Interpersonal processes and self-injury

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Interpersonal processes and self-injury

Abstract

Most interventions in health and social care settings reside within a therapeutic relationship. However if the staff member is experiencing difficult emotional reactions or thoughts this can interfere with the process of caring or helping. Staff and client perspectives are split into different articles by different authors, or within different chapters of a book. This has reinforced the difference between clients and staff. Arguably professionals are increasingly viewed as human beings with their own reactions to events, rather than detached unemotional helpers. However, the reactions of staff are often not linked to clients. Within the literature on self-injury this has not been clearly described. This thesis makes an original contribution to recognising the interpersonal processes involved when a person self-injures. Three pairs of clients and staff were interviewed about a specific incident of self-injury, with a focus on thoughts feelings and behaviours before during and after the self-injury. They were all also asked about helpful and unhelpful interventions. The data from the interviews was thematically analysed and then synthesised. This resulted in specific and common client perspectives and specific and common staff perspectives. Then each of the client and staff dyads were analysed together with a focus on the interpersonal process. This then produced an account of a synthesised process of these two experiences. Themes included description of self-injury as a cycle of shame, which begins as shame avoidance and then becomes a shame eliciting behaviour, based on other peoples' reactions. Staff and clients described similar emotional reactions, thoughts and psychological defences. Projective identification was used as a method of demonstrating the interpersonal processes between the dyads, with some similar and some contrasting internal experiences. These themes

were discussed in depth linking to relevant literature and key implications for practice were then produced.

Chapter 1: Introduction to the study

The first chapter of the thesis provides an overview of the background of the study, the aims and purpose of the study and the organization and content of the chapters that follow.

Background to the study

I began working with people who self-injure as a nurse therapist in a high security mental health hospital. I observed that alongside the experience of sexual abuse as a child, self-injury was a taboo subject and that professionals tended to focus on offending behaviour, rather than other behaviours or reasons why people had begun offending. At this time, I was involved in a group for women who self-injured that was lead by psychologists. Although this clearly was the focus and reason for the "therapeutic" group, it became apparent that the clients and staff were avoiding discussing self-injury and abuse issues at all costs. As a result, anxiety levels increased and clients began to self-injure more following the group. It interested me that in the initial aim of making self-injury a subject that could be discussed and understood, even members of staff were unable to "break the silence" on this taboo subject, for fear of making the clients feel worse.

I have also observed many staff in different settings reject people for self-injuring, keep them in hospitals longer, try to engage with them only to feel a failure when interventions did not work, or become scape-goated by other staff in the workplace. This motivated me to join a group of staff in a network called the Northwest Self-Injury Interest Group. There I met like-minded professionals, mainly nurses, and also

some psychologists and social workers. They all had similar experiences and were working to change care for people who self-injure. In the early 1990's, the group lobbied the Department of Health and the Royal College of Nursing to think about care in a different way and increase guidance for staff working with people who self-injure, but with limited success. However the group did provide thirteen years of support lead by myself and colleagues at the University of Salford for many staff in clinical settings working with people who self-injure.

Most of the clients I worked with had histories of childhood sexual abuse, physical abuse and neglect. My understanding of self-injury was based on ideas expressed by clients influenced by their own experiences. This was also supported well within the "expert by experience" and professional discourse. I had begun to conceptualise self-injury as a coping strategy to release tension, triggered by childhood trauma. Whilst this was an accurate understanding for many of the clients that I had worked with in therapy, the mental health settings that I worked in would have been likely to have a large proportion of people who had experienced trauma. This would not necessarily be the case for other people outside of this system. I became acutely aware of my drive to have a tidy theory to fit people into, within a confusing and complex experience of the self-injury process.

Many of the clients that I have worked with reported that the treatment following self-injury, especially in A&E departments was negative. In one of my previous jobs in Liaison Psychiatry I worked with the staff in this department to challenge attitudes and cope with the emotional turmoil that the staff reported. I believed that staff needed to be able to discuss and get support and supervision about their reactions

towards people who were self-injuring, in order to remain in a secure helping therapeutic relationship. When completing my Counselling MA, I studied counter-transference and projective identification. I began to draw upon these concepts to understand interpersonal issues and when I began teaching at Salford University, also incorporated this into my teaching around self-injury. On the self-injury module I chose to focus on staff reactions in the first session, prior to learning about self-injury, assessment or interventions. This ensured that staff beliefs and attitudes were targeted first in order to improve the effectiveness of interventions. Often staff knew what to do once they could see beyond their own internal experiences. I wrote an article on Countertransference and Self-Injury (Rayner et al, 2005) with my early thoughts on this interpersonal process. Although my original dissertation for my Masters in Counselling (Rayner and Warner 2003) focused on Lay perspectives and self-injury, one of the final questions was why professionals appear to have more negative attitudes to people who self-injure than Lay people. This then led to my decision to focus on interpersonal issues and self-injury within a professional helping relationship in this thesis.

Although self-injury appears to becoming less taboo, due to increased media coverage in newspapers, television soap operas and news, it compels us as people and as a society to challenge our philosophies on death and dying, or reject the person who self-injures. To self-harm on purpose can challenge our assumptions that human beings want to survive (Babiker and Arnold, 1997). In some professional research, self-injury is referred to as “Parasuicide” and thus an assumption can be made that the person wanted to kill themselves, without actually asking them. In order to continue to work with people who self-injure professional helpers need to

think about their beliefs about death, dying and survival. This can be uncomfortable at times, but necessary to truly engage with the client and their world.

Self-injury, where people intentionally cut or otherwise damage their bodies, has achieved considerable prominence in academic and popular literature. This has been documented in clinical environments, where people receive care and treatment and also in wider cultures. It is a multi-faceted issue that extends far and wide. Hawton et al, (2000) report that in England and Wales 142,000 admissions to accident and emergency departments are for self-harm. Horrocks (2002) states that the United Kingdom has the highest rates of self-harm in Europe.

Self-injury has featured in most cultures throughout history, but has been largely socially taboo within western culture. Socially sanctioned self-harm (Favazza, 1989) has a place within all cultures. However western culture tends to limit socially sanctioned self-harm to religious practices or fashion trends such as piercing, tattoos or sunbathing. Self-harm remains a taboo behaviour that elicits negative emotions and attitudes in observing others (McCallister, 2003). This in turn appears to cause difficulties with staff who work with people who self-injure within helping relationships (Rayner et al, 2005).

There is a plethora of literature available on the subject of self-injury, which is viewed variously by different writers. Many terms are used to describe this behaviour. In this study the term "self-harm" will be used for any activity that harms the self, directly or indirectly. The term "self-injury" will be used more specifically to describe the intentional direct physical injury that people do to themselves without suicidal intent (Klonsky, 2007). Both self-harm and self-injury may be socially sanctioned or taboo.

To intentionally hurt oneself, or damage one's body is seen to go against human values (McAllister, 2003). It remains a challenge to the self-preservation drive of human beings. Whilst challenging these intrinsic values, self-injury also challenges staff assumptions about sickness. The social expectation within our society is that when individuals are ill, they should try to get better: to go to the G.P. or hospital and to adhere to professional advice (Stockwell, 1984). Stockwell states that in nursing, the "difficult" patients are the ones who do not follow these rules. Self-injury goes against all of these rules because the individual is seen to deliberately inflict "sickness" on the self. As this contravenes "normal" medical practice and procedure within our health services it can result in the professionals feeling helpless, as they are unable to offer a prescription or a "cure".

Self-harm that professionals may experience difficulties with can be contained within a continuum (Connors, 1996; Babiker and Arnold, 1997). This would include problem drinking, drug taking (legal or illicit), gambling, cigarette smoking, eating disorders, as well as self-injury (physical injury, cutting, burning, scratching) parasuicide and suicide (Babiker and Arnold, 1997). Babiker and Arnold state that individual intentions of self-harm may range from decoration, lack of provision against harm, injury, through to death. The socially acceptable types of self-harm do not have the clear intention of causing harm or pain to the self, but self-injury and suicide do (Harrison, 1994). The main difference between suicide and the other types of self-harm is the conscious wish to die.

Many people who self-injure clearly separate self-injury and suicide attempts by intent (Arnold, 1994). For them, suicide is associated with a wish to die; self-injury is associated with a need to keep living and cope with life.

It should be noted, however, that self-injury may result in accidental death if the individual has insufficient understanding of the impact or severity of the injuries or if the self-injury becomes repetitive and addictive in nature. In addition, the person who self-injures to cope with life may also be suicidal and wish to end their life (Vivekananda, 2000). Thus the underlying motivation for self-injury may change; however, the method may alter or remain the same. Thus it is essential that the helper asks the person why they self-injure or self-harm, rather than assuming self-injury is an attempt at suicide. Unfortunately, self-harm and attempted suicide remain interchangeable terms in some of the professional literature, which causes considerable confusion to the reader (Shaw, 2002).

In summary, although self-harm is often stigmatised and deemed socially unacceptable, other socially acceptable methods of self-harm are also regularly practised and accepted. If the method of self-harm becomes too destructive or offensive to others, it is deemed "unacceptable" and the individual is pathologised and scape-goated. This is further compounded when professionals become involved in trying to help people who self-injure who may be perceived as breaking the norms of health improvement.

These issues provide the multifaceted background to this study and resulting thesis. The academic and personal reflections of my experiences when working with people who self-harm have enhanced my focus on the interpersonal issues that may be involved. The aims and objectives of this study emerged in consideration of this issue in more depth.

Aims and outcomes of the study

The aim of this study is to provide a rich exploration of the process and outcomes occurring between a client who self-injures and the professional helper working with them in a therapeutic relationship. More specifically the following are also aims;

1) To generate and modify existing theory on the interpersonal process occurring between clients and professionals before during and after self-injury.
2) To capture and present the clients perspective on the effects of their own self-injury and associated professional support.
3) To capture and present the staff perspective on the effects of self-injury.
4) To explore the effect professional behaviours have on the clients' emotions, cognitions and behaviours, within these relationships.
5) To use the data generated to improve and inform health and social care provision.

Chapter contents

The following chapters describe a journey of discovery and personal change through the research process and completion of this thesis. I initially had ideas of reducing internal experiences into discreet questions surrounding the experience of self-injury. However it soon became clear that these were meaningless without the unique context from that person's perspective. Thus the semi-structured interviews worked well to contextualise and also keep a specific focus. As ever, the motivation to change my perspective was listening to the participants' narratives and being in touch with my own internal experiences, before, during and after the interviews.

Chapter 2: Current concepts relevant to interpersonal processes and self-injury

This chapter begins by focusing on concepts related to self-injury moving from meanings and functions of self-injury, through to the consequences. Connections are made between self-injury and shame and then further explored using a range of relevant concepts to assist in understanding interpersonal processes.

Chapter 3: Methodology

This chapter describes how I interviewed three sets of client/staff dyads about self-injury. My journey of consideration of different qualitative methods is explored with the eventual use of a Bricolage approach. Reflexivity is emphasised to integrate my own personal experiences and highlight the subjectivity of this study and thesis. Themes emerging from the data were used to explore my own personal experiences and assumptions during the research process. These themes were knowing and not knowing, ideological countertransference, fear of negative evaluation and the shame of being wrong.

Chapter 4: Client Themes

This chapter describes the main themes of each of the client interviews and then recognises common themes.

Chapter 5: Staff Themes

This chapter describes the main themes of each of the staff interviews and then recognises common themes.

Chapter 6: Interpersonal issues between staff and client.

This chapter focuses on the relationship between the client and staff interviews. The processes are highlighted for each participant and then synthesised between each client and staff dyad.

Chapter 7: Discussion

This chapter discusses emergent themes identified from the interviews in chapters 4, 5 and 6. Self-injury is viewed as a cycle of shame avoidance and shame induction. Defense mechanisms such as splitting and projective identification appeared to be used by both client and staff during the process of self-injury. These interpersonal processes are then related to organisations, society and the blame culture that surrounds self-injury.

Chapter 8: Implications for practice

This chapter explores the implications for education, work with clients and research, following completion of this study. These areas of work have been integrated into the overall themes apparent within this thesis.

Chapter 9: Limitations of the study

This chapter describes some of the limitations of the study.

Chapter 10: Conclusion

This chapter contains the concluding remarks of the thesis.

Chapter 11: The researchers story

This chapter contains an exploration of my internal experiences relating to reflexivity.

Within this chapter, the background of the study and emerging aims and outcomes have been explored, in order to set the scene for this thesis. Consideration of the current concepts relevant to interpersonal processes and self-injury will now be considered in Chapter 2.

Chapter 2 : Current Concepts Relevant to Interpersonal Process and Self-injury.

The purpose of this chapter is to discuss the literature relevant to the research project. I began by attempting to review the literature, but this was too vast and proved difficult as I was linking three major areas of work, self-injury, shame and interpersonal issues. Each of these areas is well documented. Therefore I focused on the literature that was most relevant to my study. I selected the articles and books that represented a diversity of theoretical orientations or "schools of thought". I selected the literature based on their significance to self-injury, functions, meanings and interpersonal issues. My choice within the thesis is to deepen my understanding of projective identification and psychodynamic concepts relating to self-injury. From this sampling process of the literature I chose to focus on meanings and functions of self-injury and shame, Kleinian theory, object relations psychotherapy and Clarkson's relationship approach.

This chapter begins by concentrating on literature related to self-injury moving from meanings and functions of self-injury, through to the consequences. Subsequently I explore the connections between self-injury and shame and draw upon a range of relevant concepts to assist in understanding interpersonal processes.

Literature on self-injury appears to separate the experiences of clients and staff within different papers or chapters. Authors tend to focus on either the functions of self-injury and associated interventions (Klonsky, 2007; McCallister, 2003; Fallon,

1983), or the staff attitudes and reactions (McCallister et al, 2002; Hopkins, 2002). Therefore a fully integrated approach to the interpersonal processes surrounding self-injury for staff and clients is not always evident. Within this thesis I have recognised some separate issues and differences in perceptions and have also integrated interpersonal processes for each dyad of client and staff. I have sought to avoid pathologising the client, rather recognising them and the staff as being human beings reacting within the same continuum of internal and external experiences. Although there have been some useful qualitative reports on personal experiences of people who self-injure (Harker-Longton & Fish, 2002; McAndrew & Warne, 2005, Reece, 2005.), much research has focused on seeking common functions shared between many people, such as relieving tension (Klonsky, 2007). Unfortunately this approach fails to embrace the complexity of self-injury as a dynamic behaviour that may occur for different reasons and have different functions and meanings for each episode for each individual. This is further compounded if these reasons, functions and meanings may also be conflicting for the person. Thus I argue that self-injury is uniquely personal, varies each time and may also have competing functions and meanings for that person.

A) Functions and meanings of self-injury.

There are a wide range of functions and meanings associated with the use of self-injury in the literature. These will now be discussed in turn.

Klonsky (2007), when reviewing the evidence for the functions of self-injury using quantitative research, described the following areas; emotional regulation, dissociation, suicide prevention, interpersonal boundaries, interpersonal influence,

self-punishment and sensation seeking. These purposes have also been supported in other literature. However, I would include dissociation and self-punishment as methods of managing emotions, rather than as separate entities. I have also added other ideas from qualitative research and literature written by experts by experience.

1) Intrapersonal functions

Functional understandings of self-injury embrace the idea that it helps the person cope with negative life events. Although this idea has been useful for people who have experienced these events, there are also other people who have not had these experiences. This dominant discourse has been helpful for professionals in looking at reasons for self-injury and therefore has made the behaviour an understandable coping strategy. The most commonly reported experiences are surviving childhood sexual abuse, loss and coping with depression.

The most frequently reported past experience for people who self-injure is childhood sexual abuse or trauma. Authors have linked child sexual abuse with self-harm in women and men. (Babiker&Arnold, 1997; Van der Kolk,1989; Miller,1994). Indeed McAllister,(2003) emphasises this by stating that the vast majority of people who self-harm have a history of child and/or adult sexual abuse as well as abandonment and neglect. However, the reports I have considered often focuses on a healthcare setting where people have disclosed such abuse. Currently there is an emerging awareness of many people who self-injure who do not engage with health service provision and are therefore usually not represented in health and social care service research (Adler and Adler, 2007). Thus assumptions cannot be made about their experiences of abuse. Nevertheless childhood sexual abuse is often considered to

be a pre-cursor to self-injury by many authors. Van der Kolk et al (1996) has found evidence that severe trauma may alter the structure and chemistry of the brain and other body systems involved in the regulation of stress. These may be irreversible if the child is traumatised before the central nervous system is fully developed. Van der Kolk (1989) suggests that self-harm is a method of repeating, communicating or symbolizing earlier trauma. If people are unable to forget the trauma, but they are unable to speak out about this, then they are obliged to remember this by acting it out. Calof (1995) describes this as a method of "telling without telling" the story of the original abuse. This is considered further within the re-enactment section of this chapter.

Collins (1996) suggests that, if a child experiences loss and deprivation, there is a lack of relationships and therefore a profound sense of internal emptiness. Due to this there is a lack of introjects (internalised objects). In this case, self-injury could be understood as an attempt to live with an inside that feels deprived, empty and unfillable. People may describe how they self-injure to convince themselves that they really are alive, because they feel dead and empty. In terms of loss the person may also self-injure as an attempt to hold onto something that once existed but is now lost.

Depression has also been one of the most commonly reported reasons why people self-injure (Babiker & Arnold, 1997: Harrison, 1994). It is argued that self-injury gives some short-term relief, only for the depressive feelings to return when they view the damage. This can be a method of gaining some control over the physical self or internal feelings. The feelings of helplessness and hopelessness associated with

depression have also been frequently reported as reasons for self-harming behaviour (Harrison, 1994; Babiker and Arnold, 1997; Arnold, 1994).

As self-harm is such a multi-factorial issue, experiences of depression, childhood sexual abuse or loss are rarely the only reason that a person will injure themselves. However, the despair associated with these events may be the key to understanding self-injury. The feelings of helplessness, hopelessness and feeling trapped that underpin these experiences also exist in all of the difficult life experiences linked to self-injury In addition to these prior life events the following intrapersonal functions have been documented.

a) Coping with thinking and not thinking

Ideas relating to thinking and not-thinking have been viewed as causes of self-injury. People have reported self-injuring in order to cope with thinking, or as a method of diversion away from their thoughts to stop thinking (Babiker and Arnold, 1997). Fonagy (1991) has emphasised self harm as one aspect of the psychic functioning of people with "borderline personalities". Whilst this paper was not specifically about self-injury, it is one of the behaviours that the above people may present, alongside many interpersonal problems. The main focus of this theory is that people with a borderline personality do not develop a theory of mind and therefore have severe problems understanding what other people may be thinking (Mentalization). People who have difficulties mentalizing struggle to label emotions and therefore understand them as being transient (Fonagy, 1991). They may have difficulties with overwhelming emotions and also struggle to recognise emotions and thoughts in

other people. Self-injury can be understood within this context as being a method of coping with the overwhelming emotions.

b) Being different

Some professionals focus on theories to understand the differences that are thought to exist in people who self-injure (Evans et al, 2000). Not surprisingly these theories do not often feature in "expert by experience" explanations of why they self-injure. However, they appear to help the professionals by creating a split between staff and client and locate the problem in the client (Procter, 2004). Within these theories there is a notable absence of staff reactions or attitudes to the person and the self-injury, thus the focus remains on the client.

One of the reductionist professional theories of why people self-injure is because they are more impulsive than other people. Evans et al (2000), in their research paper, interviewed people presenting after "deliberate self-harm" to one Accident and Emergency department. Participants were interviewed and asked to complete the I-V-E impulsiveness questionnaire, (Eysenck & Eysenck, 1991), the Hospital Anxiety and Depression scale (Zigmond & Snaith, 1983) and the State-Trait Anger Expression inventory (Spielberger, 1988). This was the first study to relate specific genes to the personality trait of impulsiveness. It was found that there was no significant relationship between TPH intron 7 polymorphism and a standardised impulsiveness score. However, they did find a significant relationship between impulsiveness and the 5-HT2c genotype. Evans et al found no difference between impulsiveness scores in people who repeated self-harm and people who did not. So conclusions could not be made about people who use self-harm more than once

being more impulsive than people who only did this once. Unfortunately, the inclusion and exclusion criteria were not clearly specified, and the term "deliberate self-harm" was only vaguely defined. It would have been useful to know how many people in the sample had taken overdoses, cut, burnt or tried to hang themselves. The study found that people who self-harm were more impulsive than "normal people", but did not state how they self-harmed, nor who these "normal people" were. This article concludes that impulsiveness plays a role in whether a person self-harms, but may have no influence on repetition. Unfortunately, without a clear definition of methods of "deliberate self-harm", it is unclear whether it was people who cut. An assumption is made here, that people are either impulsive or not impulsive. But in reality people can be impulsive at times and not impulsive at other times according to context.

Other professionals conjecture that there is a genetic contribution to impulsiveness (Eysenck & Eysenck, 1991). One part of this theory is that there is a variation in serotonin function, i.e. decreased serotonin levels in people who self-harm. This gives rise to another theory that the act of self-injury serves to increase the serotonin levels in people who have a deficiency. Reduced serotonin levels have also been linked with impulsiveness, aggression and people who have histories of childhood abuse (Cocaro et al, 1989, Van der Kolk et al, 1996). Although co-existence was supported in these research papers, the causative relationship required was not "proved", so a deficiency in serotonin has not yet been proven to trigger repetitive self-injury.

The literature surrounding Borderline Personality Disorder (BPD) focuses on physiological differences in the brain. Meares et al (1999) found a localised

neurophysiological dysfunction in the brain of people with BPD. Meares et al state that cognitive and memory deficits in BPD may be the result of severe trauma. However, this theory assumes all people with this diagnosis have experienced severe trauma. Brenner et al (1995) suggested that a reduced hippocampal volume found in people with BPD is a correlate of memory defects. Pre-fontal brain activity has been linked with higher order modulation of affective expression (Schore, 1994). Evidence presented by Schore supports the possibility of a cascade of descending inhibitory tracts emerging from the frontal and prefrontal areas of the brain. Insufficient development of these areas will lead to dysregulation of emotional experience and expression. This has been a commonly reported issue not only in BPD, but also with people who self-injure. This theory has been supported by Van der Kolk et al (1993) who found this to be an effect of psychological trauma in children and adults. Thus people who self-injure may experience overwhelming emotions that they cannot cope with, or verbalise, due to these differences in the physiology of the brain. They may then need to self-injure in order to cope with these emotions.

A pre-occupation with, and exaggerated awareness of, somatic sensation is also often associated with BPD (Meares et al, 1999). This may also be important for people who self-injure as they might use the cutting to stimulate somatic sensation or physical pain. This may be due to a disturbance in attentional focus (Meares, 1997). This disturbance is thought to be a result of disruption of the activity of a notional cascade of neural loops emanating from the prefrontal region of the brain. These are concerned with attention and thus are different to those involved in the regulation of emotion. If selective inattention does not develop, the person cannot “screen out” or

"turn off" redundant stimuli and the person will be unable to focus on meaningful stimuli (Meares et al, 1999). As with people diagnosed with somatization disorder, it could be argued that some people who self-injure have failed to develop adequate systems of stimulus intensity control. Hence the person self-injures to cope with intense stimulation.

