [Yeah] You know if you don't want to do it, you can say it right and maybe the next time you say nah, that's not quite such a good idea but anyway let's have a go, yeah?

10). J: When Jane wakes up she

11). M: Okay, Jane wakes up and she's what that morning, anyway

12). J: Happy

13). M: Are you happy, no

14). J: Yeah but if things were different she would be that would change it but no it's the bystander that changes it, isn't it (yeah) Jane wakes up and is very upset.

Jane has recognised the role of the bystander and is beginning to feel relaxed by being playful with what the bystander can do.

15). M: Okay, so what could the bystander do at that time?

16). J: Make me a cup of tea,

17). M: Laugh, yeah, what else?

18). J: Give me a cuddle.

19). M: That's right yeah, anything else

20). J: Just reassure me

21). M: Mhm, anything else that the adult can do

22). J: Make her feel safe and wanted

23). M: Yeah

24). J: and loved

25). M: and loved, good, anything else, that this adult would do, --- under the circumstances now?

26). J: Make me a bacon sandwich

27). M: Laugh, yeah -----

28). J: eh, have all my school uniform ironed for me, (mhm) nah that never happens, I've always ironed my own clothes, for ever, (yeah) laugh (yeah) ehm, I don't know.

29). M: Well that's a good start though, when you think about it, so those were the things that were missing, so anyway, that's, the bystander has done that. Now what else could the bystander do in the circumstances, when you think what happens next? So in the sequence the last time you spoke about going down the stairs didn't you [yeah] okay, so what could the bystander do instead, ----in that situation?

I wanted to assist Jane in the imagery as per (Arntz & Weertman, 1999) so I kept emphasising the phrase ' what could the bystander do ' .

30). J: Get up and make me, my breakfast, laugh.

31). M: They've made you breakfast and a cup of tea but what else would they be able to do, when they go downstairs, what?

32). J: They would be able to protect me from his viciousness.

33). M: So maybe the bystander could do what?

34). J: Get my dad to leave and lock him up in the shed down the garden all day.

35). M: Yeah, well that's a start, okay, let's just play around with some ideas, you know its up to you but, let's just say that could, that's one possibility

36). J: Yeah but I wanted to see my dad when I got up, my Mum had left, my brother had gone, and it was a bit,

37). M: Yeah, yeah, yeah but wait yeah, okay but you're jumping ahead, okay but, you've got this other adult now, okay and their taking care of you, they've given you a cuddle, their looking after you, made you a bacon sandwich, made a cup of tea, got you up in the morning, gave you some reassurance, okay, so you're not all on your own, ok.

38). J: Well the bystander could mediate and go downstairs (mm) try calming my Dad down and leave me to get on with things,

39). M: mhm, so you could have went to school that day, perhaps or, what else would, what you've got to choose, its up to you, you've got to choose about what, how you want this to end. So we're changing it remember, because that's what the bystander's doing [right] he's or she, we're not giving it a gender yet, but would

40). J: I'd want the bystander to phone the doctor

41). M: Mhm, for who, [Dad] for your Dad,

42). J: Because I honestly think he should have been sectioned at that point in time.

43). M: Okay, cause you felt what about your Dad

- 44). J: That he was going to kill himself
- 45). M: Okay, okay, right so you felt that he was definitely at risk of suicide [yeah] yeah, okay and what else would this adult do,
- 46). J: Just get him help really, (mhm), I know I was upset but I wasn't on drink and drugs so I suppose it was a bit clearer for me (mhm, mhm) cause his mind was completely influenced by the effects as well (yeah), so I think ehm, all I would have wanted was for him to have got some help I think (yeah) and taken out of the situation and for me to have just gone and stopped anywhere, I don't know.
- 47). M: So; that could have all been done by an adult around at the time couldn't it?
- 48). J: Yeah
- 49). M: Yeah,
- 50). J: and somebody that could have just stopped him from drinking (yeah) whisky and Valium just doesn't work (yeah) and he was really addicted to them Valium and the whisky at the time.
- 51). M: and what else could the bystander have done for you, okay they've taken care of Dad now so Dad's been taken care of, they've done all the things that you've asked you know, so dad's been taken care of so what could the bystander or the adult do for you?
- 52). J: Find out where my Mum had gone, (yeah) I didn't know, (mhm) she just vanished, —and —you know, what they could have, it already happened
- 53). M: Yeah, but think of if the adult had managed to get your dad sorted out okay, [right], what could the adult do for you now cause your still left there.

Would you have gone to school that day do you think or do you think the adult may have done something different?

End of ten minute taped section.

This exercise became a pivotal point in the process of the therapy because it revealed some of the unmet needs Jan had had when she was still a child. What she needed was love, protection, security and an adult to shoulder the responsibility (Arntz & Wertman, 1999, see no's 12, 14, 16, 18, 20, 22, 24 etc in paragraphs above). She also gained insight into her feelings of anger when she realised that she felt abandoned, unprotected and even blamed for the incident being reported to social services. After some sessions later she had worked out why she often got angry in situations with her partner and in other relationships where any signs that she might be subjected to blame and criticism and possibly abandonment would stir an emotional reaction of an intensity she often could not understand in relation to the incident itself but nevertheless felt at the time. This often led to self-harm or dissociating to prevent the loss of abandonment that Jane feared if she expressed her anger (see earlier text, pages 5-6).

Work ended after 30 sessions of therapy that included intensive restructuring of Jane's cognitions with particular reference to shame, failure, and anger. Some of the work required understanding of the interpersonal components that Jane had experienced in gaining access to the way Jane had construed her thoughts and gave meaning to her experiences before it was possible to work with aspects of the more recent trauma. This made the work both challenging and rewarding especially in seeing Jane taking full part in life by applying for a college course, looking for part-time work to support her-self and becoming more assertive within the relationships she had before she left therapy.

Summary and discussion:

When faced with a complex presentation it can be difficult to find literature that directly corresponds to the wide and varied difficulties presented for guidance on treatment. This case represents the way that a combination of approaches was used within a CBT (cognitive behavioural therapy) framework.

Despite no clear protocol to follow, all of the techniques that were used were still held within both the principles of a general cognitive behavioural theory and of the recent developments for treating intrusive memories and other symptoms of PTSD. It seems that by sticking closely to and following the client's needs, whilst maintaining a collaborative approach, worked well.

Personal reflections and professional learning:

This was a very challenging and rewarding case for me and provided me with ample material for professional growth. My main focus for the work was post-traumatic stress symptoms but the appearance of complications from childhood trauma factors posed the main challenge. I can now appreciate more fully that the diagnosis of post-traumatic stress disorder can cover a wide span of presenting difficulties. This can be a single traumatic event to multiple traumatic events combined with other psychological difficulties that lead to a complex case such as the one described above.

In the early sessions a formulation was depicted which provided a base to understand the interrelationships between all of the different parts. When childhood memories were processed the information was then fed back to the client using those links as a backdrop to understanding. The route between the processing of childhood memories/ schemas and adult based perceptions of everyday events could then usefully be challenged. The imagery with re-scripting technique (Arntz & Wertman, 1999) may therefore provide a very useful tool for any similar types of complex presentation. Most of my caseload involves working with clients who have a complex range of symptoms similar to the case above. The successful outcome in using this technique has inspired me to consider using this as a therapeutic tool in similar cases in the future.

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Part D:

LITERATURE REVIEW:

TITLE: A review of female and male anger experiences and expression with implications for therapy.

Abstract:

Objective: to review the current literature for evidence of gender factors for differences found in the experience and expression of anger with implications for therapy.

Method: Eleven studies were found that examined the above objective in 2003. A further three studies were found and added in late 2005. All of the studies used self-report measures to assess either gender differences and or sex-role differences on anger experience and expression and ten studies used standardised methods of assessment. Studies were grouped according to the findings for comparison.

Results: Evidence from these studies suggests that non-clinical populations vary from clinical populations in terms of anger experience and expression. All the studies found evidence for differences on gender for anger expression. Contextual factors that included demographic, social and interpersonal factors significantly affected the measures of both anger experience and expression. Gender-stereotyping judgements about displays of anger were highlighted as important factors for therapeutic practice.