BPD as a diagnosis has been useful to help some professionals explore what this means and describe and categorise client experiences. However when a label is attached to the person it depersonalises and removes context (Procter, 2004). This can then result in "signs and symptoms" being seen, but the person overlooked. Additionally any staff reactions would be detached from the patient and therefore may also be overlooked. My position on the use of Borderline Personality Disorder is that the client may or may not find this a useful diagnosis and may actually find this offensive. However for staff the diagnostic category can assist in the process of finding evidence or literature to support practice. I would work with the knowledge of Borderline Personality Disorder if the person has been given this diagnosis and understands it.

c) Preventing suicide: ensuring survival

Self-injury has been understood as an externalised representation of an unconscious wish to end life (Tantam & Whittaker, 1992). However, Babiker & Arnold, (1997) and Harrison, (1994) report that many people believe that self-injury is a way of coping with life rather than ending it. The initial view is contentious because, by definition, people would not be consciously aware of their unconscious motivation. More recently, psychoanalytically orientated therapists such as Nathan (2004) have agreed

with Babiker and Arnold and regard self-injury as different than suicidal behaviour. The corollary to this is agreeing that self-injury at the level of a lived experience, is not consciously destructive, but is a survival mechanism to deal with overwhelming problems. This concept highlights the survival nature of self-injury and the potential role that an unconscious wish to die may or may not play within it. Again these views can decontexualize from the clients' reported reasons for self-injury.

Fenichel (1945) suggested that self-harm could be explained as the person (or animal) sacrificing one part of their body in order for the rest to survive. This would also be similar to people finding themselves in a situation where they feel they have no other way of coping. Here self-injury can be understood in terms of sacrificing a part of their body in order to enable both their body and mind to survive and may be considered a useful explanation along with the others already mentioned.

Ensuring survival and preventing suicide has become a widely accepted method of understanding self-injury when professionals work collaboratively with the client to create meaning (Babiker and Arnold, 1997; Harrison, 1994; Connors, 1996).

d) Coping with emotions

Within professional and service user publications, this is the dominant explanation of why people self-injure. A commonly reported reason is to "release tension" (Harrison, 1994; Babiker and Arnold, 1997). Wegscheider Hyman (1999) reports guilt, anger, anxiety, disgust frustration, hate, depression, helplessness and fear of loss as emotions prior to self-injury. She states that any emotion that is considered negative and/or overwhelming could actually be experienced prior to self-injury. McAllister

(2003) emphasised guilt, blame and shame particularly if people had experienced childhood sexual abuse and had began to self-injure to cope with these emotions. Expression of emotional pain is also regarded as a function of self-injury (Harris, 2000), so feeling emotional pain or sadness could also be an emotion experienced prior to self-injury.

Shame has been recognised as an emotion occurring prior to and following self-injury (Connors, 1996). Shame can be regarded as a physical sensation that occurs as a response in a socio-cultural context (Crowe 2004a). If individuals transgress social norms, feelings of shame are usually experienced. This implies judgement and exclusion by others. Lewis (1971) identifies that the main difference between guilt and shame is that guilt is an evaluation of the behaviour, but shame is an evaluation of the self. Shame is accompanied by a sense of shrinking or of "being small" and a sense of worthlessness and powerlessness. Therefore, when people feel shame they are more likely to feel observed by others and are more concerned with others opinions of them and thus feel more isolated (Crowe, 2004a). This has been a response commonly reported by people who self-injure, but not necessarily expressed using the word shame (Pembroke, 1994; Babiker and Arnold, 1997).

Authors such as Klonsky (2007) describe the function of self-injury as "affect regulation", but do not elaborate which emotions the person is attempting to regulate. A focus on relieving stress, rather than shame appears to be a more socially acceptable function. However, the role of shame prior to self-injury has been recognised by some authors. Huband and Tantam (2004), for example, make the emotions explicit by stating that guilt, shame and anger are experiences prior to self-

injury. However, they did not explicitly name these as reasons or triggers for self-injury, but just state that they occur prior to the behaviour.

Shame has been explicitly linked with other issues associated with self-injury. Andrews (1998) has stated that shame is a mediator between childhood sexual abuse, depression, eating disorders and post traumatic stress disorder (PTSD), but did not link this with self-injury. However links between childhood sexual abuse, depression, eating disorders and self-injury have been prevalent in other literature (Farber, 2000; Babiker and Arnold, 1997). Miller (1994) has also linked self-injury with these issues and also PTSD.

The diagnosis of Borderline Personality Disorder (BPD) has also been linked with shame and "never being good enough" (Crowe, 2004a P327, 2004b P335). She advocates that the characteristics of BPD are better understood as a chronic shame response. She states that shame is difficult to articulate in words and thus may be conveyed to others through the body and gives an example of self-harm. She describes self-harm as an expression of shame.

Milligan and Andrews (2005) found a significant relationship between shame, anger, childhood abuse, suicidal behaviour and self-harm. This was statistically significant in their research with women who have offended. However this was in a group of women where 60% of the sample was both suicidal and also self-injured. They found a significant correlation between experiences of shame and anger following self-injury, but did not record any reports of this prior to self-injury. They found that

women who expressed suicidal or self-harming behaviours also expressed shame about their behaviour, character, body and appearance.

What has not been clear in the literature and research so far is how shame may trigger self-injury and also occur following self-injury. Self-injury can be used as a method of helping the person avoid emotions and thoughts. This may be achieved by dissociation or a diversion of focus. The focus may be shifted to the external chaos for other people, or rituals for the person before or after the self-injury. Dissociation is a method of splitting off parts of a personal experience from the self, to avoid at all costs the integration of thoughts feelings, memories and bodily sensations (Pearlman & Saakvitine, 1995). There are different levels of dissociation linked to self-injury (Connors, 1996). Some people describe being dissociated from the pain and have a sense of control over the self-injury. Other people have reported that pain is experienced but that a dissociated part of the self is inflicting the pain. Miller (1994) describes how people may use self-injury to cope with dissociation. By experiencing physical pain, the person once again regains a sense of themselves within their own body. Connors (1996) describes self-injury as having a central role in the management and maintenance of the dissociative process. She describes self-injury as causing or coinciding with a switch to an altered state, thus helping the person to disconnect from current distress. She also views self-injury as a method of preventing or halting dissociation. Thus self-injury can be conceptualised as a method of ending or preventing dissociation, but also a method of facilitating the same process.

Masking could be regarded as a type of dissociation. This is where the person may cope with unbearable feelings by self-injuring so that the physical pain masks the

emotional pain (Miller, 1994). This acts as a distraction from the emotional pain and provides a focus for healing and relief. In addition to masking being an intra-personal strategy of moderating mood, for some people it can also become an interpersonal strategy whereby these emotions may also be avoided by the external pandemonium caused by the self-injury.

Rosenfield (1971) stated that destructive impulses could lure people who self-injure into an ideal world where need was absent, quick solutions are provided and psychic pain would not have to be faced. This produced a "Nirvana" like state where they feel nothing, have no conflict and are liberated from need or pain.

e) Creating emotions

Emotions may be created by using self-injury. This may be to avoid the numbness or lack of emotion, or alternatively can be used to avoid other emotions. Sensation seeking has been a function reported by some people who self-injure. Predominantly this seems to be understood as a euphoric experience, but there are some theories that self-injury induces an analgesic effect, which avoids sensation, this could also be understood as dissociation. For example, painful stimulation has been demonstrated to result in increased release of endorphins (Farber, 2000,). It has also been found that intrusive thoughts trigger an endorphin response that release natural opiates found in the body and provides a form of analgesia (Strong, 2000). People who self-injure have been found to have high encephalin (a natural opiate) levels when they are self-injuring. These reduce when they stop self-injuring. It is unclear yet whether it is the intrusive thoughts or the act of self-injury that result in an increase in encephalin levels or any of the natural opiates. Increased catacholamines

(dopamine, adrenaline and nor epinephrine) are also thought to trigger the hyper aroused state experienced when people who cut become agitated and feel the compulsion to cut (Strong, 2000). Again this is a reductionist theory that is used by professionals, rather than people who self-injure and locates the "difference" with the person who self-injures.

f) Self-punishment

Ferenczi (1956) suggested that self-injury occurred when murderous wishes have been redirected from the objects in the external world towards the self. Freud (1917) theorised that some of the verbal attacks of his clients on themselves (such as being worthless, stupid, weak), were also reported to have been used against their loved ones in the past or present. Freud believed that, instead of attacking the external objects (or people), his clients had become the object and thus could violently attack themselves from this safer perspective.

People who self-harm can be perceived as sado-masochists. Collins (1996) explains that, by definition, masochism is about satisfaction or pleasure in experiencing pain. Thus it is the pain, rather than the consequences, that brings relief. This may be true for some people who self-injure that enjoy physical pain. However, many people describe the sense of relief that follows self-injury, rather than enjoying pleasure from feeling pain. A sadist gains satisfaction from the infliction of pain. Thus in the latter case, the person who self-injures by cutting the skin would be sadistic in relation to parts of themselves. This may occur when the person sees the skin or body part as not belonging to themselves. A person may experience satisfaction from experiencing self-inflicted pain with or without also believing that they should be

punished. Collins (1996) conceptualises self-injury as a method of self-punishment, as described above. She emphasises expressions of "I don't deserve any better", "I need to be punished" and guilt and responsibility in terms such as "I'm to blame" when people self-injure. However she does not explicitly link these expressions to shame before self-injury, but only describes shameful experiences accompanied with disgust and guilt, following the behaviour.

g) Externalisation

Self-injury can externalise the internal emotions and thoughts onto the body, or onto other people or objects. Babiker and Arnold (1997) have reported the idea that people can understand physical pain more than emotional pain.

Self-injury can also have a function of regulating emotions by externalising them onto others or objects. Object relations analysts regard the self-injury as a method of eliminating the bad object/self that has polluted the body (Nathan, 2004). Here the conscious wish is to preserve the body rather than to destroy it. This is illustrated when people talk of the need to get the "bad, evil blood" out of their system. This may a useful explanation for some people who self-injure.

h) Communicating to the self

Many psychosocial theories would support the idea that self-injury is a method of communicating feelings. This may be a communication to the self or to other people. McAlister (2003) refers to self-injury as a symbolic method of crying. As with crying, the person may not have the words to describe why they cut, but just know that it helps. Strong (2000) also likens self-harm to crying and labels this as a "bright red

scream". In effect, the body is used to visually describe emotions. For example, as said by a female patient

> "my body looks how I feel" (personal communication 1993).

Within psychoanalytic theory, self-injury has been linked with regression (Hibbard, 1994). This is where the person returns to an earlier developmental stage to cope with difficult feelings. Thus, self-injury can be understood as a method of self-satisfaction that is characterised as reacting in childish, self-centred ways in which immediate gratification is sought.

Some theorists focus on the importance of the skin in the earliest mother-child relationship. This is where the first emotions are communicated, from tenderness and warmth to disgust and hate (Pines, 1980). Pines suggested that individuals can safely regress to regain the most primitive form of maternal comfort. This is a repeat of their infantile experience of a mother who could care for the body, but not the feelings. The skin is also the first site of physical or sexual abuse and therefore is the first assault on the person's boundaries, so could be used as a method of punishing the skin or re-enacting the abuse. These ideas can be useful for professionals in theorising about people who self-harm, but could be offensive to the person who self-harms if ideas of infantile regression are discussed openly. However, the suggestions about the skin seem very important as many people who self-injure will say that they are using the skin to communicate, or alternatively, may be seeking the skin soothing described earlier.

Self-injury can also be understood in terms of an existential statement, a means by which the person is able to confirm their existence and boundaries between being alive and dead. Babiker and Arnold (1997) wrote of an adaptive function of pain that can help people determine whether they are alive or dead. Thus self-injury may be used when a person is feeling depersonalised, (a process of being dissolved or loosing one's identity) as a way of finding one's person again, or reintegrating. As one female patient said,

> "I need to see my blood, so that I know I am still alive" (personal communication 1994).

Self-injury clearly has many functions and meanings to the self. The person may experience many of these each time they self-injure. These have been discussed at length. However when other people observe self-injury or the after effects of this behaviour interpersonal functions occur. Staff may assume that the person who self-injures intends these interpersonal effects to occur, but this is often not the case.

2) Interpersonal functions

The intrapersonal functions above may describe the functions if the self-injury occurs in private. However if the self-injury enters into the public domain, functions take on an interpersonal element whether the person intended this or not. Sometimes this results in the observing other feeling responsible in some way for the self-harm or the person doing it (Rayner et al, 2005). This may be a conscious or unconscious process and is reflected in staff and/or family and friends feeling that they are being

"manipulated", or that they did something wrong and therefore are to blame. There are various functions when self-injury moves into the interpersonal domain.

a) Communication with others

Self-injury has also been described as a vehicle for the expression of feelings, including rage, frustration, guilt and shame (Connors, 1996). This strategy can be effective if people need to communicate these emotions while attempting to protect other people from their effects. Connors also links these emotional responses of guilt and shame to a sense of being "needy" or requiring help.

b) Maintaining interpersonal boundaries

Self-injury can be used as a response when the person is feeling rejected, but it can also be used to encourage people to reject them to prevent a close relationship occurring and further rejection (Farber, 2000). In addition, it can be used to test relationship boundaries with people. This may be in terms of how far they can be pushed, and also to get others involved in acting out interpersonal issues or re-enactments. It may be used as a retaliative behaviour, in order to get someone in trouble or to express frustration, anger and helplessness. Here, self-injury is conceptualised as a method of acting out intra-personal difficulties due to past experiences of rejection. This has frequently been reflected in anecdotal evidence from clients in a variety of clinical settings and is a strong theme in the literature.

c) Initiation/ritual

When focusing on groups of people it has been observed that self-injury has a role in initiation or ritual. Ross & McKay (1979) noted that some women in their research

group self-injured as an act of initiation rite, which took place within many other ritualistic behaviours such as chanting and sitting in a circle. Self-harm as a ritual or initiation rite is not uncommon, and certainly links into some religious rituals (Favazza, 1996). It may also be used within institutions to gain status and recognition, especially among peers in an anti-establishment culture. It can become a learned way of coping with life and a way of maintaining status in a very difficult institution. Many people self-harm for the first time when locked up in institutions (Ross and McKay, 1979). If self-harm were understood as a response to feelings of helplessness and being trapped, it is not surprising that being locked in a secure environment may exacerbate the need to self-harm for some people.

d) Interpersonal influence

The short span of attention in institutions often becomes plentiful following self-injury (Ross & McKay, 1979). Lovaas and Simmons (1969) stated that this attention exacerbated self-injury. This can become a way of drawing attention to oneself if all other methods fail. Other people cannot ignore self-injury. This is a traditional theory within health services and can be expressed by staff when they believe that the person is "manipulative" or "attention seeking" (Rayner et al, 2005). Within this function, self-injury can be understood as a method of gaining control externally of the body or other people when the person feels out of control within. This would also link in to the behavioural concept that self-mutilation is an operant response, a behaviour which is acquired and maintained by rewarding responses, such as attention (Davies et al, 1998). Here, self-injury is more than just an intra-personal coping strategy; it is also a method of stimulating interpersonal or environmental change.

e) Re-enactment

Re-enactment of abuse is predominantly a method of intra-personal communication that is documented mainly in the psychoanalytic literature (Farber, 2000). Re-enactment of abuse is also common where the victim may duplicate physical damage to the body that was previously committed by the abuser, such as mutilating breasts. Stone, (1987) suggests that a process exists, whereby a person may use his or her own skin as a symbol for an offending person. As such, the person who self-injures may take the role in re-enactment of the abuser or the victim interchangeably. Although essentially this is an intra-personal coping strategy, inter-personal effects may also occur, such as the need to be rescued being fulfilled.

My theoretical view on self-injury is that it has many intrapersonal and interpersonal functions and meanings. These are also varied within the context of each individual episode of self-injury. Due to the mutifactorial nature of self-injury there are often many functions occurring at the same time for each episode of self-injury (Rayner et al, 2005). These functions may be complementary or competing at the same time. The functions described here can be a useful method to assist in the understanding of why people self-injure. If the self-injury enters the interpersonal domain, the internal effects on the observing other need to be considered alongside the impact upon their behaviour. These are now considered as consequences of self-injury.

3) Interpersonal consequences of self-injury

Following self-injury there may be many consequences, especially if other people become involved. One of the commonest reported reactions is rejection and negative

evaluation from others (Pembroke, 1994; Babiker and Arnold, 1997; McCallister, 2002). This in turn can lead to re-confirmation of the person's negative beliefs about themselves and other people. The previously described functions of self-injury may have worked well for the client for many years in private. However, when they or their families and friends present to professionals for help, further difficulties have been reported (Pembroke, 1994).

Staff can experience personal, ethical and professional issues when a client self-injures. Their emotional reactions and attitudes may prevent a trusting therapeutic relationship from occurring with the client (Rayner et al, 2005). This in turn can then make any intervention impotent, or lead the staff to reject the client. Arguably, when self-injury becomes an interpersonal process, the other person's reactions take over unless carefully managed. This can then exacerbate the original emotions, thoughts and behaviour of the person who has self-injured, thus it is important that staff learn to deal with the emotionality of their work with clients.

Self-harm has consistently been referred to as a highly stigmatised behaviour (Connors, 2000; Babiker and Arnold, 1997; Pembroke, 1994). The labelling process has often included referring to the person in terms of the behaviour, such as "cutter" or "self-injurer", thus depersonalising them. Pembroke (1994) described her own experiences of contact with health services, showing how the way that nurses responded to her influenced the way in which she perceived herself: sometimes the depth of feelings aroused provoked further self harm. Even those sympathetic to the client's plight may feel strong emotions in dealing with this challenging behaviour. Allen and Beasley (2001 p 73) stated that;

> 'Self-harm is undeniably an emotive issue, which evokes a response and opinion arguably in all of us'

It is likely that anyone who has close contact with a person who self-injures will experience an emotional response to this behaviour. The unhelpful reactions of helpers as a result of their lack of understanding of those who self-harm have been challenged and extensively documented, particularly by people who have used healthcare services following self-injury (Pembroke 1994). Indeed, the intense anxiety experienced by staff has been described as "castration anxiety", and results in staff feeling 'impotent' and helpless following self-injury by a client (Pao 1969). These extreme reactions may limit helper's ability to maintain a therapeutic relationship and prevent any further help being given (Connors 2000). All too often rejection of the person occurs, which may reinforce their feelings of lack of self-worth and negative self-beliefs. Connors (2000) discussed the often-negative effects of self-injury on a therapist's emotional equilibrium. These include fear, anger, helplessness and feeling a failure. It is for these reasons that responses, thoughts and feelings of those in contact with people whom self-injure need to be explored, but also in relation to the thoughts feelings and responses of people who self-injure.

Articles about self-injury have been vastly produced since the work of Favazza (1989b). There are many useful interventions and frameworks documented, however, there still remains reports of negative interaction with staff in hospital settings. It seems that the emotional reactions of staff to self-injury and associated interpersonal processes have a significant role to play in successful interventions for clients. In

order to explore this further, some key concepts about interpersonal processes will follow.

Interpersonal processes

Transference and countertransference are concepts at the core of this study. These interpersonal processes occur within a variety of helping relationships, but are most commonly documented at length within the psychotherapy and counselling texts (Gabbard and Wilkinson, 2000). There are many different and occasionally conflicting definitions of transference and countertransference. The following definitions have been selected based upon suitability to this thesis.

Transference

The origins of the word transference in Greek and Latin mean "to carry across" (Clarkson, 2003); thus a sense of movement from one place to another. There is great debate about what is being transferred, but commonly agreed concepts are that behaviour patterns and emotions are transferred from client to therapist. Transference demonstrates the use of past learning by the client which is used to influence the present relationship with the therapist. Currently transference is often viewed as a natural and necessary part of behaviour (Clarkson, 2003), but Freud had concerns that transference interfered with psychoanalysis. People often expect from the future, similar experiences that they have had in the past. Thus in terms of the therapeutic relationship, clients may expect similar interpersonal interactions from their helpers that they associate with their past relationships. Transference is viewed as the clients' reactions and staff reactions are viewed as countertransference reactions.

Countertransference

Countertransference, is the transfer of the therapists' emotions and behaviours onto the client (Clarkson, 2003). This tends to have two aspects, what the therapist brings from their life experiences (proactive countertransference) and also what the therapist reacts to in the client (reactive or inductive countertransference). The latter is when the therapist reacts to the client's projections, personality and behaviour. Reactive countertransference can be concordant or complementary. Racker (1957) described complementary and concordant projective identification as part of the therapist reactive countertransference. Complementary projective identification is where staff may feel emotions that complement a client's self-belief and emotions. For example, a client may believe that they should be punished; they self-injure, then the staff may feel angry and behave in a punishing way. Concordant projective identification is associated with empathy. The immediate emotional reactions of staff and client are similar. For example, the client feels out of control and self-injures and the staff do not know what to do and feel out of control.

Recognising countertransference in nurses has led to a reported improvement in client care (Winship 1995), enrichment of nursing knowledge (Thompson 1990) and a sense of professional growth (Stickley and Freshwater, 2009). However, countertransference in staff can be overlooked in favour of staff skill enhancement and a focus on action (Stickley & Freshwater, 2009). Thus a focus on what to do, rather than how to understand a given process or issue tends to dominate training or education. Staff attitudes can be a method of conveying a countertransference reaction in the form of thoughts about the client, their behaviour or their diagnosis.

Staff Attitudes

Many people who injure themselves in psychiatric settings are labelled as "manipulative" or "attention-seeking" (Clarke & Whittaker 1998). As a defence mechanism, this serves to make the professional feel better about themselves, locating the source of difficulty with the client rather than looking at their own knowledge, attitudes, beliefs or emotions.

Staff attitudes have been reported to be an issue with people who self-harm (McAllister, 2002), but also with people who have a diagnosis of personality disorder. Walker et al (2004) compared attitudes of prison officers and psychiatric nurses. They found that the nurses expressed more concern and felt more vulnerable when working with people with a personality disorder diagnosis. Prison officers were generally more positive, warm and expressed a liking and interest in the patients. They conceptualised the patients as being cognitively incompetent and thus not responsible for their actions. Walker et al (2004), hypothesised that this may have made them more accepting of patients with this diagnosis. Nurses however were more likely to see the patient as being cognitively competent and thus responsible for their actions, therefore felt less warmth towards them and were less able to like them. So here a concept of impairment or incompetence seems to help, rather than the idea in psychiatry of people with this diagnosis not being "mentally ill" and therefore in control of their own actions.

Markham and Trower (2003) found that qualified psychiatric nurses expressed less social rejection and perceived people with schizophrenia to be less dangerous than

people with a borderline personality disorder. However health care assistants did not hold these views. All of the nursing staff had lower optimism for treatment, for people with a personality disorder diagnosis than for people with a diagnosis of schizophrenia.

Markham and Trower (2003) studied how the label BPD affected staff perceptions and causal attributions about patient behaviour. They found that patients with this diagnosis attracted more negative responses from qualified Mental Health Nurses than those with depression or schizophrenia. Staff believed patients diagnosed with BPD were more in control of negative behaviour than the others with a "mental illness" and therefore reported less sympathy and optimism for treatment outcomes. For clients with this diagnosis, events tended to be attributed to the person rather than the illness or environment. BPD was perceived to be a stable condition that was not "treatable". So an understanding of diagnosis or interpersonal issues within an attachment or re-enactment of abuse framework, could help staff reduce the extent the person is believed to be in control of their behaviour and also increase empathy with the patient (Warne and McAndrew, 2007). If staff are able to empathise with the patient, they are more able to understanding causal attributions about behaviours such as self-injury.

Lack of knowledge

Whilst emotions may run high in staff working with people who injure themselves, this may be further compounded by lack of knowledge. For example, in a study by Jeffery and Warm (2002), medical workers (healthcare professionals) were said to know less about self-harm than people who used this behaviour. Whilst these authors did not

state which type of nurses took part in the study, they found that professionals with psychosocial training had a better understanding of self-harm. Although mental health nurse education tends to be based on psychosocial theories and skills, all nurses need to be able to work professionally with an unbiased attitude towards people who self-injure. Increased knowledge and understanding can support helpers in remaining unbiased when working with this group (Rayner & Warner 2003).

So staff attitudes, emotional reactions and limited knowledge about self-injury effect staff reactions. As the staff react, they may experience increased anxiety due to these challenges and then use psychological defense mechanisms to cope.

Defense mechanisms

In analytic terms, people have been reported to use psychological defences such as splitting and projective identification (Gabbard & Wilkinson, 2000). These defenses produce complex and chaotic reactions in the therapeutic setting, particularly from helpers. Most studies tend to focus on these defense mechanisms within clients rather than staff. However, staff are human too and may also use these mechanisms. If staff countertransference is the focus of the literature, the existence and impact of staff defense mechanisms are recognised by some authors (Alexandris and Vaslamatzis, 1993; Gabbard, 1993: Pearlman &Saakvitine, 1995; Warne & McAndrew, 2006).These concepts are also useful in understanding staff reactions within this relationship and thus are useful within this study. These concepts have moved from being perceived as pathological in nature (Klein, 1946) to being perceived as a normal way of coping in stressful or traumatic situations (Rayner et al 2005). Arguably we are becoming more able to view professionals as humans with

psychological defense mechanisms and emotional reactions. For the purpose of this study, splitting and projective identification are key defense mechanisms that will be used to understand the interpersonal processes of self-injury.

Splitting is a defence characterised by polarisation of good and bad feelings, of love and hate, of attachment and rejection (Kraft Goin 1998). This intrapersonal process clearly works to protect a person from anxiety, but often leads to turmoil and confused reactions from professionals. People who self-injure may label staff as "good" or "bad", and this may be mirrored when staff label clients in the same way. An example of splitting is a concept of "idealised specialness", where clients may view one helper as perfect and special and another as bad and worthless (Kraft Goin 1998). Staff may also view certain clients as "good" or "bad"

Klein (1946) first introduced the term projective identification to describe a defence mechanism that operates from early life. Projection was understood as an activity of projecting unwanted feelings, sensations and associated parts of the self on to the external object. Projective identification occurs when parts are projected 'in' to the object or person (Richards, 2000). This idea has been developed further and is now thought to be an interpersonal communication strategy about inner world experiences, and has been noted in suicidal clients (Malin & Grotstein 1966). Such a mechanism is very controversial, with many different definitions. Ogden (1982) viewed projective identification as a process in which the therapist actually becomes involved in the client's "inner world". The client's projected material is internalised and fully experienced by the therapist, who may find it hard to differentiate between

feelings that may be projected from the client and emotions linked to their own life experiences in their countertransference reaction.

Ogden wrote about projective identification as having three steps. The first is the (usually unconscious) projection of a part of the self into another person. The second is an interpersonal interaction, where the projector actively pressures the recipient to think and feel in accordance with the projection. The third and final step is identification with the projection by the recipient. For example, if a person expects you to be angry with them and you are not (first step), they then walk out and slam the door (second step) and then you become angry (third step). This stepped approach to projective identification is helpful in breaking down the interaction between client and staff. It lends itself well to developing empathic awareness in staff for the client's internal experiences.

When working with people who self-injure, the psychological defences used by the client may produce negative reactions in staff because the projections and behaviours bring up emotions in them that they find difficult to deal with. Gabbard & Wilkinson (2000) explored the common counter- transference reactions that follow. I have used these reactions to link to self-injury (Rayner et al, 2005).

People who self-injure may report feeling helpless and staff can perceive them as such. Professionals may feel they must "do" for a client and become a "good parent" to make up for previous negative parental experiences. This then may create an overly dependent relationship and reciprocates the splitting and projective identification. Staff may then rescue the client rather than empower them as adults.

People who self-injure can sometimes become an exception from usual procedures. Staff may feel intimidated and as if they are "walking on egg shells" (Gabbard & Wilkinson, 2000). Therefore, usual boundaries, such as time and contact may be changed. This may then result in extended sessions or time spent with the client, late night phone calls and meetings away from the clinical setting (becoming friends), or even sexual contact. The staff member finds it difficult to say no to extra sessions for fear of how the client will react. This is a real issue for nurses, as the idea of an "individualised, flexible approach to nursing" may be emphasised by the staff (Cleary 2003) and may also be the expectation of the client and their carers (Arnold, 1994). Thus, a fine balancing act may occur between client-centred care and protection of staff/client boundaries.

Staff may feel that they are being taken over by powerful feelings of hate or rage that do not belong to them (Gabbard & Wilkinson 2000). Alternatively, they may become increasingly angry at work. This may result in angry outbursts with clients, colleagues or in their personal lives. The issue of feeling rage and hatred, especially about a client, is still often taboo in professional helping relationships.

People who self-injure may elicit an anxious response in staff as their coping strategies often create ethical and professional dilemmas (Fieldman 1988). Sometimes staff may have a fear of complete fusion with the emotional state of the person they are trying to help. They need to be able to cope with their own anxiety by reflecting on and contextualising the process in order to continue to engage with people who self-injure. The development of these skills is an essential aspect of clinical supervision when working with people who self-injure.

As the client is feeling so helpless, staff may also feel very helpless. No matter what they do, their help will not work or is "not good enough" They can feel disliked, incompetent and ultimately worthless as professionals These are often the most difficult feelings for staff to deal with, and could be classed as a concordant projective identification (Racker 1957), as described earlier.

People who self-injure may experience angry reactions from staff. This can then result in staff feeling guilty because as professionals they feel that they are not supposed to have strong emotions about clients. This may then lead them to reject the client (withdrawal) or alternatively they may attempt to support the client by showing how devoted they are as a helper, possibly becoming over-involved. Both reactions are common nursing counter-transference responses (O'Kelly 1998). Staff may also feel guilty about not "helping enough" or not providing a "cure". Alternatively these reactions of guilt, helplessness and worthlessness may be conceptualised as shame responses from the staff. Although these reactions from Gabbard and Wilkinson (2000) seem clear, shame is not explicit within their explanations. However, staff too can feel shame relating to their therapeutic relationships.

There is a limited amount of work that focuses on countertransference and shame. Lewis (1971) noted that certain words were used by staff in the context of shame. These were, uncomfortable, insecure, uneasy, confused, inadequate, stupid, helpless, unable and impotent. These are similar to some of the countertransference reactions previously described. Staff reactions could lead to experiences of shame, as reports of feeling angry, guilty, helpless, worthless and a failure could be

conceptualised as shame. When the clients devalued or devaluing representations resonate with the staff's unresolved shame, this can result in countertransference identifications and enactments (Hahn, 2000). In order to cope with shame, staff have been reported to reject the client (Retzinger, 1998). Rejection by helpers has been described by many authors following self-injury (Babiker and Arnold, 1997;McAllister, 2002: Pembroke, 1994). An alternative to direct rejection of the client is for staff to believe that they do not want help, cannot be helped or are beyond help (Hahn, 2000). These reactions have been described when working with people who self-injure (Pembroke, 1994).

There appears to be little connection in the literature between staff countertransference and shame and working with people who self-injure. However there is an emerging link between parents of people who self-injure and shame. McDonald et al (2007) reported that mothers of adolescents who self-harmed experienced guilt and shame. This in turn effected their reactions and responses. They questioned their relationships with their children and thought that they may have failed them. The mothers also described feeling guilty about their denial or minimisation of their child's difficulties. This then pushed them on a journey to find a reason for the self-harm and increased hypervigilance with the child for the future.

Upon viewing the intra and interpersonal functions of self-injury and the resulting interpersonal consequences, it became clearer to me that staff reactions needed to be taken into consideration alongside client's experiences. Thus a move towards integrating the client and staff relationship became essential in my search to understand interpersonal processes and self-injury. However within this chapter this

became difficult to achieve, especially when publications focused on diagnosis and pathologising the client, or if the defense mechanisms were described purely from a clients point of view, omitting the use of such strategies by staff. This also became difficult when selecting research methods for this study. Participants were interviewed separately due to confidentiality and then transcripts were brought together to create a new integrated understanding of the interpersonal process. This method of research is examined in Chapter 3.

Chapter 3: Methodology

This chapter describes how I interviewed three sets of client/staff dyads about self-injury. The research process is examined within an approach known as bricolage. The chapter is written in chronological order to illustrate my journey as a researcher and the mixed methods of qualitative inquiry that I used along the way. I did not intend to create a bricolage at the beginning of the process, but looked at various methods, methodologies and philosophies and selected the theories, tools and techniques that I thought fitted the task at hand. This fitted well with McLeod's (1996) consideration of a bricolage, that is a pieced together solution to research issues that is unique to each research experience.

Bricolage seemed an effective and appropriate way of combining my research inclinations and those methods I thought might best help me in answering my research question. Denzin and Lincoln (2000) used the term Bricolage in the spirit of Claude Levi-Strauss (1966). The French word, *bricoleur*, describes a handyman or handywoman who makes use of the tools available to complete a task. Such an approach is what I aimed to do within this research project. I started off with critical incident technique in mind as this was more useful in the earlier stages whilst planning interviews. Critical incident technique helped me deconstruct the "incident" of self-injury and ask clear questions. As a therapist and nurse I have come to view myself as an integrative psychotherapist, using integrated theories and techniques or using eclectic approaches that draw upon various underpinning theories. Gobbi (2005) has argued that nursing is a bricoleur activity, in that "practitioners draw on

the 'shards and fragments' of the situation-at-hand to resolve the needs of the individual patient". In research terms bricolage seemed a similar notion. Denzin and Lincoln (2000) describe the bricoleur as struggling to work between and within competing and overlapping perspectives and paradigms. Within my clinical work this was the case as I often drew upon cognitive behavioural, humanistic and analytic theories and interventions selecting methods and theories that suited the client or situation at hand. As a researcher I also engaged with other discourses and texts, which exposed me to a variety of ontologies, epistemologies and methodologies. Although I had worked for many years using clinical interventions and theories and have synthesised ideas to suit particular work and clients, I had not done this with research methods, my previous research using one model and the associated theory and philosophy. Thus a challenging part of the process of this thesis was to create a bricolage that embraced the complexity of the overlapping and competing methodological issues.

Bricolage is both concerned with multiple methods of inquiry and also diverse theoretical and philosophical notions of the various elements encountered in the research act (Kincheloe, 2001). I was keen to use the methods and philosophies that fitted the research question, rather than having a prescribed methodology that would influence the outcomes. I wanted to see the interpersonal processes for what they were and then utilise theory to support the research process, rather than let theory restrict my view. I wanted to engage with "not knowing" and then construct various states of "knowing". A variety of ways of seeing and interpreting is embraced by Kellner (1995). He states that any single research perspective is ridden with assumptions, blindnesses, and limitations and can lead to one-sided reductionism.

The bricoleur uses whatever is useful to deal with the task at hand creating a product known as the bricolage (Gobbi, 2005).

Contained within this methodological bricolage are an integrative emotionalist approach, the use of narrative, phenomenological philosophy, critical incident technique and use of the self as data by using reflexivity. The latter is emphasised to integrate my own personal experiences and highlight the subjectivity of this study and thesis. These parts of the bricolage are now considered.

The focus of the thesis is to provide a rich description (Geertz, 1973) of the interpersonal processes occurring between a client who has self-injured and their professional helper in order to increase knowledge. The central premise in this study is that not only is each person and relationship viewed as being unique, but also that each time a person self-injures should be viewed as a unique experience. For each of these experiences, many different, sometimes conflicting interpersonal processes occur simultaneously. Within this research, each participant individually interpreted the world and events and then created their own meaning. I then analysed and synthesised these views, between each dyad, which gave rise to various unique meanings of the interpersonal processes of self-injury.

In the previous chapter, the literature revealed a clear focus on the meaning or function of self-injury. There was also recognition in much of the literature of how self-injury may affect staff. However these seemed to be issues considered without or in different contexts. Thus the self-injury remained an externalised event with the client, or was reported to be a client behaviour that staff had difficulties with. Within

this thesis, I have brought these separate narratives together and also created a third synthesised meaning between each pair of people interviewed. This was based on my own interpretation of what may have been occurring before during and after the incident of self-injury. Both parties had explored in the separate interviews their perspectives, but had not discussed them with the other participant. I believe that to understand an interpersonal process between two people, both accounts need to be linked together and a new meaning created alongside each individual narrative.

Qualitative, inductive methods of inquiry have been chosen, as the knowledge that I want to generate would not be easily accessible using quantitative methods. I aim to provide a rich description of an interpersonal process rather than measure. Much qualitative research aims to observe a complex group of factors that interact and influence each other and are difficult to measure (Bannister et al 1994). Thus, those difficulties that arise for quantitative methods become advantages for qualitative methods. I sought to describe and understand the unique interpersonal process in each relationship between each person who self-injures and their carer, rather than look for transferable similarities. I looked for co-existing phenomenon, rather than causative relationships. I was not seeking to blame people who self-injure or judge how professionals cope with this, but instead take a view that people cope in the best way that they can in a given situation. Thus as a researcher, I have tried to avoid judgement and sought to describe and make sense of these interpersonal processes. The client and staff narratives are descriptions of a reality that is subjective rather than objective and thus need recognition of patterns in phenomena rather than facts that can be controlled and generalised. (Stewbert &Carpenter, 1995). I take the view that there is not one reality but multiple realities co-existing at any given time. These

narratives are constructed by individuals in order to understand their given situation within that context at that moment.

I have chosen a qualitative approach to the research as this approach has the capacity to recognise the importance of thoughts, feelings and formulations, and engages with complexity and pluralism. Qualitative approaches to research often take the form of social inquiry that focuses on the way people interpret and make sense of their experiences and the world that they live in (Holloway & Wheeler, 2002). The experiences of people are ultimately context bound and cannot be free from time, location and the mind of the person concerned.

I was specifically interested in peoples' individual perspectives and hence required an approach that was able to embrace different viewpoints that may be competing as well as similar. I viewed my relationship with the participants as being equal as human beings, researching "with" rather than "on" (Hollaway & Wheeler, 2002).

In searching for an appropriate method of data collection, closely structured questionnaires or interviews seemed too restricted for collection of the rich content required for this study. Unstructured interviews could lack direction and I was specifically focusing on client and staff experiences before during and after self-injury. I was keen to focus on a specific incident of self-injury and not just generally discuss interpersonal issues and self-injury. I viewed each episode of self-injury as unique and was expecting the client and staff to have their own individual meanings constructed before, during and after the event. Semi-structured interviews were selected for this study. This ensured some focus but also flexibility and space to

consider additional items deemed relevant by the participants. Direct observation of the self-injury and interactions between the client and professional, would have been very valuable and was discussed within supervision, but these could have been ethically compromising and would not have allowed enough space for each person to reflect and provide a retrospective meaning within context. Self-injury can be a very private behaviour, to directly observe this could be compromising for the client and the researcher. In addition to this I would be very much part of the process I was attempting to observe. My own emotions and beliefs would have been directly influenced by witnessing the self-injury. I could have increased the possibility of focusing on my emotions and thoughts, possibly to the exclusion of the participants' reactions in this difficult situation. Whilst my reactions are integral to the research process, these reactions would not be as extreme as when watching someone self-injure. In addition to this, I could also have been more at risk of focusing on the behaviour rather than the person or the interpersonal process. Therefore, I felt adopting a retrospective interviewing approach was the most appropriate approach to adopt. I wanted to hear how the client and staff constructed meaning about what they had experienced. The process of constructing meaning may not usually occur during self-injury, but needs some reflective space to develop. I was still affected by the descriptions of the self-injury during the interviews, but this was to a lesser extent. Whilst considering this point, I considered adopting an ethnographic based approach as a research method. Such an approach could provide me with a focus on how meaning is negotiated within a social context through the process of interaction with others (Hesse-Biber & Leavy, 2006). However this approach often uses participant observation and for the reasons set out above I did not want to employ this method. Additionally classical ethnographers often seek an objective account of observations

and I knew that I did not want to do this either as I believe subjective accounts provide a richer description. Here I have taken an interpretive approach that understands subjective reality and consists of meanings produced by individuals within their social context.

The creation of a Bricolage helps avoid the reductionistic knowledge arising from, externally imposed methods and continues the pursuit of complexity by sidestepping monological forms of knowledge (Kincheloe, 2005). Monological knowledge is produced when researchers pursue the rationalistic quest for order and certainty. I was acutely aware that self-injury and interpersonal processes did not lend themselves well to such knowledge. Monological perspectives on the world fail to account for the complex relationship between material reality and human perception. This is reflected in my belief that there is not one "truth" that fits all, but many different accounts based on individual perceptions of the same event. As part of a larger process that is ever changing, bricolage engages with a reality that is not a fixed entity (Kincheloe, 2001).

There are different methods of using bricolage within research papers. Many authors focus on the use of bricolage as a concept or metaphor. Sometimes this occurs in relationship to the research participants understanding as a type of bricolage. The alternative position is to develop a bricolage as a methodology where the research methods and philosophies are contextualised as the bricolage (Kincheloe, 2005, 2001). The following research papers have been considered within these categories.

Hester (2005) explored contraceptive consumers' accounts about the third generation oral contraceptive and associated blood clots. Bricolage was used in this paper as a metaphor to highlight women's decision making. Hester wrote about how the interviewee's in her study used bricolage to construct meaning incorporating their bodies as tools for making sense. This is different to my use of bricolage in this thesis. I have not focused on how the client's or staff create a bricolage to understand self-injury. In a similar approach, Broom (2009) used bricolage to conceptualise the therapeutic trajectories of patients with cancer. He focused on how patients' decision making and sense making practices occurred within pluralistic health care environments. He did not use a postmodern or relativist stance in this research. His methodology drew on interpretive traditions in qualitative research, but did not use bricolage as a research methodology. Within this thesis I have use bricolage to connect and create the method and methodologies, rather than as a conceptualisation of how research participants make sense of self-injury. Russell and Tyler (2005) used bricolage as a concept alongside branding in relation to the transitional experience of gendered consumer culture for a group of teenage girls. In this research project, they collated information about a shop called Girl Heaven, used participant observation in store, interviewed employees and then eight girls aged 10 and 11. The follow-up study occurred when the girls were 13-14, when they were given cameras to take pictures of their shopping trip and produce a textual analysis and visual display with a group discussion. Again here the bricolage concept was used to understand how the participants related to gendered consumer culture, rather than how the research was conducted. Aagard (2009) uses bricolage to describe the first hospice and palliative care program in Tanzania. She used` the concept to describe the nurse as the bricoleur for the implementation of the new

method of working. Again here bricolage was not utilised as a research methodology or method, but as a concept to describe the activities of the nurse. Markham (2005) used bricolage again as a concept, rather than a research methodology or method. Her story was conceptualised as the bricolage. However she did link bricolage clearly with the concept of reflexivity during qualitative research. She presents findings from an ethnographic research project that explores the concept of "Go ugly early", as it was claimed and lived out by a group of men in the university bar. She produced a narrative that interweaved scholarly literature, fictional literature, research journals and participant accounts.

Other authors use bricolage as a method of combining different methods, methodologies and philosophies in their research. Kincheloe (2005) has combined ethnography, textual analysis, semiotics, hermeneutics, psychoanalysis, histography, discourse analysis and aesthetic criticism in the methodological bricolage. Nuttall (2006) uses a combination of qualitative research methods to produce a bricolage of interpretive phenomenology, case studies, reflexive action and writing. Within this research project on how psychotherapists integrate theories and techniques, he also connects these to the six stages of heuristic inquiry. He likened Heuristic inquiry to bricolage, but considered the former to have a more structured framework. Riches and Dawson (2002) used a biographical approach, analysing family stories of a death of their child and the social construction theories of grief, within a post-structural perspective. Gubi (2009) completed a small-scale study on the impact on counsellors of working with clients who have experienced spiritual abuse. Heuristic and interpretive phenomenological analysis were combined in the research methodological bricolage. Minge and Zimmerman (2009) engage cultural studies,

feminism, queer theory, rhetorical criticism and auto ethnography in this article as a form of bricolage. The renaming of violent sex narratives was achieved through power pleasure and play. The authors in this paragraph have documented how they have all conceptualised the research methods, philosophies and subject theories in the studies as combined within the bricolage. This differs to using bricolage as a method of conceptualising participants' methods of understanding within the interviews.

Within my bricolage I have focused on conceptualising the research methods and philosophies, rather than conceptualising the participants' method of understanding their interpersonal process of self-harm. The client and staff perspectives from the interviews in this research could have been conceptualised as using bricolage to create their own meaning and understanding of their self-injury. Clients and staff may have utilised a mixture of media influences, web based resources, narratives from other people, literature from the professional press and service user experience lead publications alongside their bodies and resulting thoughts and emotions to create their own meaning. Media influences have increased in recent years on self-injury especially with inclusion of storylines featuring characters that self-harm on television. Examples of this are in Hollyoaks, Buffy the Vampire Slayer and Star Trek. This study did not focus upon external influences on how participants' made sense of self-injury. Thus the participants' were not asked about this in the interviews. Instead the focus of this study was on the interpersonal processes between client and staff.

Chapter 6 (Interpersonal issues between client and staff) of this thesis could also be conceptualised as a bricolage that I created from the synthesis of the two narratives

of the client and staff interviewees, with my reflexivity and self as data and psychodynamic theory. However my main use of bricolage in this thesis is as a research methodology. This is supported by the work of Warne and McAndrew (2009) who advocate the use of bricolage with divergent methods of inquiry and diverse theoretical and philosophical understandings within the research process. As my research project progressed my ideas of how I had used the methods and philosophy changed. I began by focusing on critical incident technique, then moved towards phenomenology as a philosophy and later on in developing my methodology chapter of the thesis I began to use narrative inquiry and reflexivity as concepts within my bricolage. I was able to unite these approaches within the framework of a methodological bricolage in order to conceptualise how I conducted this research.