Conclusions: The most notable findings were that variance seemed to be marked in clinical versus non-clinical groups, and that men and masculine sex-role types, seemed to use more aggressive forms of anger expression. Factors such as sex-role socialisation processes seemed to account for some of the differences found. Implications for therapy might suggest that taking a comprehensive and contextualised account of an individual's history to be important. Also that personal beliefs and biases within the individual therapist may need to be accounted for where anger is considered as problematic. Future research may include a more broadened approach to the variance of anger measurements that includes contextual factors to be measured.

Recommendations may include the use of more qualitative studies to determine contextual factors as a step towards developing a single standardised measure across populations to be carried out as may non standard populations

for comparison. Also the non-clinical sample might need to be drawn randomly from the general population as opposed to psychology students who in terms of demographic, social and other factors may not give a true picture of variance. Studies of gender differences in anger might need to be carried out in the UK.

Introduction:

The diagnostic basis for classifying dysfunctional anger was difficult mainly because dysfunctional anger was not listed as a discrete diagnostic feature in the DSM-IV-TR manual (2000), but is addressed indirectly through other diagnostic criteria on Axis I and II within the manual. It was therefore difficult to define exactly what an anger disorder might be when using the diagnostic criteria above (Eckhardt & Deffenbacher, 1995).

This was further complicated when the criteria for Borderline Personality Disorder (BPD) for example was examined. BPD was reported to be the most likely diagnosis given to intensely angry clients, especially those who are female at a predominate rate of 75% (DSM-IV, 1994). The revised diagnostic manual (DSM-IV-TR, 2000) makes no mention of this. Several figures were proposed for the number of different ways someone can meet the criteria for this disorder, starting at 93, and between 128 and 256 (Eckhardt & Deffenbacher, 1995; Skodal et al, 2002; Bateman & Fonagy, 2004) respectively. Antisocial Personality Disorder may be under diagnosed in females (DSM-IV, 1994) and it is possible that the different rates between Borderline and Antisocial Personality Disordered diagnosis along gender lines may reflect bias in clinical judgements based on stereotypical beliefs about appropriate displays or expressions of anger (Kelly & Hutson-Comeaux, 1999).

For example, a common myth and stereotyped belief about anger is that it is a male emotion and that if women get angry they do not show it (Kring, 2000). Adherence to stereotypical beliefs like this may have detrimental effects on therapeutic practice and seriously undermine the therapeutic alliance (Sharkin, 1993; Kassinove & Tafrate, 2002, Chpt 6).

Cultural attitudes in institutional settings have been demonstrated as sharing this problem. For example, were a woman to demonstrate anger within a mental health setting, this could be interpreted as part of the woman's mental ill health symptoms instead of a healthy response to events or circumstances.

Cultural stereotypes therefore could lead to differences in conceptualisation of mental health problems as well as the type of treatment offered (Cordall, 1999).

In wider social settings, Cox et al's, (1999) study argues that anger in women can be shaped by culture and can also be interpreted by the culture the woman operates in. In Gilligan's (1990, in Turkel, 2000) study of adolescence for example girls generally are reported to lose their ability to express anger from the pressure created in trying to be seen as good and popular. Also causes of anger and direction of anger expression were reported to be different in girls. Causes came from interpersonal experiences and the anger was directed inwardly. Boys on the other-hand got angry about performance evaluations and directed their anger outwardly. This is further evidenced by Thomas's (2004) study of men, which comes to similar conclusions. A study of older women between the ages of 62-79 years also found that the women inhibited their expression of anger to avoid conflict and to prevent disruption of their personal relationships (Minick & Guelder's, 1995).

Continuing within cultural themes differences have been argued to exist between the way women and men express emotion. She argues that women are raised in an environment that encourages emotion and men grow up learning that only sissies show their feelings. Anger and aggression is fostered in boys, which can also be used to channel other emotions whilst in contrast women may express anger by the use of other emotions saying that they are hurt etc., (Turkel, 2000). It seems therefore that anger is neither expressed linearly nor experienced in a linear fashion but may be accompanied or preceded by other emotions or expressed through other emotions (Hatch & Forgays, 2001).

Where anger is suppressed perhaps through the use of other emotions a variety of negative affective responses such as depression and somatic problems are thought to ensue however empirical evidence has yet to establish conclusively that a causal relationship exists between these factors (Newman, 1999). In Thomas's (1993) study the somatic responses to anger in women were found to vary according to the intensity of the anger felt, thus the more intense the anger

felt the more suppression might be needed leading to a variety of health problems, however somatic responses were also found where women did not suppress their anger.

The distinct variables had yet to be identified consistently across studies reviewed on differences between genders on anger carried out by Sharkin, (1993). Since this review different studies have shown that the experience and expression of anger between men and women fluctuate according to variables other than gender per se, such as social context, status and gender roles (Sharkin, 1993). The most divergent gender differences seemed to occur within the context of interpersonal relationships (Kring, 2000).

Some of the studies above seem to suggest that cultural influences and stereotypical biases are operating to influence the differences in conceptualisation of anger between the genders. Other findings in these studies suggest that generally gender roles, culture, status and socialisation factors influence the differences found on anger expression between genders. However replication of methods across studies and consistency of findings seems lacking. This paper reviewed fourteen studies in an attempt to investigate any differences to be found within or between genders on anger experience and expression and will discuss the possible implications for treatment on dysfunctional experience and expression.

Clarifications:

One of the main difficulties in finding suitable studies on anger is that the terms, anger, hostility, aggression and violence can be used interchangeably (Thomas, 1993, p13). For the purposes of this review I have chosen studies that deal with anger per se that may also report on other aspects such as violence or aggression but where anger is the main thrust of the study.

As previously mentioned dysfunctional anger does not occupy a separate diagnostic category in DSM-IV-TR manual (2000) and it seems that the lack of definition of what is dysfunctional anger as opposed to healthy anger becomes problematic. A healthy form of anger expression has been described to be

positive, assertive, and problem-orientated (Deffenbacher et al, 1996) whereas in contrast someone who is objectively judged to be angry to excess in frequency and duration and which is disproportionate to the event or person who triggered it may have an anger disorder (Kassinove & Tafrate, 2002). However can this description of an anger disorder apply both to someone who is verbally and physically abusive to others as well as someone who experiences anger but they either suppress it or take it out on them self in some way?

A definition of dysfunctional anger in psychological terms may need to be less confined to aggression and violence and may need to be more attuned to other difficulties. It may be more helpful to see that it is the consequences of the thoughts and behaviours chosen to channel anger leading to detrimental effects that are better indicators of dysfunction. Therefore the review will be concerned in looking for any implications in the findings in the studies that suggest that anger experience and expression or lack of anger experience and expression can lead to difficulties for the individuals concerned. Also, difficulties in definition and conceptualisation of anger problems will be discussed and will be referred to again later in the review (Edmonson & Conger's, 1996).

Method:

Reports were collected of empirical studies measuring differences between and within genders on anger. The purpose of which was to determine which factors account for these differences and the implication of this on the treatment of anger difficulties in therapy.

The computer databases used to carry out the search for these reports were PsychINFO, Ovid Online (includes, Medline, Cinahl, Embase, Journals@Ovid, PsychInfo, Amed, British Nursing Index), Biomed, Ebsco EJS. The terms used in the searches were Women and Anger, Women's Anger, Gender Differences in Anger, Gender and Emotion, Anger, Anger Traits, State Anger, Trait Anger, Female anger difficulties, Female emotion difficulties, Anger Control, Anger Management, Gender and Anger. Originally the electronic

resources were searched for citations from 1989-2003. More recently the searches included citations up until 2005. References in the relevant publications were also cross-referenced.

The articles chosen for review involved the study of anger in male and female participants that reported findings either to support or refute gender differences in the various aspects of anger. Studies were included that conducted research on participants about their experience and expression of anger and that specifically looked for differences between or within genders for comparison. The studies use different types of measure or combination of measures in their search for individual factorial differences and as such it is not possible to undertake a meta-analysis or statistically compare results across studies. Studies added in 2005 are numbered 12-14 inclusively.