Narrative inquiry was included in what has become my methodological bricolage as the participants were telling their stories of self-injury. Narrative Inquiry refers to a story and how that story is generated (Polkinghorne, 1995). Crocket et al (2009) used narrative inquiry to find out how clients benefit from staff supervision. The findings of this study were in the form of reflexive stories told by each researcher. The telling and re-telling of stories contributes here to the creation of a rich description of peoples' experiences. The telling and re-telling of stories within my study helped create new meaning for the participants and myself. Kirkpatrick & Byrne (2009) conducted a narrative study exploring the experience of moving on from homelessness for people with major mental illness, after they had found permanent housing. 12 participants were interviewed up to three times over 6 months. They also completed two months participant observation prior to the interviews. The stories created were viewed as a co-creation between researcher and interviewee. This may

be an advantage as the researcher's contribution is clearly recognised, rather than a more positivist viewpoint that may avoid recognition of how the interviewer may influence the reported story. For example, Mun (2010) published her narrative based research where she has asked 30 mental health nursing students to document everyday experiences on an acute mental health ward. These narratives were then analysed and interpreted from the philosophical notion of hermeneutics. Common themes were then drawn together from the experiences relating to critical thinking.

For this study I really wanted to focus on individual stories from clients and staff and also bring these together. In order to increase understand of any interpersonal process, the client story needs to be viewed alongside the staff story and then a further story can emerge about the interpersonal process. Depending on where observers stand, they will perceive different phenomena in different ways. So the client would understand self-injury from their position, staff from theirs and I too also understood from an external position hearing both stories after the event. This knowledge cannot stand on its own, but stands within a context. I argue that self-injury can be de-contextualised if the clients' perspectives are taken away from the context of the relationship with the staff, if they have one. Kincheloe (2001) regards this as intertextuality. A central idea of this notion involves the concept that all narratives obtain meaning in their relationship to reality, but also from their connection to other narratives. In accepting the notion of intertextuality, narrative became an important part of my bricolage for this research.

In the earlier stages of the research process I also considered the use of grounded theory. This is a method that allows movement from data to theory involving the

progressive identification and integration of categories of meaning from the data (Willig, 2001). Glaser and Strauss (1967) first developed this approach then pursued different types of grounded theory in later years. Glaser's view (1992) is considered the "traditional view" of grounded theory with a perspective that there is a discovery of a truth that emerges from the data. Researchers are asked to enter the field of inquiry with as few pre-determined beliefs as possible in order to remain sensitive to the data. Thus literature is only reviewed later on in the research process. However Strauss and Corbin (1990), with their "evolved view" of Grounded Theory, did not believe that there was a truth to be discovered, instead they argued that truth is enacted. Thus they accept a multiplicity of truths and perspectives. They advocate engaging the literature at the beginning of the research process. In this thesis I did engage with the literature throughout the process, not just after the interviews. Both approaches to grounded theory advocate coding the data. Coding identifies a set of dimensions and explores the content in the light of these. Grounded theory has been criticised as being positivistic and not compatible with qualitative research (Willig, 2001). However this only applied if Grounded Theory was viewed from a constructivist paradigm. Charmaz (2000) argues that Strauss and Corbin assume the existence of an external reality as they develop analytic questions, hypotheses and methodological applications. However a constructivist grounded theory has been based on the work of Charmaz, where the researcher is viewed as a co-creator. I was keen that the content of my data would not be interpreted through coding methods that might filter out some less obvious meanings that may emerge from the interviews. In effect I was trying to avoid ideological countertransference and wanted to let the themes emerge from the content.

The use of bricolage was introduced to me later on in the study. By this point I had gone through a process of considering the use of grounded theory and ethnography and then had attempted to use critical incident technique to construct and carry out the interviews. I then read further about phenomenology, post modernist concepts, narrative inquiry and reflexivity. All of these methodological approaches seemed to have clear views on how they should be used and again sometimes these were competing, sometimes they were complementary. For example, whereas I liked the focus of phenomenology on understanding and interpretation, I disliked the bracketing of presuppositions. I also liked critical incident technique as a method of structuring my interview, but found the focus on science and the assumption that the person carrying out the task knew the function of this behaviour more difficult to accept. These tensions are discussed in more detail.

The overall approach of this thesis, is an interpretive understanding influenced by the philosophy of phenomenology. Phenomenology aims to describe the structures of the lived world. It rejects scientific realism and focuses on the ordinary conscious experience of everyday life (Schwandt, 1997). Hermeneutic Inquiry emphasises understanding and interpretation, more that description (Holloway & Wheeler, 2002). Hermeneutics is the theory of interpretation of meaning. Within this study I was asking participants to interpret their meaning of a specific self-injury. I then also interpreted a synthesised meaning between staff and client.

Phenomenology attempts to capture experience without imposing on it any prior theoretical views help by the observer. This was an important position for me in the

research process. I wanted to interpret meaning, but without heavily relying on theories and becoming focused on these and perhaps missing the lived reality.

Heidegger explored the meaning of being a person in the world (Holloway &Wheeler, 2002). He doesn't bracket and suspend presuppositions like other phenomenologists, such as Hussell, but encouraged researchers to examine them and make them explicit in the research process. This approach resonated with me as I had many previous years of knowledge and experience on this issue, which I could not just ignore. I believe that the researcher cannot be separate from their internal experiences and thus bracketing or suspending all assumptions is impossible. Instead assumptions need to be recognised and explored using a reflexive approach. My presuppositions were contextualised and examined within chapter 1 where I described the background to the study. I also discussed these in supervision. Willig, (2001), argues that genuine phenomenological research should not study people's cognitions but should understand the lived experience. Here the phenomenological approach did not fit my questions around thoughts, feelings and behaviours before during and after self-injury. Although these questions may have restricted feedback on the lived experience, I also asked them in conjunction with other more open questions.

Phenomenology can be used as a philosophy or as a methodology within research. I have chosen to use phenomenology as a philosophical orientation, not as a methodology. Reaching this decision arose from a reflexive re-reading a number of research articles that had used phenomenology as a methodology, or had used methods based on this as a philosophy. For example, Rolls and Relf (2006) used

phenomenology as a methodology in their research. Here the researcher sought objectivity and control of her own emotions, due to the emotional nature of the study. The study focused upon child bereavement services over a three-year period. The authors used reflexivity to bracket their values, emotions and interests that may have impinged upon their research. The "bracketing interview" sounded a useful way forward. The researcher was helped to access her unconscious assumptions and values within the research supervision relationship. However there was also an assumption here that talking about these personal values and beliefs would remove their influence on the researcher. Whilst I believe it is useful to recognise these issues and although I acknowledge they may be part of the researchers subjectivity they cannot be removed.

Likewise Rosedale (2009) interviewed 13 women following breast cancer treatment and drawing upon Strubert's descriptive phenomenology, bracketing was not used, rather she tended to regard women or "survivors" as a group, rather than keeping with the individual experience. She used validation of the researcher by having another team to examine the data, codes and interpretations. There was also an emphasis here on being less subjective, rather than viewing her own interpretations as unique. These papers, although interesting lead me to think that I did not want to use bracketing as a concept, but to embrace my subjectivity and recognise how this has influenced my research. This lead into a more reflexive approach, recognising my beliefs and assumptions and how these may have influenced the research.

I began to focus on hermeneutic phenomenology. Smith (1997) used hermeneutic phenomenology to explore the problem drinker's lived experience of suffering. Here,

phenomenology was used as a philosophy and a research approach. 6 people were interviewed and the content was analysed using an interpretive process. The researcher kept a reflexive journal recording the involvement of the self in the research process. I thought that this was an excellent idea. However in her research Smith also asked Independent experts to validate the themes identified by the researcher. This implies that the subjective view of the researcher was only valid if other "independent" people agreed with the themes. This challenged my beliefs of subjectivity being important in research and also that unique experiences were not as important as common agreements. For me this tended to challenge the philosophy of heurmeneutic phemonenology. Yousefi et al (2009) conducted a phenomenological study to explore the comfort experiences of hospitalised patients during their admission to Iranian medical or surgical wards. 22 participants were interviewed about comfort and then the contents were analysed. The researchers linked common themes as part of the analysis. McConnell- Henry et al (2009) state that neither Husserl nor Heidegger aimed to produce methodologies, but they offered phenomenology as a philosophy. However other authors have created methodologies linked to these philosophies. Paley (2005) criticises nursing phenomenologists for linking themes in their analysis as this can be conceptualised as categorisation. He views this as a negative thing to do as he believes that this directly opposes the philosophy of each story being unique. So rather than following methodologies that may have misinterpreted the original philosophy of phenomenology, I decided to remain with the concept of each persons interpretation of each event being unique, even if it transpired there might be common ground between some of the stories.

Within the emergent bricolage that became my methodology, alongside phenomenology and narrative approaches, critical incident technique provided a tool to structure the interview schedule. The latter was utilised as a method, rather than a methodology (Hollaway and Wheeler, 2002). This was chosen because it is a systematic, inductive, open-ended procedure for eliciting verbal or written information from participants (Norman et al, 1992). This was important to me as this qualitative method helped structure the interviews and focus on the effects of a critical incident, in this case self-injury.

Flanagan (1954) clearly viewed this method of research as "scientific" in nature. This perspective did not fit well with my views. Byrne (2001) stated that critical incident technique emerged from the assumptions that the scientific method could facilitate the observation and categorization of all behaviours. I agreed with the observation, but did not want to categorize. However, many authors in more recent years have used critical incident technique in a qualitative fashion (Aveyard, 2002; Brostrom et al, 2003;Conway, 1998; Henderson et al, 2003;Jackson & Stevenson, 2000). Indeed, Kemppainen (2000 P1264) views critical incident technique as "a highly flexible qualitative research method". Critical incident technique has been seen as capable of capitalising on participants' stories, but avoids the loss of information that occurs when complex narratives are reduced to simplistic descriptive categories (Norman et al, 1992).

A critical incident is defined by Flanagan (1954, P327) as:

"Any observable human activity that is sufficiently complete in itself to permit inferences and predictions to be made about the person performing the act."

To be critical, the incident must occur in a situation where the purpose or intent of the act seems clear to the observer and the consequences are sufficiently definite to be clear about its effects. It is the inferences of the observer that I am especially interested in; the thoughts of the professional about the person who has self-injured and about the consequences of their "behaviour" or interactions with the client. However, if self-injury is perceived as the "critical incident", often the client's purpose is unclear to the worker, apart from the direct behaviour of self-injury. Professionals may begin to influence the consequences of the critical incident. Thus within this project, staff may have been clear about the effects of self-injury, but the consequences of the behaviour may be dynamic in nature. Additionally the client will also be an observer to the critical incident. Thus, I used the technique slightly differently to Flanagan (1954), I focused on one incident and two observers, then compared their interpretations and consequences of the critical incident. This is more in line with other qualitative studies using this method (Norman et al, 1992).

Flanagan (1954) stated that the critical incident technique should not be seen as a single rigid set of rules governing data collection. He perceived this technique as being a flexible set of principles that must be modified to meet the specific situation at hand. Indeed, this has been the case since Flanagan first published his work. He describes the observation becoming "fact" depending on the "objectiveness" of the observer. This is an outcome clearly linked to a positivistic philosophy and within this project I was not expecting the observers to be "objective", but welcomed their subjectivity. I therefore will not be labelling their observations as "facts" Whilst Flanagan (1954) was seeking to minimise inferences and interpretations of a subjective nature, I was intent on actively seeking them. In more recent years

researchers have used critical incident technique in this way (Byrne, 2001; Norman et al, 1992).

My research methodology was unique to this study and emerged in response to defining the aims, outcomes and data collected. Bricolage does not simply *tolerate* difference but *cultivates* it as a spark to researcher creativity (Kincheloe, 2001). Sensitive to complexity, bricoleurs use multiple methods to uncover new insights, expand and modify old principles, and re-examine accepted interpretations in unanticipated contexts. The ultimate manifestation of this approach was that I was able to draw on personal narratives of self-injury and also staff experiences and uncover new insights and interpretations by bringing two narratives together reflecting the interpersonal process. This approach fitted my research as I wanted to avoid the deductive qualitative studies where the theory becomes a framework for the entire study, an organizing model for data collection (Hesse-Biber & Leavy, 2006). This could have limited or distorted knowledge through a theoretical filter and may have lead to ideological transference. Bricolage allowed me to create an inductive approach where the theory was generated from the interviews, with as little theoretical filtering as possible.

Levi-Strauss argued that the bricoleur specialises 'up to a point so as not to need the equipment and knowledge of all trades and professions, but not to the extent that they can only serve a particular purpose' (Levi-Strauss 1966, 18). From this analogy, when researchers learn a methodology, they either learn them as a bricoleur acquiring sufficient familiarity to apply the methodological principles to research situations, or they learn them as a researcher who applies the lens of the theory or

philosophy to the practice of research. Operating as bricoleur, the researcher does not need to be constrained by the methodological theories and philosophies that the methods are conceptualised within. I had many struggles when viewing critical incident technique and also phenomenology where I agreed with some aspects but not others. For example, critical incident technique as a problem focused approach did not fit with my view that self-injury was a useful method of coping. However, by using this as a tool to plan the interviews, I was able to draw on phenomenological perspectives to re-frame self-injury in a more positive light and not label it as a problem.

The bricoleur works with a heterogeneous collection of fragments, noticing discontinuities, parallels, connections, differences and similarities between them (Gobbi, 2005). The fragments are then connected into constructions which are neither total nor whole, but through which the elements that constitute the situation are recognised. For example, during the analysis, I focused on the content at hand and went through a process of noticing connections, disconnections, differences and similarities. I then brought this analysis together to create new meanings between client and staff that had not been constructed by the interviewees, but by myself as a participant in the research process and methodological bricolage. I did this to illustrate the interpersonal processes in play and in so doing, create a new meaning from a different position.

This is a stance to be found elsewhere, for example, Hesther (2005) uses bricolage to create new understandings in his work on consumer responses to the contraceptive pill and criticises Strauss's ideas that the bricoleur did not create new

meanings. I believe that through my study I was able to create new meanings, from clients, staff and when analysing the experiences of the client and staff together.

Within bricolage there is a view that research methods are actively constructed from the tools at hand rather than a passive process where the "correct," universally applicable method is applied (Kincheloe, 2005). This idea was important to me as I believe research is a dynamic creative process, not merely following a set of procedures. Research strategies could not be created in advance, but true to the nature of bricolage were created during the research process. After battling with different methods and methodologies of research, I decided that I wanted to refuse the passive acceptance of externally imposed research methods.

The final part of the bricolage to be considered in this chapter is reflexivity.
Qualitative approaches to research acknowledge and embrace the role and beliefs of the researcher and recognise that they both influence and are influenced by the process of engaging in research. A reflexive approach recognizes this reciprocal relationship and seeks to make it explicit (Etherington, 2004).

Reflexivity is a critical self-reflection on the researchers own biases and theoretical predispositions (Holloway and Wheeler, 1996). It recognises that the inquirer is part of the setting context and social phenomena. Thus it can be used to critically reflect on the whole research process. Within a hermeneutic philosophy, humans are perceived as being self-reflective people whose experiences in life are in a temporal and historical context. Preconceptions and provisional knowledge are always revised in the light of experience and reflection (Holloway & Wheeler, 1996). Thus content is

always open to multiple interpretations because researchers are reflective people involved in their own relationship with the world and others.

Reflexivity is the capacity to reflect upon one's actions and values during the research, when producing data and writing accounts, and to view the beliefs we hold in the same way that we view the beliefs of others (Seale, 1998). As a therapist and also a nurse I had worked for many years on this skill of reflecting in action, as well as afterwards. Thus whilst completing research and writing this thesis I have also emphasised the value of reflexivity and the use of myself within the bricolage.

Townend and Grant (2006) recognise two different levels of reflexivity in their research paper on driving phobia. (1) Personal reflexivity, where the researcher acknowledges and reflects upon the ways in which their beliefs, experiences, values, political influences, culture, gender and environmental context influence their research. (2) They also describe epistemological reflexivity, where the researcher engages with questions related to underpinning theories of research and the research process. Both types of reflexivity are considered and presented in my chapter of the "researcher's story" In this chapter, I expand upon areas of reflexivity to be found in the other chapters of this thesis. McCabe and Homes (2009) recommend focusing on the interpersonal process between the interviewer and participant in the research as part of reflexivity, moving beyond the traditional ideas of researcher bias. Examples of this interpersonal process between myself and participant are also considered in chapter 11.

A variety of studies have utilised reflexivity either as a concept or as a tool within the research process. For example, Cooper and Burnett (2006) used reflexivity in their study looking at the experiences of how young mothers were communicated to by health care professionals. In so doing, they drew upon discursive psychology and positioning theory. In their paper, they provide a reflexive commentary that captures the interpersonal processes involved in interviewing them.

Likewise, Jootun et al (2009) use a reflexive process in reporting their findings from a longitudinal study on how new members entering the profession learned to nurse. They emphasise Dowling's (2006) idea that reflexivity involves being aware in the moment of what is influencing the researchers internal and external responses, while simultaneously being aware of their relationship to the topic and participants. An example of this is when I was aware during the interview process of how my beliefs of self-injury often being linked to abuse could effect how Angela responded to my questions. She had experienced loss, rather than abuse. I was able to remain open to her different viewpoint, rather than pursue questions that may have assumed a history of abuse. This then assisted in weakening the links between abuse and self-harm.

Smith (1997) utilised a reflexive journal recording his involvement in the research process when he was using hermeneutic phenomenology to explore the lived experience of problem drinker's. I used reflexivity within my bricolage as a method of integrating my own subjectivity as part of the methodology. This supported my hermeneutic phenomenological philosophy embracing my unique interpretation of the research.

An alternative approach to using reflexivity within research is to focus on reflexivity ability within the participants of the study. For example, Dilks, Tasker and Wren (2008) conducted a grounded theory based approach to their research, using reflexivity. Six psychologist-client pairs supplied three tapes of therapy sessions spread across the course of therapy for people with psychotic experiences. Then each participant was interviewed separately. Reflexivity was related to how the therapists facilitated this process with the clients, rather than the researchers using reflexivity on themselves within the research activity. In a similar vein, Auerbach & Blatt (1996) in their research study focus on disturbances in reflexivity and self-awareness. They interviewed 40 young people in acute mental health services who had severe mental health problems. Also Crowe (2002) in her study focusing on how women used reflexivity in relation to their depression, did not use reflexivity to focus on her beliefs and prejudices. All of the authors within this paragraph did not use reflexivity as a concept on themselves as researchers but focused on how the participants used reflexivity within their studies. Within my research I wanted to use reflexivity as a tool to include myself in the research process and methodological bricolage. I will now describe the process and activities of the research, before reflexively exploring the situatedness of [my] self within the process of completing this research.

Interview schedule

According to Flanagan (1954), the interview method is the most satisfactory form of data collection for Critical incident technique. Many studies employing this form of data collection use a semi-structured interview technique (Brostrum et al, 2003).

Within this study, staff and clients were interviewed separately following a "revelatory incident" of self-injury, thus using a "retrospective account" (Norman et al, 1992). This was important as I wanted to access a retrospective understanding as the participant had time to reflect on the situation. Memory is unreliable, but I was not seeking a mere description of events, but a unique explanation with personal meaning and context attached. Empathic listening was utilised when interviewing alongside summarising and clarification skills, in order to check out researcher perceptions with the participants (Norman et al, 1992). The use of questions around negative behaviours as well as positive assisted in reducing a positive response set frequently reported by researchers.

The questions for the client interview and revelatory incident report sheet were:

1) Think back to when you self-injured on (insert date and time). What were your feelings, thoughts and behaviours prior to self-injury?
2) What were your feelings, thoughts and behaviours during self-injury?
3) What were your feelings, thoughts and behaviours after self-injury?
4) Were there any other consequences to your self-injury?
5) What were the positive professional interventions?
6) What were the negative professional interventions?
7) How did these interventions affect your feelings, thoughts and behaviours?

The questions for the Professional interview and revelatory incident report sheet were:

1) Think back to when your client self-injured on (insert date). What were your feelings, thoughts and behaviours prior to their self-injury?

2) What were your feelings, thoughts and behaviours during their self-injury?
3) What were your feelings, thoughts and behaviours after their self-injury?
4) Were there any other consequences to their self-injury?
5) What were the positive professional interventions?
6) What were the negative professional interventions?
7) How did these interventions affect your feelings, thoughts and behaviours?

The questions were purposely similar for client and staff members. This was to compare and connect perceptions and reactions between the two people in the given situation. Following identification of these questions, I returned to the literature. In qualitative research, the literature review is often completed after analysis. However due to my previous scholarly activity and twenty years of work and study with people who self-injure, an initial literature review was completed to contextualise and justify the research. During completion of the analysis the literature was reviewed again to place these findings in the context of what is already known. So the literature was briefly reviewed, the proposal completed and the interview schedule designed. The next stage in the research process was to seek ethical approval.

Ethical approval

The University of Salford research ethics committee approved the study without amendment. Research and Ethics committees in Mental Health Trusts and Salford University were approached for ethical approval before the study commenced.

Informants were assured of confidentiality and gave informed consent, verbally and then documented.

Professionals were selected from Mental Health Trusts, from community and hospital based settings were targeted. The members of staff selected must have been working in a close therapeutic relationship with a client who often self-injured (five or more times in the last year). These dyads of professional helper and client were selected from as wide a variety of settings and professionals as possible. Each client and professional were interviewed following an episode of self-injury. I had the idea that if further episodes occurred frequently, critical incident forms could be used following the interviews. However the Trust ethics committee did not like this idea so this was removed. At this point I was seeking to collect as much data as possible and had not anticipated the depth and amount of content that would occur with six interviews alone.

The major areas of concern for the committee were:

The "scientific" validation of the protocol

How subject confidentiality would be maintained through out the study and in the published findings

The apparent lack of procedural plan should the person being interviewed state that they were immediately going to harm themselves.

In further discussion with the Nurse Consultant in the Trust following the admission that there were no self-harm policies in place, he agreed with my prior plan that

responses to people wanting to self-injure in the interview would need to be negotiated and planned individually with the care team supporting the participant prior to the interview. These plans were in keeping with the care plan for that person, rather than a procedural plan for all clients. This was discussed with the staff prior to the interviews. Confidentiality was considered in more depth with my supervisor and agreed that we could keep transcripts of interviews out of the thesis. The protocol is not "scientifically validated" as this was a qualitative study. I added a more in depth outline of the methodology to help the committee understand the differences in terminology and philosophical background and thus why the schedule would not be "scientifically validated". All of the changes in the letter from the Local Research and Ethics Committee were completed and a new application was made which was approved by another committee. This was one of the most challenging points of the research process, where I had many thoughts of giving up and not completing the study or the thesis. However I was able to recognise and challenge my thoughts and continued with my determination to achieve full ethical approval. This has also been reflected upon further within the latter section of this chapter. I felt quite isolated and misunderstood within my qualitative philosophy. I then moved to become quite angry at committee members due to an apparent lack of knowledge about these methods. This was further compounded by the unavailability of the nominated committee member who was allocated to support me in my resubmission for ethical approval. At this point I became aware of another similar process for feelings helpless, hopeless and a failure, surrounded by "support systems" that were not supporting me. This helped me to further empathise and reflect on the experiences of many of the people I had worked with who had been self-injuring and might have encountered a similar lack of support.

Recruitment

Participants were recruited via the local mental health trust. Many staff showed an active interest in the research and supported my role and interests. However this did not result in any referrals, rather an explanation of who was not ready to talk about self-injury. There appeared to be quite an air of protection from the staff and a concern that talking about self-injury would make the person self-injure more. This perspective was also shared by the staff on the ethics committee. A more successful method of referral was to approach people who self-injure directly and then they decided if they wanted to take part or not. Two of the clients were encountered as service user representatives and presenters at a trust training day on personality disorder. The other client was known by a colleague who thought he may be interested in taking part. It seemed as though staff were quite concerned about protecting their vulnerable patients. This was most apparent in the forensic setting that the ethics committee encouraged me to start with. The clients seemed to be viewed as too fragile to tell their own stories of self-injury. I had hoped that clients may be discussing their self-injury with staff as part of their care package, but this may not have been the case. If this was occurring, staff may have realised that verbalising self-injury would not necessarily result in increased behaviour of this nature. I began thinking about the secrecy that surrounded self-injury and communications about why clients' had self-injured. This helped me add further detail in my recruitment letters asking for clients who had previously spoken about their self-injury with other staff members, so that the research interview would not be their first disclosure. I reconsidered my recruitment process and instead approached clients directly. When the client had agreed to take part and had time to think about their decision, they gave me details of their chosen carer and I contacted them to see

if they would also take part in the research. This was a much more successful strategy for recruitment. Clients were given the information sheet in Appendix 1 and staff were given the sheet in Appendix 2. Then they were able to consider if they wanted to participate. At the interview informed written consent was recorded using the consent forms in appendix 3 and 4.

Selection

Participants were chosen on the basis that they were considered apparently helpful in generating an understanding of interpersonal processes and self-injury. People were selected based on their first hand experience of regular self-injury over the last twelve months, or longer. The staff were selected by the clients as being "closest" to them. Thus then the clients gave permission for the staff to be contacted. All staff approached agreed to take part and were also happy that their clients wanted to take part. Three clients were interviewed and three staff.

Initially I asked for people to have self-injured in the last twelve months. However one of the clients had not self-injured for two years, but this was a very memorable event for him and also the staff. The clients selected the incident of self-injury and often did not expect the staff to remember. However, the staff were very clear about remembering the same incident.

Interviews

I wanted client and staff views to be of equal value and considered separately and then together within their relationship. Therefore, I wanted to interview pairs of clients and staff who were in a "close" therapeutic relationship.

The qualitative method of interviewing was selected as it welcomed spontaneity and creativity and assisted in the development of a trusting relationship. This was essential due to the delicate nature of the interview and its focus on self-injury. Participants needed to feel secure enough to talk to me about their personal experiences and their associated thoughts and feelings. Semi-structured interviews were conducted based on the interview schedule and were dynamic and interactive in nature. Additional questions were asked spontaneously where relevant to the participants' responses in order to explore issues further. The interviews continued until the participants had exhausted their description of events and any further information they wanted to describe relating to the interview. This tended to occur after about sixty minutes. Interviews occurred until previous themes were confirmed and there were few new themes. Morse (1989) states that saturation point can be a myth, that there will always be new themes emerging if you continue. Instead several samples are selected from different backgrounds and cultural environments. As I completed the interviews I realised that some themes were re-appearing but others were still different. However the depth of content was unexpected and therefore a decision to stop interviewing was reached with my supervisor. In this study, the participants had varied age and gender, although all of the selected carers were male. There was some variation of cultural backgrounds of the clients and carers, but all were white and British. The depth and quality of the content also lead to a detailed analysis, focusing on the clients themes, carers themes and also to the interpersonal processes between the specific client and their carer.

Following each interview and process within the research, I completed a reflective diary where I described my own internal experiences and how this had affected my behaviour. The reflexive approach enabled me to focus on my own beliefs and feelings in the same way that I was focusing on those of others (Arber, 2006). On viewing some of my diary recordings I noticed that I became quite nervous prior to the interviews and focused on the digital tape recorder and whether or not I could use this well and also read and re-read the interview schedule. During the early interviews I was very pre-occupied with the digital tape machine recording, this made it difficult to concentrate at times. This was especially prevalent in one of the staff interviews that was interrupted four times by phone calls and residents to speak to the staff member while they were on duty. Audio tape recorders are usually visible, but my digital recorders just had a tiny light that changed from green to pink. However as we focused on the interview questions we both forgot about this issue.

Within and after each interview I was aware of what I was thinking feeling and how this was effecting my behaviour. This was difficult at times, especially with the clients as they were describing compelling and emotive experiences. However as a nurse and psychotherapist I was experienced with this level of disclosure. I was able to avoid judging the clients for their actions, but this became more difficult when I interviewed staff. One member of staff took an expert position and tried to 'teach' me about research and Borderline Personality Disorder. I pushed my emotions down in the interview, but when transcribing became quite angry with him. This was then reflected in my supervision when my supervisor focused on this process. He had noticed the "expert position" of this member of staff and while discussing this I became aware again of my irritation towards this participant. The interviewee began

the interview by being quite client focused but then seemed to feel "put on the spot" when I asked him if he had anything else he wanted to add to the interview. He reacted by taking an expert stance and assuming my research was of a positivistic nature. I reflected after the interview on my anger and how I began to judge him for coping in this way. I began to think about a client I worked with in therapy who used to do this and remembered how I thought about his behaviour. I was then able to move to a more understanding position and think about how he had coped in the best way he could at the time. These thoughts recorded in my diary, also helped me in my analysis and discussion when I was describing how staff used defence mechanisms and coping strategies. I became aware of being more judgemental to the staff for behaving in this way, thinking that "he should know better". However when I was in the more comfortable role of therapist to the client, I was able to avoid making this judgement. I was then able to think more compassionately about the staff participant in that he was coping in the best way that he could at that time.

I really liked the other staff and began thinking how nice they would be as carers. In one interview I became slightly anxious as he spoke about the traffic news that morning, when a person on a nearby motorway bridge was threatening to jump off. This was where his client used to go when suicidal. He explained that he had a fleeting concern that this may be her. I also shared this anxiety with him, but soon found out this was not her. It did however remind me of the constant threat of anxiety that I had experienced in clinical practice when working with clients who self-injured. To have had a good session with them and then suddenly they became suicidal or had a need to self-injure. This also seemed to link into a sense of not knowing which reaction to expect from another person. This process was also described by his

client. She used to worry about how her stepmother would react when she came home from school and also if her housework had been good enough. This seemed to be linked to a fear of negative evaluation described later in this chapter.

Within the client interviews, I generally felt sad and protective of the clients when they spoke about their experiences. I had written in my diary that I also became angry at times that they had been treated in a way that had encouraged them to "never feel good enough" and to think they were worthless and deserved to be hurt and punished. This seemed to be related to experiences of shame. Two clients spoke about the stupid questions that staff asked them in A&E. At this point, I began to wonder if they thought my questions were stupid. I asked them if they were ok answering my questions and they both stated that this interview was different. The difference also seemed to be linked to the time passed between the self-injury and the ability to reflect on past events. This interested me in that the clients both described experiences of being devalued and then moved on to judging the staff for being "stupid". This was another example of the shame cycle described in the discussion chapter to follow. One of these clients also tended to use short answers and I found myself asking more and more questions. At the time I was aware of this and tried to ease off, as this could be intimidating for the client. I got to the point that I even suggested thoughts, as he seemed to have difficulties verbalising these, but was able to inform me of his behaviours and emotions. He was then able to clarify his thoughts with me, as I gave him a variety of thoughts that he may have based on paraphrasing what he had said to me. However, at times I did feel "not good enough" as a researcher and as if I was getting things wrong. I reflected on this during and after the interview in my diary. I coped with this by reflecting his words back to him

instead of using my own when paraphrasing. This seemed to help and he started agreeing with me.

So my internal experiences and behaviours before, during and after the interviews were noted in my diary and recognised and these notes then became the basis for discussion in my supervision. These reflective and reflexive opportunities continued throughout the research, but were more fore grounded during the transcription and analysis stages of my study.

Analysis

All interviews were self-transcribed. This was a really important process where I began to have an intimate knowledge of the data and internally digest this (Etherington, 2004). It was useful to transcribe the first two interviews, prior to interviewing the next participants as I was able to amend how I helped the client to decide which incident to focus on. I also became able to identify some of my biases due to the questions I asked. I became aware in the later stages of the research process, how I became so focused on breaking down the interpersonal reactions into thoughts feelings and behaviours that I omitted questions around how the participants thought that their behaviours affected the other person in the therapeutic relationship. However these issues did sometimes naturally emerge in the interviews, as they were semi-structured.

Analysis is concerned with themes, concepts and assertions and their interrelationships. I was able to think laterally and across the interviews for themes, rather than apply a more reductionist model of coding and focusing on specific

words. I was keen to interpret the themes within the context that they were given, rather than as separate entities. For example while focusing on the client issues shame emerged for one client as an explicit emotion prior to self-injury, but for the other clients and staff, they reported emotions such as anger, self-disgust, helplessness and worthlessness, that may be conceptualised as shame, or accepted in their own right as separate emotions.

This was a rigorous analysis, in that I wanted to present accurately what the participants had experienced and conceptualised about this. In some way this was a straightforward and uncomplicated thematic analytical approach. I went through a process of sorting, organising and reducing the content into manageable themes and then also related these themes to the overall picture. I then presented the themes in the form of a narrative account. (Schwandt, 1997). The analysis was completed naturally without theory driven structures. This was to enable a clearer view of the themes, rather than being distorted by a complex procedure to follow and a theory within which to interpret. Therefore the theory emerged from the analysis, rather than the analysis being restricted by theories or structures. This was an incredibly liberating process that I only dared to complete with the support of my supervisor.

Firstly I read the entire description of the experience to get a sense of the whole. I then re-read the transcripts and considered this as an individual account. I then studied the clients' interviews together and then the staff interviews together and noted emerging themes. I clarified and elaborated the meaning by relating each narrative to each other and the whole. I then described individual themes and drew cycles of self-injury processes for all participants. I then focused on common themes

between the clients and then the staff. Finally I focused on themes occurring between the client and their member of staff. I reflected on the constituents in the concrete language of the subject by making connections to the literature and core concepts such as transference and countertransference and projective identification. It was then possible to integrate and synthesise these insights into a descriptive structure of meaning of the experience. Thus I emerged with six individual client and staff narratives, and also a synthesis of each dyad based on my interpretations of the interpersonal processes. I decided to present the data in three separate chapters; the clients, the staff and my interpretation of the client and staff interpersonal relationship where I brought together each pair of interviews. I decided to do this as each individual story needed to be expressed in its own right in the detail of the interview. I wanted to record what was happening to each of the participants' experiences before during and after self-injury. I wanted to explore thoughts, emotions and behaviours for each participant then integrate the interpersonal process by bringing together the themes from the paired interviews between client and staff. This was a synthesis of perspectives that was often absent from the professional literature and also in professional practice (Rayner et al, 2005). So rather than present the analysis as single independent narratives I presented my interpretation of an interpersonal process between the client and staff based on my observations when I viewed the two interviews together.

I did not take the analysis back to the participants to review, partly due to confidentiality and ethical issues, as the linking of pairs, potentially made the staff account identifiable to the client and visa versa. Additionally the level of analysis meant that I was considering the participants viewpoints stated in the interviews and

also went through a process of analysing the staff and client interviews together. This was new information as this was my perception of what had occurred, rather than their perceptions. So the critical elements were described singularly then within the context of groups of clients and carers and then finally within the context of the clients' relationships with their carers. Hermeneutic phenomenology can unveil concealed meanings in the phenomena. The client and staff narratives were part of a new narrative when they were considered together in the interpersonal context. In this inquiry, the individual stories were familiar to each participant, but they were unfamiliar about the other person's narrative or my interpretation of a third narrative shared between the client and staff.

As the study progressed I increasingly became aware of my personal values, beliefs, emotional reactions and how these had affected me as a participant in the research process. Initially I captured much of this reflexive thinking to each by providing an end note to each of the relevant chapters, rather than add a separate chapter, to demonstrate a continual process. However, I later built upon this initial approach and added a separate chapter on the researcher's story in order to enhance reflexivity. Richardson (1997), states that there is a need for 'critical friends' who can challenge the self-deceptions of researchers. I would agree that even if I was attempting to take a reflexive stance that I would still be bound by my personal values, motivations and actions. Therefore additional reflexive spaces were created in supervision and also with colleagues who had knowledge about self-injury and interpersonal processes. Within the research process I was able to recognise how the experience of others disrupted my acceptance of what was the case (Ramazanoglu and Holland, 1999). By listening and taking on board what the interviewees said, I was able to challenge

some of my beliefs about why people self-injure and also why staff react in ways that they do.

Through the process of completing my research I was aware of some parallel processes. For example, as I was completing my discussion chapter and as the following themes emerged I began to consider how these themes related to myself as a researcher and a human being.

Knowing and not knowing

Throughout the process of the research and writing of this thesis, I have oscillated between knowing and not knowing. The interviews were a structure to know about the processes. When applying for ethical approval within the trust, I became aware of my insecurities about "not knowing" and used the literature review to assist in my process of "knowing" and being "expert" Whilst this seemed to be required by the committee to gain approval, this did not sit well with my qualitative method of inquiry. However using a hermeneutic philosophy helped me explore my previous knowledge and beliefs about the subject. When analysing the interviews and writing up the discussion chapters I was keen to remain without knowing for long enough to let the true stories emerge, rather than look to the literature for confirmation or methods of analysis. It was incredibly liberating when my supervisor asked me to avoid the literature and make my own meaning of the research. This really energised my writing and made the analysis a very enjoyable part of the process.

The position of not knowing for me was exciting and creative but could flip into thoughts of "I'm not good enough". This process seemed to push me into knowing and making sense and then thinking "I am good enough"

Ideological countertransference

When I applied for ethical approval I was aware of my need to give the right answers in order to gain approval. At the meeting the committee were keen to hear of plans and procedures and defined outcomes of the research, more in line with a positivistic philosophy. This experience again seemed to push me back into a preoccupation with these processes and methodologies. This was a useful process and needed to occur for approval, but again did not fit well with a creative method of inquiry that I hoped to achieve.

Also later in the research process, around the time of my internal review I became aware of how much I was focusing on knowing which research methodology I had used and why. Although this is a natural part of the process, I struggled to find the confidence to state my individual method, instead I focused on research literature and methods. I was aware that when I was in a position of being unsure about my knowledge of research, I became more pre-occupied with methods and philosophies. I seemed to use these ideologies to confirm my research approach, enhance my security as a researcher and confirm my beliefs of being "good enough".

Also during the interviews I also became preoccupied with asking the "right" questions in the right way. However I gradually relaxed during each of the interviews

and followed the participants' lead as well as continuing to reflect on my actions, thoughts and feelings during this process.

Fear of negative evaluation, the shame of being wrong or not "good enough"

However, as the meaning of the research was truly my own, I had much fear of negative evaluation from others. I had concerns about being wrong or my thesis not being "good enough". These fears were explored in supervision and also when I presented my findings to colleagues. Although I usually embrace the idea that I am unique and will do things my own way, this was difficult when doing research. I was happier about the content relating to self-injury, but had less confidence in my skills as a researcher. I am also very aware of the dominant "scientific" paradigm and also expected observing others to minimize my outcomes or devalue them. This seemed to link into my internal sense of shame and fear of being a failure as a PhD student and researcher.

This chapter has described the process that I experienced whilst completing this research. I have described the development of a methodological bricolage constructed around a hermeneutic phenomenological philosophy, and the use of critical incident technique, reflexivity and narrative inquiry. Within this bricolage I have described the location of my self as bricoleur, researcher, practitioner and person. I have drawn upon processes of reflexivity to better understand and present the effects of my own experiences on the research process.

The themes used to reflect on my awareness of the research experience of ideological transference, *knowing and not knowing* also emerge in the chapters that

follow. These themes were taken from the client and staff interviews that are documented in the following two chapters; Client themes (Chapter 4), Staff themes (Chapter 5) and then integrated in Chapter 6.

Chapter 4: Client Themes

This chapter describes the main themes of each of the client interviews and then recognises common themes.

Following transcription of the interviews the client themes were analysed. These themes follow in this chapter, supported by direct quotes from the interviewees. Sub-headings were either in the form of direct quotes from the person interviewed, or summaries provided by myself. Any text contained within speech marks, either in the paragraph or sub-heading was taken as a verbatim quote from the interview transcript.

1) Mark's themes

Mark started self-harming at 11 and was now 31. He stopped self-harming 3 years ago, thus he had been doing this for 17 years. He did not want to stop it just fizzled out. He had been working with Ian for the last 6 yrs.

a) Before self-injury – interpersonal issues leading to anger

Mark saw interpersonal issues as his trigger. He attacked a man in the pub because he thought the man liked his girlfriend. He stated that when he was angry with one person he was angry with everyone. So here he described a lack of containment when feeling angry. This anger seemed to be directed at the person in question, then generalised to everyone.

> "I get angry at one person, I get angry at everyone."

At this point he did not talk about self-anger. Initially Mark did not state that he was angry at himself, but later in the interview said he was angry at himself for what he did.

For Mark it was initially easier to express anger at others than to himself.
He stated that he was feeling scared, especially of going back to hospital. So fear and anger were experienced, and he also had an awareness of possible consequences being self-injury. It seemed as though hospital admission was a negative consequence of self-injury for him in the past.

<u>b) During the self-injury- increasing self-anger and keeping safe</u>

Initially Mark said that he did not have rituals, and then said he did.
Mark began his rituals by getting things ready, cleaning and sterilising his tool for self-injury. He choose a piece of glass in this incident. He said that a razor blade was too sharp, too easy. "Sharp but not too sharp". So the self-injury must not be too easy, it needed to be difficult for him.

Mark cut his shoulder in this incident, but would cut all over his body at other times. He stated that he usually cut the top of his torso.

> "Mainly my torso, the top bit, so I can hide it."

This was because he could hide it, but sometimes he got to the point where he did not care and cut his arms.

"I suppose I did it on my arms when I wanted people to know."

At this time he wanted people to see the wounds. So Mark had different functions for cutting and these linked to a position on the body. He clearly wanted to keep the cutting private for most of the time, but sometimes reached the point of not caring if people knew. He did not state that he purposefully wanted other people to see his self-injury.

"I didn't want people to know, I kept it hidden. I was good at that."

He said that he was very good at hiding the injuries. He was proud of this and it seemed to be an achievement for him. He was proud that he had kept a secret. He seemed to feel good that he had the power to keep this information private. For Mark, it was important not to talk about the self-injury and to focus on him as a person. Here he seemed to be hiding the self-injury so that people did not know. Thus the self-injury was intended as an intra-personal coping strategy, but sometimes he said that he did not care where the wounds were. In this instance, the interpersonal effects would be more obvious as he was saying that he did not care if other people knew about the self-injury. So it seemed as though, self-injury could be utilised as a method of coping that was kept private from other people, or it could have been an interpersonal communication strategy, where other people knew about the wounds. This was not described as being intentional here, but as an accident.

Bodily self-control

Mark was in control of his body during the self-injury. The self-injury here seemed to be an effort to take control of his mind by cutting the body. This then resulted in respite of the mind and a body "like jelly". For Mark this was a comfortable place to be.

Functions – management of anger

> "Self-injury was to cope, overdosing or chucking myself off a bridge was to die."

Mark stated that his self-injury was not about killing himself at this time or usually. He also said that he went too far with the cutting once as he was so angry. Here he was aware of the dangers of this method of coping with anger, he could become too angry which resulted in too much damage.

Mark reported that he would overdose or throw himself off a bridge or on a railway line if he had an intention of killing himself. So here he seemed to be saying that if he was aware of suicidal intent he used different methods of self injury that increased danger levels and were more likely to kill him.

> "Just do it! Because I am doing it I get angrier, it helps me cut."

He described a process of increasing his anger in order to self-injure. He stated that he thought, "Just do it". For Mark the act of self-injury was hard to do and he needed

to be sufficiently angry in order to do it. Unfortunately he also stated that occasionally he became too angry to control the cutting. This may then have resulted in severe damage or death that would not be intended. Here the anger and the process of self-injury seemed to have potential to become out of control. A method of regaining control could also indicate a loss of control if the anger increased too much. It seemed that the rituals prior to cutting helped in focusing Mark's attention and anger in a more controlled manner.

> "The anger disappears in a second. Sometimes I feel the cut, not all the time, it depends how angry I was."

He stated that sometimes he felt the cut, other times he did not. The angrier he was, the less likely he was to feel the cut. So the more extreme the emotion, the less likely he was to actually feel the initial cuts. This clearly had safety implications in that if he needed to feel pain, he would need to cut more and need to increase his self-anger to do this. Mark had thoughts of deserving to be hurt, so therefore would need to feel pain at some point in the self-injury process.

c) After the self-injury- consequences

i) Short-term consequences

"Numbness"

Mark said that he felt no emotions after the self-injury. For him, self-injury stopped the anger and fear and resulted in him feeling relaxed. His "anger goes in a second" So here Mark was aiming at numbness. He built his anger to cut and then felt numb. For

Mark, his self-injury stopped emotions and thoughts for a short period of time. It was an alternative to prescribed or illicit drugs that may have produced a similar effect.

"After Sunday lunch feeling" and a "Relaxing Buzz".

Mark described his experience following self-injury:

> "Didn't feel high, just a relaxing buzz"

He would sit and stare at the roof for hours. This "buzz" seemed to give him the numb feeling, which relieved his anger and sadness that he had felt previously. He reported that his

> "Body goes like a jelly"

and he experienced an

> "After Sunday lunch type feeling, zonked in a chair".

So a physically relaxed sensation, a stupor. This seemed to alter his state of consciousness and numb his thoughts and emotions. This clearly was an effect that lasted for a few hours for him. Self-injury here helped distract him from looking at internal experiences and processing them in a different way. It helped him stop the thoughts and feelings and feel more in control of his mind, but at the same time experience a lack of control over his body.

Wound care to avoid NHS care

> "I do my best to look after my wounds, depending on how bad it is. I then go to hospital if I really have to."

Mark said that he always tried to look after his wounds, to avoid going to hospital. He also stated that he often had:

> "Bad wounds as I am not a surface cutter".

Self-care was an important issue to avoid exacerbation of his emotions and low self-esteem. Clearly going to hospital seemed to make him worse. He wanted to keep his self-injury private.

NHS Care – making private pain public.

Mark went for stitches. He said that he felt guilty and embarrassed for up to two days later. This happened to him anyway, even if he did not go to hospital.

> "I was in a vicious circle and just got angry and then after the self-harm I feel down again. I felt I could never get out of that rut."

Here Mark was saying that the self-injury helped him numb the anger initially but then the anger returned alongside guilt, shame and embarrassment. Self injury was a short-term fix that did not stop the cycle of hurt. The hurt does not remain hidden if

the person has to attend A&E. The private hurt became public, so although the person was not isolated anymore their privacy had been lost.

The emotional cycle of hurt

Mark reported feeling sad, then angry and that he self-injured to release the emotions but then began feeling down again after a couple of days. Later the consequences of self injuring for Mark were feeling angry, guilty and ashamed, suggesting that self-injury appeared to have a mood regulation function. This worked initially and then triggered the emotions that lead onto further self-injury in a cycle of hurt. The self-injury here seemed to introduce guilt and shame that were not expressed prior to the self-injury.