Study	Type of Measure	Participant Type	No. Inc.	No. F	No. M	Gender Variable
1. Spielberger et al, 1995	STAXI	Heterogeneous Young Adults	1010	616	394	Between
		University Students	284	199	85	Between
2. Suter et al, 2002	STAXI NAS	Prisoners	171	50	121*	Between
3. Milovchevich al, 2001	STAXI PDQ	General Population	353	202	151	Between
4. Fehr et al, 1999	ISA	Psychology Students	124	73	51	Between
5. Kelly & Hutson-Comeaux, 1999	Questionnaire on reactions to ERS.	Psychology Students	77	33	44	Between
6. Hutson-Comeaux & Kelly, 2002	Questionnaire on reactions to ERS.	Psychology Students	177	60	117	Between
7. Kopper & Epperson, (1991)	TAS, AX and BSRI	Undergraduate Students	455	242	213	Between
8. Kopper, (1993)	TAS, AX, BDI, BSRI, BDHI, IBS, JAS.	Undergraduate Students	629	407	222	Between
9. Kopper & Epperson, (1996)	TAS, AX, BDHI, BDI, BSRI/SF	Undergraduate Students	318	183	135	Between
		Students	387	262	125	
10. Deffenbacher et al, (1996)	TAS, TAI, BDI, AEI, NAEL, ACQ	Undergraduate Students	274	158	116	Between
11. Thomas, (1993)	STAXI FAS	Women	479	479	0	Within
12. Thomas, (2003)	Semi-structured interview	Men	19	0	19	Within
13. Cox et al, (2004)	STAXI PAQ RAS	Women from General population	123	123	0	Within
	Semi-Structured interview	Women from Sample above	16	16	0	Within
14. Cox et al, (2004)	STAXI M-C SDS EEQ BSI Anger Diversion Vignettes	Female students	514	514	0	Within

*** This was a separate study conducted by Howells, K. (2002) on male prisoners with findings used as a comparison.**

List of abbreviations used in table and as expressed in studies:

STAXI: State-Trait Anger Expression Inventory, TAS: Trait Anger Scale from STAXI, AX: Anger Expression Scale from STAXI, SAO: State Anger Out subscale on STAXI, SAXO: Spielberger's anger expression out, TAI: Trait Anger Inventory, AEI: Spielberger's Anger Expression Inventory, NAEI: New Questions on Anger Expression Inventory

NAS: Novaco Anger Scale, FAS: Framingham Anger Scale, BSRI: Bem Sex-Role Inventory, BSRI/SF: Bem Sex-Role Inventory-Short-Form, BDI: Beck's Depression Inventory, BDHI: Busse-Durkee Hostility Inventory, IBS: Interpersonal Behaviour Study, ISA: Interpersonal Script Analysis, ERS: Emotional Response Scripts, JAS: Jenkins Activity Scale, ACQ: Anger Consequences Questionnaire. PDQ: Personal Description Questionnaire, PAQ: Personal Attributes Scale, RAS: Rathus Assertiveness Schedule, BSI: Brief Symptom Inventory, EEQ Emotional Expressiveness Scale. M-C SDS, Marlowe-Crowne Social Desirability Scale.

Results:

Participants:

Eight of the fourteen studies used university undergraduate students including one described as young adults, three studies used the general population, one used prisoners and three studies looked at women only and one study used men only. Although the new additions and one of the previous studies are not between gender differences they have been included because all of the studies consistently show the presence of other factors to account for differences in experience and expression of anger between men and women.

Settings:

Where university students were used the research was conducted on the site of that particular university, all were American in nationality except one study,

which used Canadian students. Two studies used the general population and both were conducted using a randomly selected sample, one from an Australian City and the other an American State. Prisoners were also from two separate Australian sites. The rest of the studies used American citizens and therefore this might point to a shortage of studies in the UK.

Assessment Measures:

The studies examined in this review span the last fourteen years and seem representative of the movement from using a single unitary measure for anger variation to using different combined instruments to determine factors in anger between and within genders. The most commonly used measure is Spielberger's (1998) State-Trait Anger Expression Inventory (STAXI). It is not clear whether any of the studies used the newer version of the (Spielberger's, 1998), which is a self-report measure of 57 items to measure the experience and expression of anger and is divided into three main parts. However Spielberger's (1995) study would have used the previous version of the STAXI that had 44 questions.

The test's wide spread use and citation in the studies reviewed may point to its efficacy as a measure of anger variables. However it seems that this test alone is limited in scope on gender difference variables for experience and expression of anger with many of the studies in this review incorporating other measures to account for the differences. Please refer to table above. This seems to suggest that factors other than gender may account for differences in anger experience and expression.

The STAXI has been used in all but four of the studies so it seems reasonable to examine this instrument more closely. The STAXI is a hand scored assessment and self-report measure with good coefficients for State Anger and Trait anger from between .84 to .93, on Trait Temperament from .84 to .89 and on Anger Expression scales from .73 to .85. It can be used on children aged 12 to adults up to age 67 (Spielberger, 1998). State anger is measured on a four point Likert scale from 1(not at all) – 4(very much) so and it assesses the frequency and intensity of angry feelings at a given moment in time. Trait

anger is measured using two subscales of Angry Temperament, Angry Reaction, and Anger Expression, which are measured using three subscales of Anger-Out, Anger-In, and Anger Control. Both of these parts also use a four point Likert scale from 1(almost never) – 4(almost always).

The following abbreviations indicate the parts that were used in the studies indicated in brackets:

STAXI: State-Trait Anger Expression Inventory (1,2,3,11,13,14) TAS: Trait Anger Scale from STAXI (7,8,9,10), AX: Anger Expression Scale from STAXI (7,8,9) SAO: State Anger Out subscale on STAXI, SAXO: Spielberger's anger expression out, TAI: Trait Anger Inventory, AEI: Spielberger's Anger Expression Inventory (10), NAEI: New Questions on Anger Expression Inventory (10).

It seems clear from further examination of the studies that interest in anger expression and experience has been of primary concern for all of the studies. This trend may be in part to the reports from Spielberger's (1995) study, which found a number of significant differences in scores using the STAXI for gender variance specifically within the sub-score questions reporting differences for experience and expression.

Gender differences were reported on the Trait anger scale with males scoring significantly higher with scores on the Temperament subscale leading to an increase in the overall significance. Men were also found to have significantly higher scores on the anger expression in and out subscales. Although no significant differences were found on the overall scores on the Trait anger reaction subscale, men had higher scores on two items (I feel annoyed when not given recognition for good work; I get angry when I am slowed by others mistakes), women scored significantly higher on one item (It makes me furious when I am criticised in front of others). Overall increase in Trait anger scores for men was found on two items in particular (When I get mad, I say nasty things; when I get frustrated, I feel like hitting someone) suggesting that men have a higher tendency to express their angry feelings in physically or verbally aggressive behaviours.

It seems reasonable to conclude that the STAXI whilst being a robust measure showing good reliability and validity for anger experience and expression fails to capture the more intricate variables for differences found across gender and or sex role variance (Kopper & Epperson (1991). This may have been a consideration in the rest of the studies being reviewed and may partly explain why other measures were being used in those studies.

Qualitative analysis may provide the means of exploration so that issues can be identified which may be too complex to investigate by quantitative means (Banister et al, 1999). This might have helped to identify factors to account for the variance across gender and sex roles on anger experience and expression but only two of the studies listed used a qualitative analysis (12, second part 13). All of the other studies used questionnaires and quantitative analysis.

Methodology:

All of the studies use self-report measures and standardised tests with the exception of (4, 5, 6, & 12, second part 13). Study (10) developed their own further tests such as the NAEI & ACQ, which are new questions used to enhance the area of enquiry into anger expression and experience. Study (4) devised their own test, the ISA (Interpersonal Script Analysis), from data supporting a questionnaire to measure cause, reaction, and partner response. The interpersonal script is described as a cognitive structure held by a person, which represents a sequence of actions and events of repeated similar experiences in a relational and interpersonal setting (Fehr et al, 1999).

ERS (Emotional Response Scripts) for studies (5, 6) were devised by the authors with scenarios depicting emotional situations in order to judge happiness, sadness and anger. Pre-testing the scenarios was carried out prior to their use in this study (Kelly et al, 1999; Hutson-Comeaux & Kelly, 2000).