Expecting rejection

Mark thought staff were thinking

> "Waste of space, here he is again, wasting our services"

Then he got angry with the staff.

> "I didn't ever really like going to hospital, they are never really sympathetic."

So he expected the people he was seeking help from to reject him. Therefore it made sense that he would attempt to self-care instead of going for outside help. This expected rejection seemed to exacerbate the situation for Mark. He admitted that the

shame and guilt would follow anyway, even if this was an internal expectation. It seemed more difficult for him to have perceived an external reality of this state as well. Following self-injury, for Mark, an internal experience of shame, guilt and self-rejection occurred. If the external reality also confirmed this, he felt angry at himself, but also at the other helpers.

> "No I am not wasting your services."

Fulfilling masochistic needs

Mark thought that causing fights was the only other way to externalise his anger.

> "I want to get hurt".

He stated that people thought he was weird as he enjoyed being punched.

> "Cutting works much better than fighting, it's like a drug".

Needing to hurt was a very strong theme here. If he could not get other people to hurt him, he would hurt himself. If he could not hurt himself he would try to get other people to do it. Either way he experienced a release when he hurt. So although he did not disclose this fully, there needed to be some thought processes around "I deserve to hurt". He clearly did not want to look at this any deeper in the interview and indeed talked about self-injury as an avoidant strategy. The self-injury fulfilled the need to be hurt, where he did not need to involve other people. He thought fighting with others was not as effective as the self-injury, as this relied on other people to get

involved. Because this behaviour was interpersonal, there was also further risk of effects from other people. As people may have thought he was weird for wanting to be hurt, this also had a function of them rejecting him, which further confirmed his negative self-beliefs. Self-injury had the bonus of being a private strategy that he could prevent becoming interpersonal and public and thus remain more in control for him.

Although self-injury clearly helped Mark he did not want others to have a similar experience.

> "I wouldn't wish this on my worst enemy"

So this would not really be useful, even for someone who you really hated. This was clearly an undesirable experience for him, even though it worked and had some positive functions. His self-injury began to spiral out of control over time.

ii) Longer term consequences

"Self-injury was the right thing to do"

Mark did not think he should not have done it. He was very confident that

> "Self-injury was the right thing to do."

So there was no regret about doing it for him. This was the best way he had found to cope with his anger.

"Other people stop you from doing it".

So if you self-injure, other people try and control you and stop you feeling better. So by stopping self-hurt, the staff were actually increasing anger and a need to hurt becomes more powerful. This exacerbated the self-anger and also turned this outwards to anger with other people. This then resulted in his other major method of coping with anger, which was to fight with other people. If he couldn't hurt himself then he needed to get other people to hurt him. So staff trying to externally control Mark's body or behaviours, actually increased his need to self-injure.

Other people's reactions – protecting privacy

> "I don't want other people's reactions."

Mark stated that he did not want other people's reactions. This appeared to confirm that he was using self-injury to gain intrapersonal effect, rather than interpersonal effect. He stated that;

> "I don't get a reaction at the flat where I live with the staff there."

This seemed to prevent the external reinforcement of his internal expectations.

> "I wanted them to look at it like I haven't done anything."

He seemed to want staff to help him keep his self-injury private. He also wanted them to carry on as if nothing had happened. This seems to be a method of external

containment and supported his function of avoidance of hurt or emotional pain. Mark stated that it had not been helpful in the past when people had reacted.
Mark stated:

> "I don't feel as though I can approach other people".

He therefore hid away in his flat. This helped him keep his self-injury private and reduce the negative outside influences. Essentially he was saying that he did not want his self-injury to affect other people and if it did he did not want to know about it.

"You had to get good at hiding self-injury in hospital".

Mark was clear that self-injury became more difficult in hospital settings

> "When in hospital if they found out you would get thrown into a bare room"

This sounded as though this was perceived as a punishment by Mark. So here the reaction by the staff was to isolate Mark if they found out he had self-injured. This was similar to the process described previously where he was "hurt and alone" This reinforced Mark's beliefs that hurt should not be discussed with other people. This then had the function of pushing self-injury back into the domain of a private act, rather than involving other people. When self-injury becomes public, others may assume that self-injury is intended as a method of influencing their behaviour. Here this clearly was not the case, so Mark had to become skilled at concealment. When patients are admitted to hospital they are encouraged to be open about their

problems or illnesses. Here this was entirely the opposite. When Mark tried to be open about his hurt, it seemed that staff could not cope with it.

Protecting helpers and preventing empathy- self-injury as diversion

"I don't think anyone ever did anything that was helpful, apart from Ian."

He stated that even Ian found it difficult to talk about self-harm because he was a man. So an idea that men shouldn't talk about self-harm. Mark stated all the way through the interview that he wanted to avoid talking about self-injury, but here stated that the member of staff had difficulties talking about it. So Mark's self-injury here seemed to have a protective function for Ian and himself, in that it helped everyone avoid exploring the underlying issues. By focusing heavily on the self-injury each time it happened, this could prevent any real empathy occurring between client and staff.

d) Helpful interventions

Making private battles public

"I don't want to talk about what I have done, it doesn't help."

Mark did not want to discuss the self-injury and found that health staff were very focused on this and did not try and get to know him as a person. This also seemed to be a battle of keeping his self-injury private, when staff were trying to make this public. At this point he wanted to push them down and use avoidance as a strategy. So here the self-injury helped everyone divert attention away from the underlying

issues. Unfortunately the staff were trying to access the underlying hurt but Mark wanted to avoid this.

Avoidance/Diverson

Mark stated that it was useful to;

> "Talk about the weather and avoid talking about self-injury."

He did seem to be aware that there were other issues that he had not worked through, but did not seem ready to. He seemed to be content avoiding these and trying to stay in the current situation, rather than looking at the past. Self-injury for Mark seemed to be a coping strategy to avoid looking at deeper issues from the past. This could be perceived by staff as a negative behaviour as clients are expected to be able to make connections to process past issues when staff offer them the support to do this. However previous trauma can be avoided by staff.

"Talk about solutions not problems"

> "You need to talk about solutions not the problem".

Here Mark was focusing on solutions, rather than the pain of the problem. This would work if there were solutions, but not if the solution was to focus on the hurt within. However this opinion would also protect the staff and himself from hearing his story.

Externalising control, achieving endurance and experiencing trust without hurt

Mark really thought outdoor pursuits had helped him.

> "Canoeing, rock climbing, just general outdoor pursuits".

Again here, focusing on an external activity or experience seemed to help. So in terms of the function of the coping strategy, this was the same as his self-injury, but with a different activity that was more socially acceptable. The physical activities here would serve to control his body to the extreme, or to the point of exhaustion, where he may not be able to control his body. By pushing the body to extremes, a sense of inner calm seemed to prevail, or even an experience of his "body feeling like jelly". This is what he described following self-injury.

There also seemed to be a faith here that the endurance test would pass and he would survive. He seemed to learn that extreme emotions would pass if he did not avoid them by giving up. So he learned to focus on the external activity and ignore the internal effects. This was similar to self-injury in that an external focus was the key, but these other activities helped him avoid the internal hurt, rather than being "numb". It seemed that the inner calm following strenuous bodily activity could be substituted for the "numbness" following self-injury, at times. So he was able to learn that you could think and feel, focus on external events and then the internal events become more manageable.

These sporting activities were also interpersonal, he did not do them alone. This was the main difference that seemed to challenge his beliefs about other people. So by

experiencing endurance and achievement in a group of supportive men, he was able to re-evaluate his expectations of rejection, lack of support and trust. He learned that extreme emotions could be contained in a group and you did not have to contain these alone. If you were in dangerous situations you needed to learn to trust the other members in your team to get you all through. Mark was still learning that if you focused on the external the internal experience would pass. By doing these activities Mark had further experiences to tell, a higher self-esteem as he had achieved something difficult and had learned to trust other men to help him not get hurt.

"Get to know the person not just the self-harm"

> "I want helpers to get to know the person not just the self-harm"

By seeing beyond the self-injury, the helper could get to know the whole person, not just their behaviour. However this could also prevent the helper from accessing difficult internal experiences that may have linked into Marks difficult past experiences that he did not want to discuss.

Mark stated that he wanted helpers to

> "Look at the person's strengths and weaknesses, not just their problems"

Again Mark was stressing the importance of attempting to see the person as a whole, rather than just their problems or diagnosis. By recognising strengths, this could help

an empathic, trusting relationship develop. This also had the function of boosting Marks self-esteem, rather than making him feel vulnerable.

Use of Humour

He stated that a sense of humour was important but that it needed to be used in the right way, with the client. A sense of humour could be used to lighten the situation or in avoidance of the painful underlying issues that Mark thought needed avoiding. Funny thoughts could help you deal with a situation in a very different way. Humour could also be used to move on to focus on the person rather than the self-injury. This seemed to support Mark's previous points.

e) Unhelpful interventions

"A fixation on self-harm"

Mark did not like the idea of self-help groups.

> "Because all they do is talk about their self –harm".

He thought that talking about self-harm didn't really help. He thought it was more important to think of solutions. A focus on self-harm and problems was common within health care settings. Mark disliked professionalism, clinical and medical services. He also talked about how he responded to people who were only interested in this behaviour.

> "If people were only interested in self-harm then I did it more, they didn't get to know me as a person"

Self-injury here was used to conform to other peoples perceived expectations of him. Also it was used to mask the underlying issues that he had. It also served to keep the focus on his behaviour and prevent any trusting relationship from developing. It was a self-defeating behaviour in that what he needed was a closer therapeutic relationship, but self-injury served to distance any relationships that he was making. He was also able to provide staff with a problem to talk about and not solve. Mark seemed to be angry with the staff for not being able to help him. He would use self-injury more as this was what the staff were expecting and also seemed to have difficulties with. So here self-injury served the function of expressing anger towards others and keeping them at a distance. Mark needed to cope by self-injuring and the staff needed to cope by focusing on the external injury. All involved appeared to be avoiding seeing Mark as a person, with his internal experiences of hurt, anger and shame.

Mark thought that staff could become fixated on the method of self-injury and the bodily harm and the risk to life. As a result the communication of internal experiences was avoided or overlooked in favour of cleaning and dressing any wounds or damage to the body. In effect the internal healing may have been ignored, as the external healing was favoured. It is clearer to people how to help physical wounds heal, rather than psychological and emotional wounds.

Finding other ways of self-harming

Mark had been to a self-help group and he thought that they had just been thinking of other ways to self-harm, rather than tackling the problem. Again given his ideas that you should not talk about self-harm, this was not surprising. He thought that the

people in the self-help group were setting people up to fail. They were not talking about the persons need to be harmed, just changing the method. This may have reduced some risks, but did not address the underlying issues. By continuing to harm the self, the person would not challenge their belief that they deserve to be hurt.

In summary, Marks stated that this incident of self-injury was triggered by anger relating to interpersonal issues. This anger was initially directed at another person, then generalised to everyone, then finally internalised towards himself. He then described how he increased self-anger in order to self-injure. Fear and anger were present during self-injury, but he used rituals to try and keep himself safe. He thought that self-injury should be a private act, rather than involving other people and did not want to know about other people's reactions to his self-injury. He stated that the more extreme his emotions were prior to self-injury, the less likely he was to feel the cut. He thought that he deserved to be hurt, but did not want to state why. Once he had self-injured, he felt numb, his internal experiences had stopped and he had created some internal space by focusing on his external body. He usually wanted to hide his self-injury and injuries, but sometimes he did not care. He really seemed to want to protect other people from his self-injury and also his internal experiences, thus he emphasised keeping the self-injury private or hidden and also his internal experiences and events in his past. Unfortunately to get medical treatment the self-injury needed to become public which increased his anger, sadness, guilt and shame, although these emotions occurred in due course anyway. He also expected rejection from helpers at this time. He thought that after repairing the self-injury was not a good time to open up emotional wounds. In terms of helpful responses, Mark thought avoidance was most useful and to focus on the strengths of the person and

the solution, not the problem or the self-injury. He also found group endurance sports useful as this enabled him to externalise his control on his body and learn to trust others without being hurt. The focus on the external still helped him manage his internal world. Mark found a fixation on the self-injury unhelpful and employing other methods of harming the self. This had occurred in self-help groups and also from professionals in medical and mental health settings.

2) Mary's themes

Mary had been self-injuring since 14 and she was now 37 (23 yrs). She reported that she was getting bullied at home and bullied at school. Following her first attempt at self-injury she was referred to Child and Adolescent Mental Health Services. She had been working with Steve for 8-9 years.

The first time Mary self-injured was her most memorable time, but did not include her CPN, so we discussed the first self-injury and also the most recent.

a) First time self-injured.

i) Before self-injury: interpersonal conflict

Mary was getting hit a lot at home by her mum and she put her hand out to defend herself but hit her mum.

> "I was feeling angry at what I had done to my mum".

So she was angry with herself for hurting her mum, but did not express anger at her mum for hurting her.

> "I felt really guilty and wanted to hurt myself."

She had big guilt issues, when she actually appeared to be defending herself, this seemed to be underpinned by a need to think about her mother before herself. Mary seemed to feel very guilty about defending herself against her mum. When she told the story it appeared to me as if they had changed roles and she was beating her mum up. So here she seemed to take the responsibility for hurting her mum. By focusing on her own self-protection and perceiving this as violence, the mother's violence was minimised.

Thoughts – subjugation of own needs to protect other people.

> "I didn't want to hurt her, but she wouldn't leave me, I just had to defend myself, you know."

She appeared to be rationalising what had happened but it seemed that this did not really help the guilt and anger much. So she clearly felt guilty about hurting her mum. There was an absence of thoughts about why her mum may want to hurt her. She did not express anger at her mum, only anger at herself. She did not think about how much she was hurt. She then said;

> "I need to self-injure to make it better".

This was very spontaneous and she only sought other methods of mood changing after she had self-injured. In effect the self-injury seemed to be one of her attempts at asserting herself and putting her needs before other peoples needs.

ii) During self-injury "self-injury to stop the internal experiences

> "I went upstairs, got a razor and cut myself"

This spontaneous action seemed to be with no ritual preparations.

"Numbness"

No pain was experienced at the time, due to her emotional state. Mary stated that she did not feel any cuts while she was self-injuring. A physical numbness seemed to have occurred as a result of her extreme anger. This was then followed by an emotional numbness.

Stopping hurt by expressing pain

> "I didn't really feel like it hurt me; it never hurts me because I think the emotional state of me."

So when emotions were high, self-injury was a useful method of expelling hurt.

> "When I'm really hurting inside, the only way I can get a way out is by giving myself a physical outlet."

So for Mary, the function of self-injury was to expel hurt and emotional pain. She was not able to think of other ways of coping at the time. She did not see talking as a method of getting the emotional pain out. She seemed to talk here more about hurting than feeling angry. She could have been hurt that her mum had been hitting her. She did not actually express this and seemed to normalise this experience and focus on her guilt at hurting her mum.

Masking for "respite"

> "It gives me respite in my head; so I don't have to cope with the emotional side of it just the physical side."

Mary was stating that the physical pain was easier to deal with than the emotional pain. By focusing on the external pain or wound care, she was able to avoid her internal experiences. So coping with the physical side of the self-injury acted as a diversion from her emotional pain.

iii) After self-injury

Thoughts

Mary thought, "I've done it" as soon as she had self-injured. It seemed as though there was a sense of relief there, as if this was something hard for Mary to do.

Behaviours

Mary stopped after a couple of cuts.

> "To be honest I didn't do it because the glass was not sharp enough, but someone had seen what I was trying to do".

So someone seeing what she had tried to do had the effect of stopping her. She did not want other people to see this private behaviour.

> "I didn't realise because I thought no-one was around and when I went back to school they took me out of lessons."

Mary had stated that she was unable to find a private place to cut and the witnessing of this behaviour lead on to consequences at school. So here she learned that self-injury had a clear effect on her environment and also on other people, even though this was not her stated aim. Mary stated that this resulted in her mum then taking her to the GP and she signed the forms for consent to treatment. By Mary using self-injury as a method of coping this resulted in external changes and being referred to mental health services.

b) Most recent self-injury

i) Before self-injury: Interpersonal conflict

> "I was going through a really emotional time, stressful time, where I was living."

Visual externalisation to avoid internal experience

Mary stated that she used self-injury to cope with hallucinations.

> "You focus on your emotion, you focus on within and cutting gives you the focus on something else, which is physical something that you can see."

Self-injury appeared to be a method of focusing attention externally when internally Mary could not focus on or mange her experiences. The visual aspect was reported

by Mary as being important here, seeing something seemed to communicate to self and others and it also had the effect of avoidance.

> "You can't see mental illness, and actually having a physical outlet is quite personal; it gives you a focus on being outside rather than inside."

Being outside of the mind, Mary's internal state was avoided or ignored. This seemed to have the effect of respite from internal experiences.

ii) During the self-injury: "respite with numbness"

Mary stated that the self-injury was a distraction from the voices and only reported physical pain afterwards. She stated that;

> "There was no pain when I cut, only emotional pain before."

For her it took 30-60 mins for the pain to start afterwards. So again the self-injury acted as analgesia. It stopped the pain for a short period

iii) Following self-injury

Short-term consequences

Preventing infection by cleansing and feeling external pain

> "When you are cleaning it up, putting water on it to stop it bleeding and putting witch hazel on it to stop it bleeding and things."

Here Mary appeared to use a method to clean the wound that would be very painful. She seemed to link the pain and cleansing action. Traditionally many of our strategies for cleansing wounds are painful, e.g. antiseptics. She stated that she

wanted the Witch Hazel to stop the bleeding, but this seemed to stop the internal hurt by producing external pain. She then stated that the reason for this was that

> "You are dealing with that rather than dealing with the pain involvement"

So here the cleansing process was also helping Mary to focus on external pain. She appeared keen to prevent infection of her wound, but the self-injury also seemed to act as a method of preventing further internal contamination of her emotional pain.

Ritual self-care

Cleansing and dressing the wound was reported to be a distraction for Mary. Although she did not have a ritual before the self-injury, she seemed to have a ritual afterwards. Both types of ritual appeared to be about reinforcing safety, but the use of Witch Hazel emphasised cleansing and further distraction due to the pain of the cleansing process.

Relief from "mental crap"

Following the cleansing she would then have self-comforting thoughts of

> "I've done it now".

Mary expressed a sense of relief that it was all over. So even though self-injury was hard to do, it had helped her. She reported a heightened sense of emotions because

> "You know what you have done".

Mary described a process where she had knowledge of the cuts and that this heightened her emotions following the self-injury. She felt relieved

> "Because you have got that physical outlet, you haven't got the crap that you would deal with mentally"

This appeared to have helped her solve the problem temporarily. The physical outlet seemed to have provided a distraction from her internal world and produced some psychological space. She stated that she saw some of her internal experiences as excrement that she needed to get rid of.

Permission to self-soothe

> "In a way you are looking after yourself, because you have to. You're looking after yourself with the cuts; you're looking after yourself because you've got to keep them clean, sterile and safe."

Mary stated that self-injury made her look after herself when she would not usually be able to. So if she was hurting she needed permission to care for herself.

> "You are almost giving yourself permission to look after yourself, because you don't usually do that, you have to do it."

For Mary, who did not always look after herself, the self-injury forced her to self-care. She stated that she gave herself permission to self-care, when she may have thought that she did not deserve to be cared for.

Cleansing and sterilising to feel safe and protect others

Mary stated that she was also able to keep herself safe. She cleaned and sterilised the cut which she thought would help her stay safe. This appeared symbolically to be what she was doing to herself. By cleaning and sterilising her thoughts about others they needed to be directed towards herself. This then had the function of keeping the other person safe. This could be safer than expressing her anger towards other people, as she did not know what would happen.

Hating the self, cleansing the soul

She then described how she disliked herself when depressed.

> "Sometimes when I get depressed and when I get low and stuff, I don't even want to be in my own skin, let alone look after myself."

For Mary, if she did not want to be herself when depressed, self-injury could help her give herself permission to self-care and self-soothe. Self-injury appeared to function here as a method of cleansing her internal experiences. Mary viewed the skin as an important part of who she was. Alternatively she could have been saying that her skin did not belong to her and the internal experiences were truly her own. If her skin felt alien to her, then she would be unlikely to want to care for it.

Grateful for pain"

> "I am grateful for the pain, it keeps me focused. Oh this is better".

Mary stated that she deserved to be hurt, by feeling the pain this was an external reinforcement of her internal world. She may have been grateful for the pain as this demonstrated a relief that the internal experience had changed. She seemed to get anxious, self-injured and then felt relieved afterwards.

Other ways of coping

Mary stated that she did not know when to stop

> "I stopped and went to bed, took a couple of largactyl, you know, do all the things your supposed to do to cope."

She stated that she was able to cope in other ways following the self-injury, but not before. She described how she was not aware of when to stop, but stopped when intuitively it felt right. It also seemed as though she thought she was not supposed to self-injure. She seemed to think of self-injury as a forbidden behaviour that was not socially acceptable. This seemed to be linked to her families' responses, and also other members of society.

iv) Longer-term consequences

Chastisement

Mary thought

> "I've let myself down, it's not appropriate to cut, or self-harm".

The above statement from Mary seemed to link to judgement, guilt and shame. So these thoughts were not expressed prior to the self-injury but they were afterwards.

The self-injury here appeared to help Mary to chastise herself for coping in this manner. This then seemed to have the function of bringing responsibility and anger back to herself. For Mary, self-injury could be empowering but it also could reinforce some of her previous coping strategies that lead onto self-injury.

Subjugation and justification

She said that

> "Family members take self-harm personally; they thought it was something to do with them"

Thus even here it seemed that the family's needs took precedence over hers.

> "I only do it when I have to do it; I don't it at the drop of a hat, or when I get just a little urge to do it. I do it when there is no other choice, and I need a physical outlet when my heads going to explode or something like that."

Smaller injury to the body was better than her head exploding. There seemed to be a sense of pressure building up within the body and that there needed to be an opening to release the pressure.

"I can't say sorry to myself"

> "I have to apologise to someone as soon as I've done it, because I can't say sorry to myself, so I say sorry to someone else."

Mary stated that she would like to say sorry to herself but could not because she thought that she did not deserve it. Mary's apologising to others seemed to be a coping strategy to reduce the self-reproach and guilt afterwards.

Privacy and responsibility

Mary stated that she did not tell family members and kept the self-injury private. It seemed important that the person she told did not assume that it was all about them and their actions. The family members appeared to feel responsible for her actions, when she self-injured. This process also occurred when she seemed to feel responsible for her mother's violence on the first occurrence of self-injury. She did not talk in any more depth about her family, but she stated that self-injury resulted in other people feeling responsible for her. Her thoughts demonstrated that she felt responsible for other people's actions in the initial self-injury.

C) Interventions

i) Helpful responses

Listening without judgement

When Mary talked about helpful staff she stated that

> "They didn't judge, they didn't criticise, they just let me talk or let me say what I want to say"

Mary's view was that helping her verbalise her experiences was useful.

Validation

Mary stated that

> "They didn't challenge me about it or judge me about it."

Self-injury seemed to help her to verbalise what she wanted to say. Her relationship with some staff really helped here because they all knew her so well.