Both Thomas, (2003) (12) and Cox, et al, (2004) (second part 13) used qualitative measures using transcribed interviews for analysis. In study (12) the interviews were conducted individually with participants whereas interviews for (second part 13) were conducted through participants formed into groups.

CRITICAL REVIEW:

A general overview of all of the studies concluded that there was wide and varied measures used, which made any direct comparison extremely difficult. Findings did not seem to be consistent across the studies and this may have been due to the number and variation in the range of measures used. However what seems to consistently appear in relation to the range of contextual factors measured is that women and men differ in anger experience and expression but not just because of their gender. The factors identified seem to vary within the studies and the most significant variations seem to be reported within the interpersonal context using non-clinical general population groups. Significant variances seemed to be reported in clinical and prisoner groups.

In study (1) as discussed earlier, the main findings seemed to be that differences were found on anger expression with men using more physical and verbal aggressive means (Spielberger's, 1995). In study (10) 35 questions were added to the anger expression test and 33 questions to anger consequences test and the conclusions also suggested that males scored higher on anger expression and used more aggressive forms of expression and had more negative consequences as a result (Deffenbacher et al's, 1996). Neither study went on to consider using other variables to detect differences between female and male results despite Spielberger (1995) pointing out that significant effect was extracted by looking at the individual question scores preferred by males versus female responses.

This might point to a weakness in the STAXI questionnaire in eliciting factors for gender variance, yet nine other studies have used this measure with some studies using sex-role identification or gender role measures (3,7,8,9) for comparison. None of the studies report that they have taken individual question scores into account when reporting on male versus female responses or report on the number of females and males within the sex-role or gender role divisions. Therefore it might be difficult to decide either way as to whether just gender or sex-role/gender role is a significant factor.

In study (3) for example some evidence was found that included a male and female distinction for gender role identification and concluded that gender role was a significant factor for variance on trait anger and expression (Milovchevich et al, 2001). Masculinity seemed to score higher on trait anger and correlated with a greater tendency to express anger outwardly. Whereas in contrast femininity seemed to score significantly lower on trait anger and on outward expression. Another factor that seemed to be important was reported in the 'target' for expression of anger, with male anger towards males scoring higher than female anger towards males, but experience of anger did not differ providing possible evidence that relational structures may effect accepted rules for anger expression. A caution was raised in relation to the use of self-report measures where social rules might unduly influence reports. It was also noted that individuals might be affected by the effects created over generational time as socialising representations for experiences and observations about anger may change. This study used male to female distinctions of gender role identification, took participants from a general population sample and took into account that socialisation factors can affect the results and is therefore a positive contribution to the search for variation between male and female anger experience and expression (Milovchevich et al, 2001).

In previous studies sex-role identification seems to account for the differences in anger experience and expression found (Kopper & Epperson, (1991) (7); Kopper, (1993) (8) and Kopper & Epperson, (1996) (9) Weaknesses seem to appear when the use of students are taken as representative of wider populations and in using too many other measures against anger experience and expression making it difficult to distinguish results with any consistency.

Thomas's, (2003) (12) study is qualitative and identified the experience of anger as differing significantly with men reporting less interpersonal factors than women. The themes of right versus wrong, control and being controlled, and provocation by strangers and faulty mechanical objects, or global societal issues were identified as the main factors. The expression of anger was a factor that changed over the lifetime of the participants with youthful expressions being more volatile and aggressive in nature than when they matured in later

years, which strengthens Milovchevich et al's, (2001) arguments that conceptualisations of anger can change over time.

In contrast five studies highlighted differences for women in that anger expression and experience was more likely to occur within interpersonal contexts for women (Fehr et al, 1999) (4); Hutson-Comeaux & Kelly, (2002) (6), and Thomas, (1993) (11) Cox et al, 2004(13 & 14), which is highly distinct from male forms of experience and expression (Thomas, 2003). Women were also more likely to feel hurt and cry when experiencing anger Thomas, (1993) (11) and personal criticism seemed to be a factor of provocation for anger with expression contained within direct or indirect aggression and hurt feelings in (Fehr et al's, 1999) (4) study.

In two other studies the method of expression was thought to vary according to other factors such as personality, assertiveness and instrumentality factors and that these can be adaptive or maladaptive depending on the choice of expression for women (Cox et al, 2004;(13 & 14). The studies examined so far seem to point towards anger being a complex and multi-dimensional emotion that is subject to a number of gendered socialisation factors that effects expression of anger in particular types of circumstances. As yet, no single study seems to have managed to distinguish all of the factors for the differences that were found within and between gender variance.

When male and female prisoners were compared findings showed that women prisoners scored higher on all parts of the STAXI except the anger control subscale where male prisoner scored higher (Suter et al, 2002) (2). On the NAS women also had higher scores on anger arousal, anger cognitions, and anger behaviour. One of the triggers identified in higher scores for women getting angry was on unfair treatment.

In normal population samples from the study gender did not seem to affect anger experience and expression generally, however in clinical samples significant effects were found (Suter et al, 2002) (2). They also noted an important demographic variable within the sample used for this study; only

12% of the female prisoners within the sample were violent in contrast to 54% of male prisoners who were violent and suggested that female prisoners represented a more pathological population than male prisoners and should be treated from a psychopathological basis than a criminological one. The suggestions were based on the speculation that women in the sample may have been exposed to childhood or adulthood trauma and therefore use other means of anger expression such as self-harm (Suter et al, 2002) (2).

The differences found in anger control were thought to relate to the mode of anger expression therefore males are more likely to aggress against others or property and women are more likely to direct their anger inward leading to either depressive symptoms or self-harm (Suter et al, 2002). Support for this view comes from a comprehensive review from the Correctional Services of Canada (2003) that looks into women's anger from a prisoner perspective, which found that a link between depression or self-harm to trauma was strongly upheld in the literature that they reviewed.

This suggests that women in certain situations might feel less able to express their anger feelings such as in an abusive relational sense or in a captive (prison) sense rather than in general. A comprehensive study on non-clinical versus clinical (not prison) populations supports this view (Thomas's, 1993) (11).

The absence of a behavioural response component in Eckart & Deffenbacher's (1995) framework on anger problems has been suggested to overlook behaviours other than aggression that can occur in response to anger and need to be included to understand the appropriateness and effectiveness of the response. This might then allow for an understanding of other behaviours in the framework of anger dysfunction (Edmonson & Conger's review, 1996).

In considering the studies above it seems that it might be more important to understand the underlying contextual differences in the demographic, social nature, and situational factors of the cohorts used as participants rather than just gender per se. The implications for this on therapy may conclude that

when working with individuals, ideas within the therapist about what is normal or abnormal experiences of anger and their expression may need to be revised in light of those contextual differences. They may also need to look at the personal beliefs they hold about anger in general.

For example when stereotyped reactions to displays of anger in men and women were studied from examining the views of mental health professionals it was found that describing what was healthy for adults was closely related to what was seen as healthy for men however the same characteristics were not seen as healthy for women. The differences used to describe healthy women were that women were more submissive, less independent, less adventurous, more easily influenced, less aggressive & less competitive (Broverman et al, 1970 in Walker, 1994). In a more up to date examination of gender stereotyping in psychology students using contextual variables as part of this review, findings suggested that evaluations of angry situations were not context dependant. Overreactions were considered more stereotypical of men and under-reactions more stereotypical of women (Kelly & Hutson-Comeax's, 1999), (5).

When the validity of emotions was studied from an expression perspective rather than experience perspective overreactions to angry events where male actors were used were judged in the interpersonal context to be less appropriate. When the achievement context was used overreactions to angry events were judged to be significantly more appropriate in male actors than female actors Hutson-Comeaux & Kelly's, (2002) (6). As with the study before, this suggests that stereotypes of male and female behaviour still operate within the minds of participants (i.e. psychology students). In light of social sanctions against inappropriate reactions being used the author's suggest that further research be carried out to find out what is considered to be appropriate emotional reactions and whether these differ for women and men.

For example it was proposed that women who displayed 'inappropriate' behaviour in a mental health setting might have their displays of anger labelled as part of mental health symptomatology instead of healthy expressions of

anger against oppression and past abuse. It was further proposed that recognising our beliefs; attitudes and feelings about anger might be a first step for working with mentally disordered offenders (Cordall's, 1999). This could extend to therapists and psychologists working in clinical settings.

Finally a major study looking at within difference variables on women, assessed demographic, social and other variables that could effect anger expression and experience (Thomas's, (1993) (11). The findings lend backing to the information about the types of contextual differences that other authors have mentioned for example, differences were found in the non-clinical group in Suter et al's, (2002) (2) study where women had higher scores for aggression. The study also found that both anger in and anger out created somatic type symptoms. The intensity of emotion was thought to generate or maintain somatic symptoms regardless of expression or suppression. Higher anger prone individuals were found to have cognitions that viewed situations as being unfair to them and it has been suggested that this may contribute towards the use of anger out expression (Thomas, 1993) (11). This is also reflected in study (2) where women prisoners' sense of unfairness was seen to act as a trigger for anger (Suter, et al, 2002).

DISCUSSION:

Grouping the main findings from the studies involved in this review has revealed that there may be sufficient evidence to suggest that men and women vary in their experience and expression of anger. Seven (1,3,7,8,9,10,12) of the fourteen studies found that either being male or having masculine sex role identity was a significant factor in the type of anger experienced and the choice of method of expression.

There also appears to be evidence that there are a number of contextual factors that operate to create the differences found between male and female experience and expression of anger, which are not just related to gender difference. It may be important therefore that therapists take contextual factors into account when deciding treatment approaches. Many women for instance

have high levels of stress created within the interpersonal sphere of their lives, which acts as a precursor to anger experience. This is in contrast to men who appear to conceptualise their anger experience outside the interpersonal sphere (Thomas, 2003) (11).

The STAXI as a measure is like a broad-brush stroke attempt at identifying rates of anger experience and expression without taking into account the contextual reasons for the differences in rates of anger measures between male and female experience. Many of the studies have tried to plug that gap by the use of a variety of measures but unfortunately there does not appear to be any consistency of measurement. As a consequence therefore cannot collectively supply the evidence of the specific factors involved. The use of a qualitative study has proved useful in this respect in that detail in accounts of anger experience have highlighted a number of factors such as age variation in anger expression, and cognitive factors of right versus wrong and control versus being controlled as features of anger experience for men (Thomas's, 2003)(11). The interpersonal script analysis also revealed that women were more likely to behave aggressively in the context of negligence, lack of consideration, and personal criticism in an interpersonal context (Fehr et al, 1999)(4) and is suggestive of agreement in Thomas's, (1993) (11) study and Kring's (2000) perspective.

Limitation in the studies:

No direct comparisons could be made between the studies as each study used different measure or combinations of measures. The most widely used measure was the STAXI wholly or in part but due to the presence of different factors of measure and comparison it was not possible to directly compare one study with another. Comparing clinical groups versus non-clinical groups for example has provided valuable information that highlights the variance between them however only one study on women only, actually carried out a comparison of clinical versus non-clinical populations (Thomas, 1993) (11).

Using undergraduate psychology students as representative of the general population in nine of the fourteen studies severely limits the generalise-ability

to the rest of the population, especially where contextual variance could account for the differences found as previously discussed (Oppenheim, 2000).

Another limitation on direct comparison is the use in some studies of gender (female, male) comparison and sex-role (feminine, masculine, undifferentiated and androgynous) comparison. The advantage of sex-role comparison may lie in the differentiation within female and male populations but numbers of female to male participants falling into these groupings was not made. This meant that the number of masculine type females and feminine type males or androgynous males for example could not be differentiated. This would be important particularly when they were being compared for mental health functioning on the basis of aggressive anger expression or suppression of anger expression. Also the effects of socialisation factors might have been more easily identifiable this way.

Most of the studies use the Staxi in whole or in part which seems to be a recognised starting point (Speilberger, 1998). It seems that although this test is good for measuring anger in general terms it may not be so relevant in relation to studying the contextual factors involved when looking at gender or sex role differences. The most comprehensive author in this review has been Thomas's studies which span over a decade (Thomas, 2003 (12); Thomas; 1993 (11)). The strength of these studies lay in the contextual elements that are explored in relation to differences for men and women in their anger experiences and expressions. These seem to be important issues to consider when treating anger difficulties in therapy. The least relevant study when considering gender might be considered to be the first in the review (Speilberger, 1995 (1)). However the starting point for the studies that followed was the distinction between experience and expression to be derived from Speilberger's studies. It seems that further ideas could then be derived once anger was understood in both terms.

Recommendations for future research:

It appears that there is a move away from simple measure of anger experience and expression to the inclusion of several measures to determine gender, sex-

role, and other contextual variances. Future research may look at developing a more unitary form of measure so that direct comparisons between different populations might be studied.

The STAXI has provided a good foundational measure of anger variance in general, but weaknesses were highlighted when question in the subscales were used to highlight variance according to gender. Extension of these questions as in Deffenbacher et al's, (1996) study again would require the development of a unitary form of questionnaire to be developed so that it can be used across populations for direct comparison. Conceptualisations of what constitutes an anger difficulty might need to be inclusive of other factors rather than just violence or aggression (Edmonson & Conger, 1996).

The most comprehensive within gender study on women has been able to obtain interesting variances on a number of demographic, social and other factors (Thomas, 1993) suggesting that future research may wish to concentrate on studies with those variances as opposed to gender differences per se. Sex-role socialisation factors have been used to argue that within differences are more important than that between the genders. However this would obscure the gender differences found between other populations such as clinical and prisoner groups. Qualitative studies could be used to help develop some standardised measures for these particular populations which might help. Future research on stereotyped beliefs and attitudes about anger within the therapeutic community may shed light on the anomalies of assessment, diagnosis and treatment of anger difficulties which may help to change any adverse practise as a result of those beliefs.

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Appendices:

INVITATION LETTER

Date: 08/12/04.

To Consultant Psychiatrists'
Psychologists'
Mental Health Workers'

Wendy Scott: DPsych Research project

I am currently undertaking a research study as part of the requirements for the DPsych in Counselling Psychology, City University, London, Department of Psychology School & Social & Human Sciences.

I have chosen the following as my research question:

Title of Research Study:

‘Understanding the role of anger in the mediating factors of self-harming behaviour:’

I am looking to recruit 8-12 participants to take part in my research study. Inclusion criteria will include the use of self-harming behaviour (as per the definition) within the past six weeks, male or female, aged 18 or over.

The definition of self-harm is as follows:

- ‘An act or behaviour that results in physical harm to the self that breaches accepted norms culturally and by self report was not intended to end the person’s life’.

Taking part in this research project is completely voluntary.

All information about participants gathered during the course of the research will be kept strictly confidential. All information, views, comments, etc will be anonymised, so that participants cannot be recognised from it.

I have prepared a more detailed information sheet (overleaf), if you are interested in supporting my research study; please contact me on ☎ 024 7624 6268

Yours sincerely

Wendy Scott
CPsychol
Coventry Teaching PCT
Sage Ward
Gulson Hospital, Gulson Road.
Coventry.

Clinician Information Sheet:

Title of Research Study:

'Understanding the role of anger in the mediating factors of self-harming behaviour:'

Rationale for Study:

From my clinical observations of working with people who self-harm I have noticed how anger seems to play a part in the motivational and behavioural factors of self-harm. Literature to date appears to acknowledge the presence of anger in factors involved in self-harm, but little in depth meaning studies have been conducted to find out the way anger interacts with other factors and influences self-harming behaviour.

Aim of Study:

The aim of this study is to carry out semi-structured interviews with participants who have self-harmed. They will be allowed to talk openly and freely about their feelings, thoughts and experiences about why they self-harm. I will ask questions about anger in relation to their self-harming behaviour so that I can analyse the meaning components to understand the role of anger in self-harm.

What is involved?

I am seeking to recruit participants who have been self-harming on a regular basis and whom you know or may be aware have harmed themselves within the past six weeks.

What do I need to do?

Using your clinical judgement I would like you to identify potential participants who meet the following criteria for recruitment to my study. Before approaching them you are asked to consider the suitability of potential participants bearing in mind any risk factors and or any distress that may be caused by them taking part.

Criteria for taking part:

Participants will need to be 18 or over and have self-harmed within the last six weeks.