> "They were supportive you know, like if you need me, struggling? Give me a ring"

Mary seemed to need other people who could think about her and not be consumed by their own issues. For Mary staff needed to be good at subjugating their own needs at certain times to help her.

Ventilation

> "He lets me ventilate if I need to and I can tell him probably something that I wouldn't tell anyone else, as in a professional"

Mary and Steve (Mary's Community Psychiatric Nurse) used the term ventilation. It seemed to mean expression of emotions. This seemed to be a trusting relationship and special in that she would not tell other professionals these things.

> "I know I can ventilate towards him and he doesn't take it personally, even though I'm coming out with some crap. He just lets me get on with it, get over it. He just lets me ventilate and I don't have to watch my P's and Q's with him. I can just be... just say what I need to say" – and not think about his feelings".

It appeared that to have someone who is purely there for Mary's needs was a positive experience for her and seemed to get round her need to think about others before herself. So by the staff doing this for her, this was a very containing role.

ii) Unhelpful professional responses

Judgemental staff blaming patients'

> "The A&E staff just sort of like judge, you know they've been like you know, like you're here because it's your own fault"

This resulted in Mary stating that she did not like the general staff.

Mary did think the staff were helpful if her complaint was a physical illness.

> "If it's about a general problem then fine, you know a physical problem I go down to see them. But if it's a mental health problem I really hate, I cringe seeing the general staff before I go in."

This seemed to highlight a clear split between physical and mental health. So although she was talking about presenting at A&E with a physical issue, she clearly perceived this as a mental health issue.

Mary stated that her other method of self-harm was to overdose. This may have been with suicidal intent or to stop the voices. She stated that sometimes they were accidental overdoses as she could not sleep due to the voices and would increase her medication. This always needed a trip to A&E to get checked out afterwards, where the self-injury could often be dealt with at home as this was not too severe.

"It's just something that you have to do, in order to survive"

> "I used to feel really bad about it. It just used to make the whole problem even worse. Because you have this person who doesn't know what's going on, judging you, like you're an attention seeker, or you are just wasting their time. That's not it at all, it's just something that you have to do, in order to survive and these people are looking down their noses at you like you are something that they have just trod in!"

Mary reported clear expectations of disgust and superiority from staff. She expected this rejecting response from staff. This could be based on previous experiences in A&E or in her life in general. She appeared to have beliefs about herself that she was disgusting and inferior and therefore expected this reaction to confirm her self-beliefs. This could then have been reinforced by any external behaviour of the staff.

This was communicated via demeanour and attitude rather than anything specific that happened. Mary then explained how observant she was. This skill may become a problem in this situation, as Mary may have been very good at picking up on non-verbal communication that the health professional was unaware of. She could also be observing the staff and interpreting their reactions to fit in with her own self-beliefs, or a mixture of both.

Unworthy of health care

This then resulted in Mary expressing the thoughts;

> "I shouldn't be here, I shouldn't have bothered coming down to the hospital, I should just go and not bother seeking treatment."

These appeared to be based on guilt and worthlessness. You need to be worthy to receive treatment or other peoples' help. However she was able to cope with these thoughts.

> "But I always do seek treatment anyway. Well at the end of the day, it's their own preconceptions that are bugging them not me."

This seemed a really positive way of seeing the situation. If the attitude remained in the professional, then Mary could separate herself away from it. Also Mary seemed to

have a strong belief that she deserved to be helped. If she continued with the previous negative thoughts she may have just walked away and not received treatment.

Recommendations for improvement

> "That if its mental health you see a mental health practitioner, first rather than seeing a general member of staff. Because in that way they won't make it worse for the person."

Mary recommended that the triage nurse needed to be mental health trained, at least be psychologically minded and be able to integrate the physical and psychological.

> "I do put a lot of trust in professionals and I've never been disappointed in any way and I think they do a really good job".

This is interesting considering the last few statements about general staff. I am unsure if she was thinking about mental health staff here or all staff. She may have been feeling guilty about saying the above.

So in summary, Mary described two incidents of self-injury, her first ever self-injury and the most recent one. The first was triggered by interpersonal issues and self-directed anger and the second by voices in her head. Each time she was trying to cope with her thoughts and feelings that had become overwhelming. She had a clear thought prior to self-injury that she should hurt and it was a method of putting her needs above other peoples'. She seemed to live her life subjugating her own needs in favour of others. Self-injury for Mary was a method of having an external focus to end her internal experiences. During self-injury she felt no pain and was numb. She described a sense of relief when she had done it. Although she had no rituals prior to

the self-injury, she did ritualistically cleanse afterwards. She used witch hazel to cleanse as this caused her pain and served to prevent infection, but also helped her to continue to externalise pain and distract from her internal experiences. By cleansing and sterilising her cuts and internal experiences she kept herself and others safe. She also used self-injury to protect others from her internal experiences. Mary thought that this was a forbidden behaviour that was socially unacceptable. The longer-term consequences were feeling shame and guilt and directing anger and responsibility back towards herself. She also described needing to apologise to others for her self-injury as she could not apologise to herself. She viewed self-injury clearly as a survival strategy, a smaller injury to prevent a larger injury or death. She kept this private as previously the focus moved to the effects on other people and how they felt responsible for her doing it. She found non-judgemental staff helpful, particularly those who would validate her and help her ventilate emotions, and when she knew they were strong enough to cope. Thus judgemental staff who blamed her for the self-injury were unhelpful. It was also unhelpful for her to think she was unworthy of care.

3) Angela's Themes

Angela had been cutting for the last four years. She had also tried to hang herself a couple of times and overdosed many times. The overdosing was with intent to die, she was unsure about the hanging, but the cutting was to cope with life. She had been a senior staff nurse for twenty-two years and became quite physically ill.

> "I was thirty eight and my daughter was nine. And when my mum died, I was nine and she was thirty-eight. And it just, it just triggered everything."

This resulted in her first self-injury.

a) Initial self-injury

> "It just, made me feel alive at the time. Because I was just so blank."

Angela reported that self-injury was in response to a lack of emotions and reactions and helped her feel alive.

> "I thought it hurts, I'm alive then"

Angela stated that to feel alive was to feel pain.

Ambivalent outcomes

> "And then it just carried on and it got better and better and better."

Self-injury was stated to be a positive experience for her and the more she used it the better it became. This was an interesting idea as Angela also at other times said that self-injury was not positive for her.

> "You know, I don't know, it helps when I'm angry with myself. When there was nothing I could do. I couldn't punch anything, because there was nothing to punch. I'd gone through enough pillows, they said try ripping telephone directories up, but I had none left"

Deserving to hurt

Self-injury was described as being inevitable by Angela as she thought that she deserved to hurt.

> "You know, two hundred different ways not to self-harm, I think I've tried 198, but the bottom line is if you want to, you want to. It doesn't matter how long you try and put it off. If you want it to hurt, you want it to hurt. You deserve it to hurt."

Deserving to hurt was a key issue described by Angela. The other ways of coping she described were based on expression on anger rather than needing to be hurt.

b) Last incident of self-injury

i) Before self-injury interpersonal issues.

"From a mole hill to a mountain"

> "People come out with little tiny comments, that mean nothing to them and nothing, nothing to anybody else and yet to me they are massive."

Angela described an awareness that her perception of the comments was different than that of the person who had said them. She seemed clear that the other person may not be aware of how what they had said affected her.

Thought magnification

> "When they get bigger and bigger and bigger, then I can't deal with them".

Here Angela's internal strategies seemed to make the situation worse. By thinking about what has been said she seemed to make sense of it in a way that amplified her emotions.

The full sponge

> "It sometimes takes absolutely nothing, to drip on the top of a sponge and everything falls out of the bottom. I can't remember the exact incident, why, but I was angry, very very angry with myself."

Angela emphasized that self-anger was a key issue here, not anger at other people. She was describing long –term difficulties coping with emotional reactions.

Thoughts –uselessness and apathy

> "I was useless, I can't even deal with a basic, you know, the basics of living. I can't even deal with my daughter shouting at me, I can't even deal with you know, being upset with me over absolutely nothing. I don't care anyway."

Angela described an initial belief about being useless changing into apathy. This seemed to be an attempt to distance herself from the thoughts that she was useless.

Feelings – self-anger

Angela stated that she was angry with herself. So after hearing small comments from other people, she became angry with herself. There was no anger expressed at the other people for saying these things. Thus the anger became directed inwards rather than outwards to the people who had said the comments.

Ritual – Creative pain

Angela self-injured at home with a craft knife. She had previously tried a razor blade.

> "I have tried razor blades but they hurt. Craft knives hurt, but not the same. They may sting."

Angela stated that she had tried out different methods of cutting to produce the right pain for her. She had access to craft knives as she enjoyed doing art and craft. She described using a knife that she also used when creating something artistic. Although she was ambivalent about the positive nature of self-injury, she was clear that art was a positive activity for her. This was stated by Angela as really useful way for her to express her internal experiences as she found it difficult to verbally describe these experiences.

Keeping private. - "It's just me that needs hurting, no-one else."

She went to the bedroom, with the door shut and something wedged against the door. "Because I don't want anybody walking in". She was really clear that her self-injury needed to be a private experience. It was something that could only happen when she had managed to be free from other people.

> "It's just me that needs hurting, no-one else."

She stated that it was her that needed to be hurt, rather than other people. She also seemed very aware of the potential effect on other people, if they were to be in the house and see her. So even at this point she was also thinking about her other family members and trying to protect then. This then could have the effect of secrecy on the act of self-injury. Other people may have felt her urgency to get them out of the house. Self-injury here seemed to be about having some space away from other people to cope with her internal experiences.

Keeping safe

Angela had a big emphasis on her rituals.

> "I have to have dressings there ready, I have to have a clean blade to use, I have to have a towel, a toilet roll."

She stated that she needed to have something to absorb the blood, to tidy up afterwards. She also described a need for a clean blade to prevent infection. So here this ritual seemed to help her feel safer and more in control. Sometimes this ritual actually prevented her from needing to self-injure.

> "I have to have all these things laid out and then, then sometimes cleaning all the house, stops me from doing it".

Angela said that sometimes cleaning helped her stop the process of self-injury. The cleaning of the blade (or the house) and getting her self-injury kit out seemed to have a distracting and safety enhancing function.

> "Because sometimes I get that far I think, I don't have to. Parcel it all back up again, put it back in the wardrobe, its there, you can if you want to".

Angela reported that the ritual and her apparatus seemed to help her think that she had a choice about self-injury and that she had some self-comforting thoughts that may help her not do it.

> "Sometimes it stops me and sometimes it doesn't, no-ones got to be in the house, the house has got to be empty, it's got to be just me."

Overdosing to die

> "Well I've taken a number of overdoses and people have said to me you don't take enough to kill yourself, so that means you don't mean it, but that's not true"

So making assumptions about intent to die interfered in the therapeutic relationship. When staff assumed that they knew her intentions she became angrier.

"Petulance"

Then Angela thought about the situation from the other person's point of view.

> "And in the grand scheme of things, I understand that, it does look rather petulant, you know, being a little girl, stamping her feet. I can understand why people would think that."

Here she was clearly aware of what this behaviour may look like to other people. So she viewed her self-injury here as an angry young girl, however the staff tended to see the petulance, but in the adult woman. This could be perceived very differently. Angela seemed able to empathise well with the staff as she has also had these experiences.

Transient suicidality

She then discussed the transient process of her intent to kill herself.

> "But at that moment, you've got the tablets in that hand and the glass in that hand, you mean exactly, you mean to die. It doesn't matter whether half an hour later you don't, but at that time, when I had those there, at that time, it was so desperate that it couldn't have been anything else."

There seemed some doubt here. She was clear that this was to kill herself, but in hindsight she was saying that it could not have been anything else, so it must have been suicide. This clearly demonstrated that she has still not been able to fully make sense of what happened, even months later. The statement above demonstrates the passing intention to kill herself. Sometimes the action of taking the tablets could actually get the person to think differently about their situation, an external behaviour possibly influencing the internal dialogue. This transient suicidality could cause problems with other people as they may view suicidal intent as a more stable position.

> "But people don't get that. Because you are like half an hour later you are like oh fuck and then you have to go to casualty."

Angela described becoming more able to reflect on the process and realise what has happened. She stated that she was able to think with more clarity. Staff could often see suicidality as a permanent state, rather than a fleeting state of mind. Judgements are made that if the client is no longer suicidal then they were not before the overdose. Staff can also overlook the shame that a client feels as they did not succeed at killing themselves.

Worthlessness and deserving to be hurt

> "I should hurt, I'm not worth anything, I'm not a good person. I did something a long time ago".

Angela said that because she had an argument with her mother on the day she died, that she was responsible for her death.

> "I can have like emotional brain and normal brain. But I can't get that, that sensible bit to affect the other bit. Well I know it does, but I can't make them, I can't make them join together".

This seemed to be a useful strategy for Angela. She was aware that the emotional brain was not rational. However she was not able to bring the split together yet.

"I must be unlovable".

> "She chose to leave me".

Angela seemed angry with her mum for leaving her by choice and needed to make sense of this by blaming herself, rather than being conscious of her anger towards her mother. If she was responsible for her mother's death, then she deserved to be hurt. "I must be unlovable". If she was unlovable, this may be a reason why her mother "Chose" to leave her.

These thoughts especially had relevance when she was self-injuring or overdosing.

During the self-injury

Exposing internal to the external world – opening up

> "When I start cutting it's always really tentatively, it's like oh no deeper, deeper and only when I've got through certain layers, you know when it really opens up, I think that's enough now. Its very bizarre putting this into words you know."

This demonstrated that Angela had not verbalised this in words before the interview. She emphasized opening her skin up. It appeared that Angela was exposing hurt and vulnerability. She was exposing something that other people did not usually want to see. Most people do not like to see muscle, blood and bone, even though we are aware of what is contained within our skin. Angela seemed to achieve a lot by verbally describing her self-injury, especially what happened during the self-injury. She had explained to me prior to the interview that she struggled to verbalise her emotions and therefore created pictures to communicate her internal experiences to others. Some of these were displayed on the wall next to the room where the interview took place.

External hurt until internal hurt starts again

> "But it's very bizarre, you know like you just want to carry on, until it really, you know hurts there (pointing to sternum), in the middle of your chest. And when it actually hurts there in the middle of your chest, that's when its time to stop"

She stated that she noticed the first little bit of pain in the cut and then went numb. So for Angela there seemed to be a process of internal hurt changing to an initial external hurt, then a sense of numbness until the internal pain in the chest started and then she stopped cutting.

> "And you can just carry on like that. I could do hundreds of cuts, but you only stop when it actually hurts. So you could have, like on my leg, twenty cuts on it, until I actually got that one, when I felt like "that's it".

For Angela it began taking more cuts to get to the pain in her chest and she needed to self-injure more often to get the same effects.

Protecting others from self-injury

> "So it's nothing, nothing like as much as it was. But like when its there, I can't wait for people to get out of the house; you know begging for them to get out of the house, because I've got to. There is absolutely nothing else that can be done."

So self-injury here seemed to take on a secret addictive thought with associated behaviours that needed to happen. Even at this time she was thinking about protecting others and needed to get them out of the house while she self-injured. Angela explained that she only had rituals for the cutting not the overdosing because the intention was not to kill herself, but rather about wanting to hurt herself.

Self-injury to feel emotions and self-injury to become emotionally numb

She started off by self-injuring when severely depressed and could not feel anything. Then Angela stated that self-injury served to help her experience emotions. More recently she said that it was more about numbing the emotions for a brief period. This illustrated how the same method of self-injury can work for the same person in different ways at different times. This makes it important to find out about each time the person self-injures.

Old cuts as quick access to self-injury

She also then went on to tell me how having a cut was also a safety mechanism because if she had one cut she did not need to cut again, but only needed to open the wound up again to hurt herself. So here the process of "opening up" was emphasised.

"I don't like it that I haven't got any cuts."

She stated that she was unsure if she liked the attention she received when she had a cut, but then decided that it was not that.

"And I liked it to hurt. Maybe I'm a masochist."

It is thought to be socially unacceptable to like to be hurt. Other people then struggle to make sense of this need. This can then be pathologised and externalised to the client. It seems more acceptable for other people to hurt us, than for us to hurt ourselves.

iv) After self-injury

Feelings- Buzzy

"I feel buzzy, just like very very very shaky".

This was described by Angela as a physiological effect of self-injury. Here the body being out of control and shaking seemed to push the mind into an altered state of consciousness, where there were no thoughts or emotions, just feeling buzzy. So here again self-injury controlled the body in order to control the mind. This resulted in an altered state of mind and an uncontrolled body.

The shakes

> "Then I've go to casualty and I've been shaking so much, they are like, hold your arm still. Well I cant, why are you shaking so much? Well I don't know, I presume adrenaline. You know you do have this run instinct."

Angela said that there was a sense of not being able to control her body afterwards.

Primal scream

She didn't really know if this was a good or bad feeling.

> "It's like a really basic feeling. Like something real deep inside your body, like a really basic, like a primal scream, you know like that, like that when you hurt, you know and I'm not saying that that's enjoyable."

So a primitive, pre-verbal scream that could not be expressed in another manner.

Release

> "It's just a release of something. It's not necessarily enjoyable."

Angela reported that the self-injury helped to achieve the sense of release. Angela thought this was because she had completed the self-injury.

> "I think that's because you have just done what you have been planning, you've finally done it. But it doesn't make me feel good. I still feel angry, I still feel hurt, I still feel disgusted with myself."

For Angela, the release helped, but the emotions returned quickly afterwards.

"I'm always angry". The self-injury was triggered by anger and this returned soon afterwards alongside disgust and hurt.

Here the self-injury seemed to temporarily produce a numbness but then all the emotions returned shortly afterwards.

Avoiding contact with others to avoid further hurt

> "You sit and wait for the triage nurse, and then, it's like what have you done this time? And then you sit and wait for two hours while you are sobbing your heart out in the middle of a waiting room, while everyone is staring at you and I can never sit down. So I'm often stood for two hours, you know with my face against the wall"

Angela was describing a very embarrassing situation where the staff and the other people waiting in A&E may not have been able to make sense of what was happening to her. This then resulted in increasing anger at herself and also at the other people, especially the staff. She seemed to cope with the shame and embarrassment she experienced here by standing with her face in the corner. This seemed to help her as she could not see other people's reactions to her. She stated that she tended to stand in corners to help her feel safer when was feeling unsafe. This helped her as she could not see anyone, and therefore no-one could hurt her. This seemed to describe a process in A&E where she really did not want her self-injury to have an interpersonal effect, but as she had to come to a public place for treatment, people could see what she had done. This seemed to increase her sense of guilt, shame and embarrassment and understandably her anger at other people for making this happen in this way. "A public humiliation"

Self-anger becoming anger at others

> "Then I'm dead angry with them, because then I'm angry with everybody. Because they don't understand, they don't get where I am coming from. And they ask stupid questions."

So when self-injury moved into the interpersonal realm it had the effect of moving the anger from herself to other people. It seemed that for Angela it was very difficult to express anger towards other people prior to the self-injury.

> "I can understand that they are professionals that are busy and they are bound to think when they have lots of people and they are busy, and they have people who aren't doing stuff to themselves, they get to this stupid women that's come in again with a cut."

Here Angela was expecting this response from staff, but tried to understand their behaviour.

> "I can understand why they would get frustrated. I really can you know, and the awful thing is I was actually that person. I was actually that staff nurse on the ward when that patient, I remember her coming in, for the third time in two weeks with a paracetamol overdose. And I remember being the person saying to her, oh not again! So I've been on both sides of it. I try and keep that in mind when they ask me stupid questions."

These experiences seemed to help her empathise with the staff as she had experienced the same reactions herself. So being a qualified nurse seemed to help Angela, but this may have caused further conflicts for the staff that she came into contact with. She bridged the "them and us" gap. The staff may have got anxious about her being allowed to practice as a nurse. Angela was only able to empathise with the staff later on when she was able to reflect on what had happened.

> "I can't do that at the time, at the time I am usually shaking so much while they stitch me arm up or I am stood in the corner."

Longer term consequences.

Again here Angela stated that her family response was not always good. Her CPN's response was good, but she was really frightened of the A&E staff telling him. She was concerned that he would be angry with her.

Staff superior attitude

When Angela went to A&E the staff attitudes and interpersonal effects then became a problem to her.

> "At A&E you have people looking down their nose at you and you feel like a piece of dirt anyway and then its like, well if you meant to do it you would have taken more".

Staff saying this, were invalidating her attempt to kill herself. There seemed to be an assumption here that people remained suicidal for longer periods and that if you are "serious" you would be dead. Angela stated that she thought the staff made assumptions about people knowing how much medication to take in order to kill themselves. This then resulted in Angela justifying her behaviour to herself.

> "I only have a weeks supply at a time and I take them all."

Angela thought that staff might have judged suicidal motivation on the possible success rate of the chosen method, rather than finding out the processes and

functions of that behaviour. This could have then resulted in Angela's determination to be taken seriously next time and anger being redirected towards the staff member.

> "Well next time I will then, just watch me"

This only served to exacerbate Angela's feelings of anger, worthlessness and hopelessness.

Fear of other people being angry with her

> "He would be angry with me. And him being angry with me would be the worst thing".

After saying this Angela then stated that this had never happened, but she still expected this. This was a constant current expectation with her husband as well, that he would be angry with her. She described a constant need to check out her husband's anger towards her.

Angela was able to describe how Dave (her Community Psychiatric Nurse) seemed to feel

> "He gets disappointed and he gets frustrated and I you know, I can see that in his face when he's like (sharp intake of breath), but no he's never been angry".

She had learnt to focus intently on facial expression in order to try and predict emotions in others.

Recognition of physical pain, avoidance of psychological pain and loss

> "But then most people when you go to casualty just ignore the fact that you have tried to take your life, they just deal with the physical bit of it".

Angela then went onto explain how lovely the staff had been to her recently.

> "And they are lovely, but not one of them said to me you know, did you want to die?"

Angela was saying that it was important to ask her about the intent of her actions and not make assumptions. She stated that the mental health nurse had asked her later about whether she was suicidal or not, but by then she was not suicidal. Here the focus was on the present rather than the past and what Angela intended at the time. By focusing on the present rather than her transient suicidal intent, the suicidal moment was lost and unrecognised. This could then lead the staff to conceptualise the overdose as a method of self-harm rather than suicide.

Containing anxiety and making sense of harm to the self

> "Well I can't even understand it, so I don't expect anyone else to".

Here Angela appeared to be taking responsibility for working out her actions herself and then stated that she should inform the staff of these reasons. The helper may have assumed that the client was "an expert about herself" and had worked out why she had done everything. Unfortunately the reality of the situation may have been that the client was in a confused state and could find it difficult to explain what has

happened and why this happened. The helper had a role of facilitating deeper levels of understanding when Angela had been unable to do this alone.

> "I don't understand why that happens, why you can't, you know, at ten o-clock in the morning, you know you're so desperate that you take a whole load of tablets and by half past ten you think "I'd better go to casualty".

So when Angela was really confused and could not make sense of what was happening to her, how could she explain to the staff. The staff needed to fulfil a containing role that they could listen and explore with Angela to help them make sense of what had happened.