Clinician Information Sheet:

Title of Research Study:

‘Understanding the role of anger in the mediating factors of self-harming behaviour.’

Exclusion criteria:

Where participants are actively psychotic or where participants cannot speak English Fluently they should not be approached or asked to take part in the study.

Definition of self-harm:

The definition of self-harm that will be followed for the purpose of this study is as follows:

‘An act or behaviour that results in physical harm to the self that breaches accepted norms culturally and by self-report was not intended to end the person’s life’.

What do I need to do next?

Once you have identified suitable participants please talk to them about the study using the enclosed patient information sheet. Please ask them to contact me about any queries or information they require before making up their mind about the study. I will then send them a patient information sheet that outlines the study and gives them information about how to contact me should they wish further information or are willing to take part. Please inform them that taking part is entirely voluntary and that it does not affect their current treatment in any way. During the study the key ethical considerations will be to ensure confidentiality and anonymity of participants.

Should you require further information or have any queries please contact me using the following information.

Contact Information:

Wendy Scott , Counselling Psychologist working in Coventry PCT at Sage Ward,
Gulson Rd. Hosp., Gulson Rd. Coventry. ☎024 7624 6268

Information Sheet for Study Participants:

Research Title:

‘Understanding the role of anger in the mediating factors of self-harming behaviour’

Date:

Dear Sir/Madam,

Study Title:

‘Understanding the role of anger in the mediating factors of self-harming behaviour:’

(Mediating factors are those things other than anger that give reason to self-harm).

Invitation to take part:

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish (friends, family, your G.P. or mental health worker). Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

Taking Part:

You must not be involved in existing research or recent research. I will ask you about this before I begin the interview and you will be invited to sign a declaration to that effect on the consent form to take part in the research.

What is the purpose of the Study?

The reason for carrying out this study is to find out more about why people self-harm and in particular what role anger plays towards making the choice to self-harm. I have chosen to focus on anger because during my work as a Counselling Psychologist I have become aware that this can sometimes be a difficult emotion to experience for some people and I would like to understand more about this. The aim of the study is to gain an understanding of why anger may play an important role in self-harming behaviour. I will be conducting the study over the remainder of the year and hope to have written up my findings by June 2005

Information Sheet for Study Participants:

Research Title:

‘Understanding the role of anger in the mediating factors of self-harming behaviour’

Why have I been chosen?

You have been chosen for an invitation to take part because your mental health worker has identified you as someone who has self-harmed within the past six weeks. I am seeking to interview between eight and twelve people in total.

Do I have to take part?

You do not have to take part; it is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you do decide to take part you are still free to withdraw at any time without giving any reason until February 15th 2005, which is the time for all data collection. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.

What will happen to me if I take part?

You will be interviewed in private for approximately 50-60mins. You will only have to do this once. You will be asked some questions with regard to your self-harming behaviour and you are free to answer these as briefly or as fully as you wish. The idea is to give you a chance to talk to me about your experiences of self-harm and of anger with as little direction as is possible. There are no right or wrong answers; you are free to answer any way you wish.

Your interview will be audiotaped and afterwards transcribed for the purposes of the research. Quotes from the transcripts may be used in the write up and possible further publications but they will all be made anonymous and have any identifying information removed.

What do I have to do?

You will be invited to attend at an outpatient psychology service department, and arrangements will be made to offer you a suitable appointment time to attend for interview. If you wish to make alternative arrangements to be interviewed at a more convenient place or time I will contact you to try to arrange this. I will need a contact number so that I can get in touch with you. *(Instructions about this will appear at the end of this information sheet).*

Information Sheet for Study Participants:

Research Title:

‘Understanding the role of anger in the mediating factors of self-harming behaviour’

What is the drug or procedure that is being tested?

This is not applicable.

What are the alternatives for diagnosis or treatment?

This is not applicable.

What are the side effects of taking part?

It is not expected that there should be any side effects from taking part in the interview. However you may become distressed at talking about your experiences either during or after the interview ends.

There will be time after the interview for talking over your feelings with me.

During the interview you are free to stop at any time. If you have become distressed I will discuss this with you and you will be asked if you wish to stop. You will also be asked if you wish to continue afterwards. You can stop the interview at anytime and you will be given time to discuss your feelings at that time or to leave the interview immediately if you should wish.

All participants will be given an information sheet of a list of suitable contacts that are suitably qualified to discuss your feelings or deal with any distress that may have been caused during or after the interview. If you wish I can contact appropriate support on your behalf. If you agree to me contacting appropriate support (usually your key mental health worker or GP) I will need your consent and you will be asked to sign a consent form beforehand.

What are the possible disadvantages and risks of taking part?

There will be no risks in taking part in terms of your usual clinical care, currently or in the future. The questions will involve asking you about psychological aspects of self-harm that may become distressing to you. I have worked with people who have self-harmed before, and therefore hope that I will be sensitive to your reactions during the interview and you will be given the opportunity to take a break or leave the study if you wish.

Information Sheet for Study Participants:

Research Title:

‘Understanding the role of anger in the mediating factors of self-harming behaviour’

Life Insurance/Private Medical Insurance

This is not applicable.

What are the possible benefits of taking part?

“There is no intended benefit to taking part in this study”. However the information we get from this study may help us to develop more effective treatments for people whom self-harm. You may also find the interview to be informative.

What if new information becomes available?

This is not applicable.

What happens when the research study stops and to its results?

This is not applicable.

What if something goes wrong?

“If you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone’s negligence then you may have grounds for a legal action but you may have to pay for it. Regardless of this, if you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service Complaints mechanisms will be available to you”.

Will my taking part in this study be kept confidential?

In agreeing to take part in this research you will be interviewed for approximately 50-60mins and an audiotape of the interview taken. This tape recording will then be transcribed for the purposes of the research. Quotes taken directly from the transcription may be used in the write up and any further publication. However all identifying information will be removed and made anonymous beforehand.

All data, written or audiotaped will be kept locked away when not in use. During the taping of the interview it sometimes happens that you may reveal identifying or personal information. To preserve your anonymity the tape will be erased at that point to remove the identifying or personal information immediately. Tapes will be held until the transcription is completed after which they will be completely destroyed.

Information Sheet for Study Participants:

Research Title:

‘Understanding the role of anger in the mediating factors of self-harming behaviour’

Transcriptions will be held for a period of five years for authentication and verification purposes of the research after which they will be completely destroyed.

The researcher, the researcher’s academic supervisor, and examining body will have access to any written data after personally identifying information is removed.

What will happen to the results of the research study?

The results of the study will be reported in my dissertation, as part of my Doctorate in Counselling Psychology, in July- August 2005. It is hoped that results will be published in a psychology journal. You will not be identified in any published material.

Who is organising and funding the research?

City University is sponsoring and funding this research. There is funding for expenses incurred during the research to the researcher but no payment is made for conducting the research.

Who has reviewed the study?

This proposed study has been reviewed by leading researchers in the field of self-harm and Coventry Local Research Ethics Committee.

Contact for further information?

If you are interested in taking part or if you have any questions then please contact me, Wendy Scott (counselling psychologist) on ☎ 024 7624 6268 or write to

Wendy Scott, at Coventry Teaching PCT, Sage Ward, Gulson Hospital. Gulson Road., Coventry CV1 2HR.

When you make contact please leave a number so that I can phone you back if I cannot speak to you directly. Otherwise leave details of how and when to contact you.

Reimbursement of travel expenses:

You will be refunded for the cost of travel to and from the place where the interview will take place.

Centre Number—Coventry PCT-
Study Number—04/Q2802/85—
Ethics Committee Approval Date 25/11/04—
Patient ID Number for this Study —

Copies to:
Patient,
Researcher, and
R&D Department.

Patient Informed Consent Form

Research Title:

‘Understanding the role of anger in the mediating factors of self-harming behaviour’

Name of Principal Investigator and Contact person: Wendy Scott (Counselling Psychologist)

Please Initial Box

1. I confirm that I have read and understand the information sheet dated October, 2004 (Version No. 3) for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care, mental health care, or legal rights being affected.
3. I agree to being interviewed and understand that this will be audio-taped for the purposes of the research and that the tapes will be destroyed as soon as they are transcribed.
4. Subject to any identifying information being made anonymous I allow access to the researcher, the researcher’s academic supervisor and the examining body of all transcribed material of the interview and understand that the transcript will be kept for five years.
5. I understand that the information I give will remain confidential and that I will be given anonymity in any publication or reports that arise from the research.
6. I agree to take part in the above study.

Name of Participant	Date	Signature
Name of Person taking consent Date (if different from researcher)		Signature
Researcher	Date	Signature

Centre Number—Coventry PCT---

Study Number---04/Q2802/85-----

Ethics Committee Approval---25/11/04-----

Patient ID Number for this Study -----

Copies to:

Patient,

Researcher, and

R&D Department.

Patient Consent Form to Contact Mental Health Worker

Research Title:

'Understanding the role of anger in the mediating factors of self-harming behaviour'

Name of Principal Investigator and Contact person: Wendy Scott (Counselling Psychologist)

Please Initial Box

1. I confirm that I have read and understand the information sheet dated
October, 2004 (Version No 2) for the above study and have had the opportunity
to ask questions.

2. I consent to Wendy Scott contacting the following named person on my behalf
for the purposes of receiving their support. I understand that this person will be
someone who is already involved in my mental health care needs.

Name: _____

Name of Participant

Date

Signature

Name of Person taking consent Date
(if different from researcher)

Signature

Researcher

Date

Signature

Appendix 6

Interview Schedule:

Initially, talk to the participant, ask about the journey, weather and generally help put participant at ease.

Thank them for coming and agreeing to take part.

Go over consent form; ensure they understand what the relevant parts mean.

Ask them to sign the form if they are satisfied and that I am sure they have understood what they are being asked to do.

Introduce them to the way the interview will be conducted

i.e. (I am now going to ask you a few questions about your self-harming behaviour, there are no right or wrong answers, you are simply asked to talk as freely as you feel comfortable with, remind them that they are free to stop the interview at any time, that if they become distressed that I will stop and give them time to consider whether they wish to continue etc —————)

General headings of questions that may be asked:

1. Can you tell me a bit about why you agreed to be interviewed about your self-harming behaviour? *(Expanding questions might be: how do you feel about coming here today, and about talking about your self-harm, what was it that interested you and agreeing to take part etc)*
2. Can you tell me a little about what you do to yourself when you self-harm? *(Expanding questions might be: what is it that you actually do to harm yourself, is this the only type of self-harm you do, etc)*
3. Linked questions: When was the last time you self-harmed?
Would you be able to talk to me about what led up to that at that time?

Depending on answer

If yes ask for general circumstances, feelings context etc if required

If no move to more general episodes of self-harm, establish whether they can talk about things in more general terms, ask about circumstances, feelings, context etc if required

4. Are you or have you ever been aware of feelings of anger in yourself around about the time you feel you want to self-harm?

Depending on answer

If no ask expanding questions about what they actually do feel at this time and then expand on what that is like for them (physically, emotionally etc)

If yes ask expanding questions about anger (what do they feel emotionally, physically etc)

5. Then ask why they choose to self-harm after that (*expanding questions might be what does the self-harm do for you, how does it help, have they tried other ways other than self-harm in past, did that help etc*)
6. Round up the interview and thank the participant for their time and information.
7. Ask them if they would now like time to reflect on what they have said and to wind down.
8. Ask the participant if they have any questions about the interview or any issues that the interview might have raised for them.
9. Do they feel that they would like to talk to someone afterwards such as their mental health worker, GP etc? Will they contact them themselves or would they like me to do that on their behalf.

Appendix 7

List of themes from Interview 1.

Asking about self-harm is unexpected

Alienation

Wound up

Isolation

Withdrawal

Self-harm = looking after self

Dramatic Images

Despair

Taboo subject

People get angry about it

Lack of compassion from family

Self-harm = release

Cutting is quicker way to release pain and stress

Being Judged

Shame

Availability = choice of method

Brooding/Rumination = self-harm

Anger = self-harm

Impulsivity

Ambiguous Intent (between suicidal thoughts and self-harm)

Anger = violent acts of self-harm

Anger = acts of destruction (burning things, lashing out on walls, smashing things)

Depression = self-harm

Self-harm = calming self

Abuse = self-harm

Dysfunctional family = self-harm

Family feel shame and angry about self-harm

Talking reduces self-harm

Feeling trapped = self-harm

Rejection = self-harm

Can't express anger because of repercussions

Anger = self-harm

Humiliation

Appendix 8

Building the superordinate themes

Relieving Mental Anguish

Way to look after self

Release

Calming self

The taboo nature of self-harm

Asking about self-harm is unexpected

Sensitive subject

People get angry about it

Lack of compassion

Family feel shame and anger

Being judged

Shame

Isolation

Alienation

Withdrawal

Despair

Being wound up

Regulating the method

Availability

Cutting is quicker way

Impulsivity

Anger

Mental Anguish

Brooding/Rumination

Depression

Feeling trapped

Rejection

Ambiguous suicidal thoughts

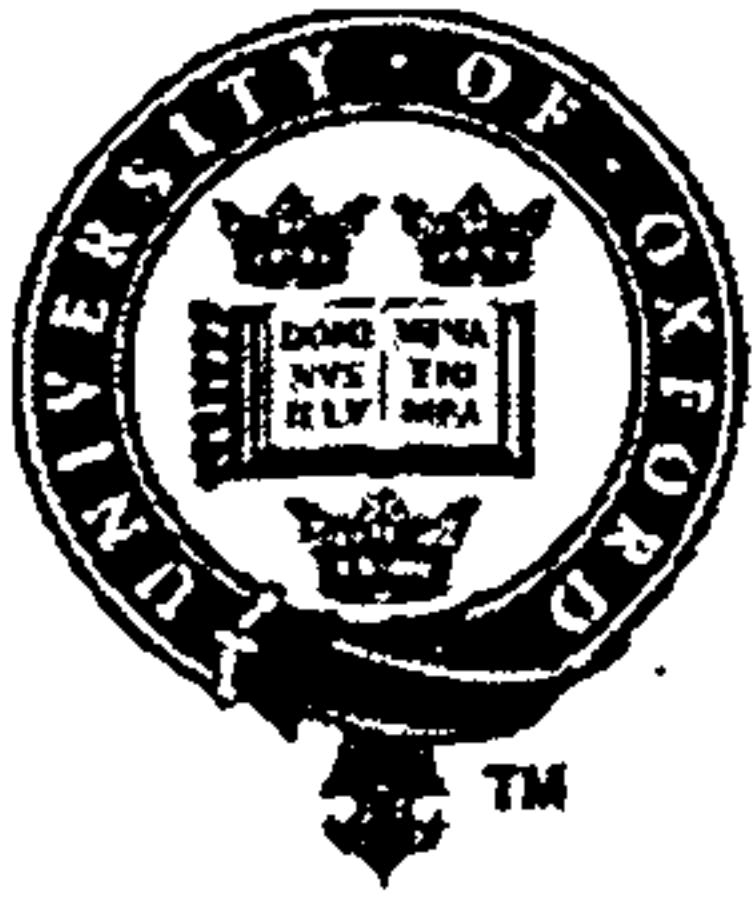
Anger

Abuse

Dysfunctional family life

Humiliation

Not being able to express anger



Oxford Doctoral Course in Clinical Psychology

an NHS Course validated by the University of Oxford

Isis Education Centre, Warneford Hospital, Headington, Oxford, OX3 7JX

Tel: +44 (0) 1865 226431 Fax: +44 (0) 1865 226364

Website: www.hmc.ox.ac.uk/clinicalpsychology

To whom it may concern

I can confirm that I have listened to extracts from 8 out of 9 disc recordings of interviews for Wendy Scott's thesis: Understanding the experience of anger within self-harm. They all contained real interviews with individual service users and match transcripts I have reviewed. I believe that the tape of participant 6 became corrupted and unusable and this was disclosed to the NHS Research Ethics Committee who reviewed the project.

A handwritten signature in black ink, appearing to read 'Rachel A. Woolrich'.

Dr. Rachel A. Woolrich

Clinical Psychologist / Research Tutor

2006-01-17

Appendix 10

List of organisations and contact details:

SIARI: Self-injury and related sites www.siari.co.uk – gives comprehensive list of web sites and telephone contact details.

Bristol Crisis service for women: helpline: 0117 925 1119

National Self-harm network: www.nshn.co.uk support helpline: 0845 7626579

Krysalis: Drop in Centre in Coventry: 024 7623 0730

Harp Place

Sandy Lane

Radford

Coventry CV1 4DX

Details of Key Worker: *individual details for each participant:*

Contact details: : *individual details for each participant:*



Coventry Research Ethics Committee

Trust Admin Centre 1
Walsgrave Hospital
Clifford Bridge Road
Coventry
CV2 2DX

Telephone: 024 7653 5219
Facsimile: 024 7653 5168

Email: pauline.pittaway@uhcw.nhs.uk

25 November 2004

Mrs. Wendy P. Scott
Coventry PCT NHS
Counselling Psychologist
Coventry PCT NHS
Sage Ward, Gulson Rd. Hospital
Gulson Rd.
Coventry
CV1 2HR

Dear Mrs. Scott

Full title of study: *Understanding the role of anger in the mediating factors of self-harming behaviour:*
REC reference number: 04/Q2802/85
Protocol number:

Thank you for your letter of 15 November 2004, responding to the Committee's request for further information on the above research and submitting revised documentation.

The Chairman has considered the further information on behalf of the Committee.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

The favourable opinion applies to the research sites listed on the attached form. Confirmation of approval for other sites listed in the application will be issued as soon as local assessors have confirmed that they have no objection.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Notification of other bodies

The Committee Administrator will notify the research sponsor that the study has a favourable ethical opinion.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

04/Q2802/85

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project,

Yours sincerely,


Mrs C Wright
Chairman


Administrator

E-mail: pauline.pittaway@uhcw.nhs.uk

Enclosures

Standard approval conditions

Site approval form (SF1)

TEXT BOUND INTO THE SPINE

Eamon G Martin
Academic Registrar

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D +44 (0)20 7040
F +44 (0)20 7040 8886
e.g.martin@city.ac.uk

www.city.ac.uk

Ms W P Scott
7 Berrill Street
Irchester
Near Wellingborough
Northants
NN29 7DT

16 September 2005

Dear Ms Scott

Re : "Understanding the role of anger in the mediating factors of self-harming behaviour"

I am writing to you to confirm that the research proposal detailed above has been granted formal approval from the City University Research Ethics Committee, following the favourable opinion of Coventry Research Ethics Committee on 25 November 2004.

On behalf of the Research Ethics Committee I do hope that the project meets with success and many thanks for your patience.

Regards



Alex Sandbrook
Graduate Education Co-ordinator
Academic Development and Services (DART)
a.e.sandbrook@city.ac.uk
0207 040 8106

Breathing exercise to lower stress/anxiety/anger levels.

- Using this breathing technique will help to lower your stress/anxiety/anger levels.
- When we feel stressed or anxious or angry there is an increase of adrenalin produced in the body. Adrenalin helps the body to prepare for action either to get away from the danger or to fight off the danger. It is often a hair trigger response reaction that we may not even be aware of in certain types of situation. It is our body's way of helping us to defend ourselves when we sense or become aware of something dangerous to us in the environment. This sends a message to the brain which in turn produces an amount of adrenalin. This is a natural and harmless reaction and is not usually a problem.
- Things become difficult when we get too much adrenalin over a period of time because we are more fearful than we need to be or we have been under a lot of stress or in the case of losing control of our anger we become violent or aggressive.
- To counteract adrenalin surge or where there is longer term higher levels of adrenalin than is healthy for us it is useful to try and do the following breathing exercise.

Please read all the following before you start so that you know what you are expected to do.

Step 1:

At first you are asked to breathe out, expelling all the breath in your lungs till it feels empty. However it can be difficult just to breathe out, so to begin with take a normal breath in then expel all the air out of your lungs till you can feel that they have emptied.

Step 2:

Take another normal breath in very slowly and calmly, not gasping it in. You need to feel that you have a measured amount of control of this.

Step 3:

Then push all the breath back out again until the lungs are again feeling empty.

Step 4:

Repeat steps 2 & 3 at least once more so that you have done the pushing out bit at least three times.

You should get a floppy feeling following the exercise if your adrenalin levels have been high or you have been suffering heightened levels of stress/anxiety/anger, this is perfectly normal and lets you know that your body is feeling more relaxed. If you do not get it right first time just keep practising until it starts to feel natural. You can practise doing this several to many times a day and you can do this anywhere without anyone else being aware that you are carrying out a breathing exercise. The long term benefits are that physiologically your body is more relaxed and psychologically you feel calmer within yourself.

Daily Relaxation Sheet:

This is an exercise to help you to relax and to give you some respite to the intrusive thoughts, flashbacks and nightmares that you may experience.

Set aside some time each day, for a half an hour or an hour to practice this technique. Once you have become familiar with the exercise you may wish to adapt parts of it and on waking or going to bed follow part or all of the routine then as well.

Firstly we are going to become aware of both the external and internal world paying attention to the five senses. That is sight, sound, touch, taste and smell.

We will concentrate our mind on the external world first and incorporate the five senses as above.

Get a comfortable place to sit or lie down, (a comfy chair or bed etc).
I will use a chair to explain the routine here but you could do the same things in bed etc.

The first sense we will focus on is touch:

Once you are sitting in the chair, become aware of the way that your feet are connected to the floor, is it a hard or soft surface under your feet, is the surface of the floor covered in a soft fluffy rug or is it a hard wooden floor etc. Spend a moment thinking about this.

Next become aware of the way that the chair connects to other parts of your body, notice for a moment each, and the way your upper thighs, bottom and back connect to the chair. Do you feel a soft or hard surface etc? How are your arms resting on the chair, are the arms of the chair soft/hard etc.

The next two senses we will focus on are sight and smell combined:

Place a scented candle or oil burner with scented oil in front where we can see it from sitting in the chair. Choose a scent that you know will feel soothing and not irritating to your sense of smell. Using the flame from the candle or burner to concentrate on the flame for a moment, also use the scent from the candle or burner and think about the soothing smell for a moment.

Next we will think about the sense of sound:

Play some music that is soothing to you, some people like to use head-phones; others prefer to play the music in the background. Spend a moment or two just listening to the soothing music.

Finally we will think about taste.

Some people like to suck a mint or something. Just spend a moment thinking about that.

Appendix 14:

We have now completed the exercise for the external world. We will now move onto the internal or the use of our mind and imagination.

To do this exercise you need to picture a scene like a beach scene or like the secret garden or somewhere you would have felt absolutely safe and secure as a child. Maybe you spent time on holiday on a farm or were brought up on a farm or used to run in the woods etc when you were a child. You are using your imagination to think up the five senses within that scene, again spending a moment or two on each.

I will use a beach scene to take you through the exercise but it can be any scene you prefer as long as you will feel safe and secure there.

Using my imagination I can see myself,

I am lying on the beach and I can feel the sand beneath me, and my toes in the sand, I can also feel the heat of the sun on my skin.

I can see the blue, blue sky and the big orange yellow sun with the fluffy white clouds rolling in above the horizon.

I can smell the salty sea air and hear the screeching of the seagulls overhead. I can also hear children playing and see them building sandcastles.

I can hear and see the rushing of the waves backwards and forwards, backwards and forwards, lapping up against the shore.

In the distance I can see a small sailing boat with the white sail bobbing up and down over the waves and hear a big tug boat hooting in the distance.

This is a scene I have created from the use of my imagination.

Once you have spent time taking yourself through this exercise you will start to notice that you feel more relaxed and will have had some time away from other more disturbing thoughts.

Also once you have practised your scene a few times you can also use this to escape from your flashbacks or your nightmares. All you have to do is this;

When you have had a disturbed thought or image appearing imagine opening a door from that place and walk into the nice safe place using the scene you created in your mind.

By practising this during the day it is possible to teach yourself to use this when you are woken by a bad dream or nightmare. The idea is to give both your body a chance to relax and your mind some respite from disturbed thoughts and images etc.

Date	Content of Intrusions Thoughts, feelings, memories etc	Feelings afterwards	Situation prior to Intrusion	Any thoughts you may now have