"Worthless with added shame on top" and the shame of not making sense

> "That's the thing and the shame of it all. Just perpetuates the feeling that you are `worthless and then you are worthless with added shame on top"

So it seemed that by taking the self-harm to another and making the process interpersonal, rather than just private, there was a greater danger of feeling ashamed. She seemed to feel ashamed for what she had done, but also because she could not make sense of what was happening to her. This may have been further amplified as she used to be a senior staff nurse and has been used to helping other people. So here self-injury was difficult to makes sense of for Angela and also the staff.

v) Interventions

Things that are helpful

"Caring and firm" helpers

> "The consultant brought me a jug of water and a glass. Just a basic thing, he didn't think twice to even ask anyone else. Caring and firm. You know, not being all dead nicey nicey to the mad patient, but just, come on, get a grip, have a drink, calm down. Just kindness I suppose"

So kindness with firm boundaries was important and just being human and having faith that she would be able to calm down in time.

Being Firm

She thought that everything Dave did was helpful.

> "Even when I don't actually want it to be helpful. Even when he's being very firm and telling me things I don't really want to hear, he's still helpful".

So even challenging her within the right relationship is helpful.

Someone to check out reality with

> "And I trust him. You know and I trust that if he tells me something that I need to stop doing or I need to really work on, then I believe he is right".

Trust was a major issue. She did not seem to value and trust her own judgement.

> "It's just that I can't see it. So I trust that if he says that I need to think a bit more clearly on this one".

Dave seemed to be able to help her judge reality as she did not trust her own emotional reactions. She stated that he may have said things she did not want to hear, but needed to. She initially got angry and explained that;

"I don't care" but then "And then after a bit I calm down and think about it and then when he's gone I think about it some more".

Calmness and Acceptance

"But the fact that he's so calm about stuff, he's accepting even though, he's disappointed and upset that I've hurt myself. He's very; well ok, not great, not the best choice you have ever made".

Angela stated that being calm and accepting was very important even though this may have been incongruous with Dave's' emotions. Subjugation of the staff emotions was a key skill. In order for the helper to be accepting and calm, they needed to be able to control or avoid expressing their own emotions. This clearly would not be the time to share those experiences. Although later on, this could be discussed so that the client begins to trust their perceptions of the staff's true emotions, they also needed to contain these in order to do what was right for the client.

Humour

"And he's funny, very very funny, that helps"

A sense of humour was really important here. This ensured that the unreal elements of the self-injury could be processed in a different way.

"I mean the other week I was talking to him, I was really really low, I head tears streaming down my face and snot coming out of my nose, I looked absolutely dreadful. And I had a load of shells on the table and I looked up at him and he had a shell on each hand on each finger like that (laugh) and I started laughing and he said, see you can't stay sad forever. He just broke the ice."

This seemed to accept her experiences, but also at the right time put some distance between her and her emotions.

Unhelpful interventions

ECT and self-injury stop thinking

Angela had ECT treatment when she was depressed and it really seemed to help her.

> "It's very peculiar, you know and it does disorientate you. Which I think is the whole point to stop you from thinking. Well it worked with me you know. I recon it saved my life at one stage. But like it did just stop everything. Just momentarily while you got it back in order."

Angela stated that ECT seemed to have a similar function to self-injury, it served to stop her thinking and feeling for a short period of time.

"Attention seeker"

Angela said that people thought she self-injured for attention.

> "Just the attitude of the people, you know. Getting told that you are doing it for attention"

This included staff but also friends and neighbours. She stated that she was ambivalent about whether she did the self-injury for attention or not, but she was clear that she was not consciously seeking attention.

> "People still shouldn't say you are doing it for attention". This was because it was a judgement and only she knew why she had done it.

Angela could not think initially of interventions that would change her experiences after the self-injury. Angela just wanted for it not to have happened, demonstrating considerable guilt and remorse, even though it had helped her in some ways.

She was then able to think of some practical recommendations and share them in the interview.

Privacy

> "I think there should be a quiet room that people could wait to be seen".

This could be used if the person was distressed.

> "I've been in casualty when you have been stood sobbing your heart out, against a wall when you have got blood running down your hands. I don't think that's acceptable to be on view".

Unfortunately this idea could also have some problems.

> "Only once have I been offered a place in a room, but I was so frightened at the time I didn't want to go on my own, because I didn't trust myself"

So she thought she may self-injure again.

> "I had everything in my bag you see, I carry it with me because I don't want to leave it anywhere in the house".

Angela stated that she needed to carry her kit with her, to keep her self safe, but also to keep her self-injury kit safe. This seemed to be a safety seeking behaviour. Just knowing it was there seemed to comfort her and reduce anxiety.

Embarrassment and social alienation

> "It's just so embarrassing. People just think you are like this weird woman. I've ended up sitting on the floor sometimes; even though there's chairs I can't sit on the chairs because I am so distressed, I have to be next to a wall. And people look at you like you are mad. It's very strange"

So another invalidating response from other people, "appearing mad" was reported by Angela. This appeared to increase her experience of shame.

In summary, Angela began self-injuring when she felt blank and this made her feel alive. More recently she used self-injury to feel numb and stop her internal experiences by opening up her internal body to the external world. She was also aware that other people did not want to see this. She wanted to keep her self-injury private to protect other people and avoid the interpersonal effects on others. She thought that she deserved to hurt and her incident of self-injury was triggered by this thought following interpersonal issues. If she felt angry with others, this was redirected to herself. During her self-injury she initially felt pain, then numbness and knew to stop when she got chest pain. She also described opening up old wounds to prevent new self-injury. In the short term the self-injury helped her feel relieved, but in the long term, she felt worthless, humiliated, guilty and ashamed. She also expected others to reject her or be angry with her. She would experience this in A&E and then feel angry towards the staff. She found useful interventions sticking to boundaries; consistency of support and a trusting relationship, where she could reality check her

internal experiences. She thought that staff should help the client express their internal world and help them understand what was happening to them. She also thought staff should understand the transient nature of suicide.

The client interviews emphasised the uniqueness of each episode of self-injury. The functions of this behaviour could change at different times within different contexts. The emerging themes that were strongest for the clients helped me to focus on the areas explored in the discussion chapter. In order to see a fuller picture of the interpersonal process in self-injury, the staff interviews need to be considered, thus they follow in the next chapter.

Chapter 5: Staff Themes

This chapter describes the main themes of each of the staff interviews and then recognises common themes. Direct quotes from interviewees are contained within speech marks. Other text involves my paraphrasing what the interviewee said, or my interpretation of what emerges from the interviews. Subheadings are either summaries of interview items or direct quotes from the participants.

1) Ian's Themes

Ian was a community support worker. He had been a residential social worker previously and stated that he had done a lot of short training through the years. This was usually over six week blocks. The training was tailored towards the clients that they were working with. This carer had been doing the job for eighteen years and had worked in this setting for six years. His two roles with Mark were as outreach and key worker.

> "My role with Mark is a little bit undefined. Because of his life circumstances, it was all kind of a rushed move. The care provision that we put together for him was done quite quickly and it was felt, it was based on what he really wanted. This was continuity of support."

So Ian's role changed to accommodate Mark's life changes, rather than him just being referred on to another service and starting with new relationships at a potentially difficult time in his life.

Responsibility for client

Ian regarded Mark as "his own man, he does his own thing." He recognised his role to influence, but that ultimate responsibility was with Mark for his own choices.

> "All I can possibly do is influence and guide. I can't tell him what to do."

a) Before self-injury

Ian recognised that the relationship that Mark was in with his girlfriend was quite "rocky" at times. He also thought that the self-injury was often triggered by relationship issues.

The sword of Damocles

Ian reported a general kind of awareness that the potential was there all the time that Mark may self-injure. He clearly saw this as Mark's "first line of defence", as a coping strategy.

> "It's always a kind of a sword of Damocles so it's not usually a question of if it was a question of when"

He described the self-injury as something that was inevitable. This seemed to help him, as he would not respond in a controlling way to try and stop Mark self-injuring. This thought seemed to help him recognise his emotional reactions without rushing into changing his behaviour. Ian was able to know his own emotions and pause without taking over the situation.

> "It feels really dreadful to be honest".

Ian seemed to feel some impending dread, waiting for something to happen with very little control over it. It appeared that Ian was waiting to respond to the injury. However he was able to cope with this internal experience and wait.

Ian thought that this emotion could be motivational to help re-evaluate interventions.

> "And to an extent it can really quite motivational. If you think of I'm not happy about this situation, so how can I manufacture something that is more appropriate or less upsetting for me and for Mark and less damaging"

The self-injury could be difficult but can be turned into something positive or less damaging to both people involved.

Ian also stated that he needed to try and see something positive in the situation or he got "a bit depressed and hopeless". A really useful method that Ian used was to positively reframe his thoughts, to try and help Mark and also himself. It seemed important here that the helper did not see themselves as being hopeless. He did not see himself as powerless as he was able to change the way he thought about the situation and positively re-frame his thoughts and emotions. Ian was able to manage his own mood, which in turn helped influence his behaviour to remain engaged with Mark. This seemed an essential skill within this relationship.

Self-injury as a block to reflection and metallization in the helper

Ian viewed the self-injury as a constant stress; it was one of his work pressures. He said that it was "quite nice" when it was not there. He also stated that

> "When it's not there is the time that you really notice, that it isn't."

It was when the self-injury was absent there was the time to notice its absence. So it seemed that self-injury could interfere with staff ability to reflect on a given situation. If staff were constantly stressed or responding to crises then it would be very difficult to reflect. This is where time to reflect is essential for the staff to be able to continue engaging with the client. He said that the self-injury

> "Influences your relationship with that person."

b) After self-injury

Not taking the blame/responsibility for the clients self-injury

Ian also stated that Mark could, at times in the past, use the self-injury against him as a weapon to ensure that he also became part or all of the blame, shifting the responsibility and therefore power to the member of staff. This had not happened in the incident we were discussing and also not for the last few years, but did happen earlier on in their relationship. Mark would say to him

> "You've pissed me off it's your fault. You're the reason why I did it."

It appeared that Ian was denigrated and hated, rather than idealised and omnipotent.

Ian stated that he was not on duty when Mark self-injured. But after the self-injury he had stayed in his flat and not responded to staff knocking on the door. The manager had been called in and had seen that he had cut and thought that he needed hospital treatment. Ian was then asked to facilitate this process with Mark.

"Professional and Objective staff"

Mark had concerns about staff attitude in A&E due to his previous experiences. However Ian had taken him to hospital on many occasions more recently and thought the staff were being "professional and objective" He stated that Mark's extreme thinking had effected his perception of what had happened more recently. Mark viewed "professional and objective staff" as a negative experience. This "blank canvas" seemed to facilitate his views that the staff had negative attitudes towards him.

> "He actually seemed to want a massive emotional response. Either an over the top caring one or an over the top angry one."

Ian reported that Mark seemed to be expecting the other staff to fit into one of the polarised positions. Ian also seemed to think that Mark had limited ability to pick up on behaviour cues and link them to emotional reactions and was also angry with himself about this. Unfortunately this also caused concern in the residential setting. Ian informed me that the policy stated that staff need a "flat emotional response when working with people who self-harm" However this policy did serve to protect the clients from receiving a shocked or disgusted reaction. So this neutral stance may be useful initially after self-injury, but then could also be interpreted negatively by the client.

<u>c) Staff coping strategies during and immediately after the self-injury</u>

Derealisation, depersonalisation and producing an emotional void

> "I'd kind of learned to switch myself off at this point."

This seemed to be a skill that Ian had to develop in order to continue in the therapeutic relationship. He stated that, as he was not good at seeing blood he had to find a way of coping with these images;

> "I've found that the best way is just to switch off and treat it as a thing" "Not an emotional thing but just a thing. So as far as I'm concerned it's just a piece of meat."

He seemed aware that this was an awful thing to say, but this was one of his strategies to remain engaged. Here Ian was able to express shameful thoughts that he had and did not criticise himself for thinking them. These thoughts, although difficult to express as a professional, had a function of preventing the recognition of the horror of the damage of the self-injury. The alternative would be to think;

> "That's really going to hurt, that's horrible, Jesus that's muscle under there."

He then stated that he would not be able to hide his emotions. So he described a process of cutting off from his emotions to cope in the "here and now" but later on he would often have a "kick back".

> "I just a have a period where I kind of fall to bits a bit. I have to just let it out somehow. So I kind of pretend it's not happening but somehow or other I have to deal with that bit at sometime, but I'm not dealing with it now."

It seemed that he was able to enter the emotional void to survive, but also knew that he would need to get back in touch with these emotions at a later date in order to survive. He appeared able to think of the wound in isolation and then return to viewing Mark as a person.

Hasn't he got any mates? (Crocodile Dundee)

> "I'm going to get on with this and do what I have to do and then later on when nobody's watching, I'll just have a blubber"

Ian quoted from the film Crocodile Dundee to emphasise the role of friends.

Ian also stated the importance of a friend who he meets in the pub to do an informal reflection and expression of emotions. This friend was carefully selected as someone who also has a traumatic job witnessing visually traumatic images in rescues. He also explained negative consequences if you spoke to someone who did not understand your job and that was too emotionally close to you.

> "He is like a useful sounding box, he's totally non-judgemental, I can say exactly what I feel, and it's pretty cool. And I think I fulfil the same role with him."

For Ian reciprocal roles seemed to work here as well. There are clear links here with clinical supervision, especially around peer supervision with someone away from your work area.

"Crap Jobs" for good people

Ian's stated that his role in this incident initially was to facilitate a visit to A&E. I asked him how he felt about this role. He stated that he was not surprised and it was probably the best decision.

> "It seemed that I was the most effective person to do that."

He reported that he also understood why the decision had been made and that other people had tried.

> "So yeah you have to be as professional as you can and just treat it as a job to do. Just to figure out the best way of achieving it. "The job was get him to the hospital, that's as simple as it gets"

He then described the use of a problem solving strategy to achieve this. There also seemed to be a sense of achievement and "specialness" here, as he was the only person that could really do the job. This seemed to have a positive effect on his self-confidence, especially as he was the "closest" to the client.

d) Interventions

Surviving Trauma Together

Ian thought he had an influence on Mark and had helped him. This in turn seemed to have strengthened the relationship. He had also managed to find his own methods of coping with the process of self-injury and not rejecting Mark.

> "We'd been through an experience that was fairly traumatic together and it was another thing not to talk about."

It seemed to be about surviving trauma together, which usually would not be discussed in detail with Mark after this had happened. This linked clearly with actual experiences of adversity in that people find a way to cope and then push the emotions down and do not talk about it. Self-injury here seemed to act as the traumatic experience that both parties were involved in at some level. Each person needed to find a way of coping to survive this trauma. There are links again here to

how people cope in abusive situations and how they would not usually talk about what has happened later on to the abuser or anyone else that could change the situation. However in this case, Mark was not alone in his traumatic experience. Ian was also traumatised and had to be able to cope to help Mark survive. It seemed that they needed to find a way of coping together that helped them both.

Accepting Failure

> "Previously some of the ways he did things were a test for staff. Kind of artificially made or created situations which were bound to fail, to be honest. Just so that he could say that you had failed."
> "So he could say, that's what always happens"

Ian stated that this then helped Mark reinforce his vision of the world. If staff have a low self-esteem or self-doubt then this would assist in disengagement or rejection.

> "So it was fairly important to me that I didn't fail a lot of the time".

This is important as Ian clearly recognised the self-fulfilling prophecy that had been set up by Mark. However he was also able to hold onto the idea that he would fail sometimes, but he stated that the therapeutic task was to try and show Mark that they could both succeed. He saw this as a negative side of Mark that was really important to get past. This could really interfere with the helping relationship.

"Bypassing failure"

> "And it is a question of getting past it. Not destroying or devaluing it, but needing to get beyond it, just so that you can forget it, you don't need to

> bother with it. We've played those games; now let's play something much more interesting where you win all the time."

This seemed a really useful way to conceptualise the recovery process. Mark appeared to be stuck in in a "game" that was confirming negative beliefs about self, others and the world. The challenge was to collaboratively find a new game that Mark and Ian could create together that was less negative and would challenge these problematic beliefs.

Discussing conflict

> "That was one of the times in our relationship where I really put my foot down. And said basically if that was the case then we would finish the relationship, because I didn't want to have that responsibility. So I said that I would just walk away. So I took what he said at face value, I took what he said as being absolutely true and said if that's the case then I had better get out."

Here Ian responded by clarifying boundaries and his aims for the relationship.
He picked up that Mark was shifting responsibility and that he did not want to take this on board and be blamed. It appeared that by clearly defining boundaries he was then able to keep out of any possible re-enactments of previous relationships. Here he seemed able to take himself out of the persecutor/victim relationship (Miller, 1994). He was also encouraging Mark to keep his own sense of responsibility and power. This appeared to result in Mark backing off after the confrontation as he seemed to realise that Ian did not want to hurt him.

Conflict resolution

Ian stated that he felt as though "the air had been cleared". So he had helped Mark keep a sense of responsibility and with some of his power and influence and they

managed to continue working together therapeutically. He then explained that he really did not like having a confrontation with Mark, but that it was a "a necessary part of any relationship."

Ian said that it would usually be him that would have to bring the conflict into discussion with Mark in order to clarify issues. This either came from Ian himself or from his manager.

> "Can you sort this out, can you find out what's been happening."

This had become more of an issue recently.

> "Certainly when I first started to work with him, it took a couple of years before I was remotely in the position where I could confront him at all about anything. And to an extent, the fact that I can, I tend to see Mark as making progress."

This can be quite a common position for the primary helper to be in. If the client is perceived as fragile and possibly explosive, staff can feel as though they are "walking on eggshells" and not want to confront them. If they do confront them they can feel responsible for the methods of coping with this stress. So staff emotion and thoughts could assist in staff avoidance of conflict and this then would reinforce the clients other methods of dealing with conflict. An alternative approach described here was for Ian to manage his own moods and then not re-enact previous abusive relationships with Mark.

Reducing polarised thinking or splitting or failure to mentalize

> "He'd dictate what he felt was his view of the world and he was very loathed to take on anyone else's. And that's changed. We're not actually there yet, but we're on the road."

Ian explained that Mark had very polarised views of other people and the world and that he could not necessarily take on someone else's views of a given situation. Ian also stated that he saw Mark's ability to now discuss conflict more openly, as clear progress.

> "It's not just black and white there are a lot of shades of grey in between."

Ian reported that by discussing these conflicts he thought that Mark was more able to listen to another's point of view and re-construct a more balanced or less extreme view of the world. Here Ian also located recovery as a process with small steps and that Mark was on this road. This then helped Mark avoid polarising his recovery.

"Fantasy replaced by reality"

Ian said that as Mark had large gaps in his life that he could not discuss, he sometimes got into expressing an alternative life that was not based in reality. Ian informed me that as he had an interest in outdoor pursuits, Mark began to state how good he was at "survival in the outdoors". Here, Mark seemed to have a polarised view of Ian.

> "He saw a person who liked outdoor pursuits as a rambo-esque figure who wanders around the woods with a big knife."

It seemed that by Ian being able to show vulnerability and state that he could not do some of the activities that Mark was claiming to be able to do, they were able to learn from each other by doing outdoor pursuits. In this way Ian was a good role model,

able to show that he could learn from others. This also helped to re-distribute the power-base.

Ian reported that Mark was able to learn to read a map and a compass and had a real sense of achievement. Ian stated that he was able to organise with friends various projects and holidays where Mark felt a real sense of achievement and recognised additional strengths. So "fantasy was replaced by reality".

Small teams of staff

> "One thing that seemed to help was when we minimised the amount of staff involved. Certainly the amount on the exterior and to an extent, to be honest, the clinical involvement as well".

Ian informed me that psychologists, psychiatric nurses and community nurses, and psychiatrists were not really needed by Mark. He reported to Ian that he only really focused on his problems with them and did not come up with any solutions.

> "But there was something missing that wasn't quite working and that something was a meaningful relationship".

Ian stated that this was eventually formed with him. He explained that staff had been informed of the destructive nature of Mark and therefore was recommended to "keep him at arms length and not get involved" This appeared to have the effect of working against any staff being able to build a close therapeutic relationship with Mark, which was exactly what he needed. Ian explained that he needed to know what had happened previously with other staff members and that this helped him avoid the "emotional roller coaster".

> "But I think overall, once we've got, once we kind of got past that and we had established a core set of staff who understood the client and were not judgemental and didn't particularly want to play the mind games any more. And he actually trusted enough to see...that he actually wanted help".

So there seems to be an understanding of how Mark had experienced other professional relationships before, but that he now became ready to engage with this team and specifically Ian. The non-judgemental staff team really seemed to help the client trust them enough to look towards self-discovery.

Creating and focusing on the "new game"

> "Once we had formed a therapeutic relationship and basically got rid of the distractions, because that's what they were becoming, then once we had figured out pretty much where we wanted to go with this, we all decided we didn't want to deal directly with the self-harm."

Ian talked about the old Mark who was deemed to be "manipulative, egotistical and a fairly unpleasant person.

> "At that time the staff thought that if they sat down and talked about the self-harm that he would do it more often."

This was also actually supported in Mark's interview. Ian explained that staff were aware that Mark would use self-injury as a threat, a type of "emotional blackmail" They did not want to get involved with this as it seemed to make the situation worse.

> "We didn't feel confident that we could deal with that, we didn't feel that it went anywhere". "We wanted a new game".

Outdoor pursuits as a "new game"

> "I kind of thought to myself that one of the biggest problems was Mark's self-image, self-loathing if you like and his anger, his anger in a word, the red mist. He was pretty much angry at everything. The responses he was getting from established services weren't actually helping, to an extent they were just feeding him and making it worse. So we decided that outdoor pursuits, climbing, canoeing, surviving, going for walks, was an approach which may work. This could give him some real and valid experiences."

Ian then described an outdoor activities holiday he had taken Mark on and how he had learnt about being in a small supportive group.

Learning to trust and value other people

> "A golden rule is that you mustn't get hurt because you are in the wilderness there are all these issues about, so you tend to look after each other".

Ian reported that Mark experienced unconditional support from these men that he had not met before.

> "Just because you are there you are part of our group that means you are important and I'm going to look after you".

This was an aspirational activity, a challenge. Ian said that for the first time Mark seemed to see people for who they really were, rather than the expected stereotypes.

"Going beyond the comfort zone"

> "It certainly pushed himself physically, beyond his comfort zone. Well beyond"

Ian informed me that he was also able to use the difficult times within the sporting activity to help Mark recognise his ability to deal with extreme life events. They were then able to reflect on his endurance to survive the event when he was thinking about self-injury in the following months.

"An endurance test"

> "I said because when you think it's really really crap, this is crap, it's really hard and he was not happy, afterwards the rush he got from that was just incredible."

Ian reported an incredible sense of achievement and an ability to reflect and use his ability to endure and survive. Although self-injury can have the function of avoiding inner experiences by focusing on external activity, by enduring extreme physical activity it appeared that Mark learned to endure extreme outer and inner experiences without self-injuring to try and control them. It seemed important here that the intervention linked the outer and inner experiences, as self-injury did. It seemed that this endurance activity served as a container rather than projecting issues on to others, Mark was able to cope himself with the help of others in a trusting relationship.

Bearing adversity and having faith in the future.

> "I think a lot of the time with Mark he simply didn't understand what was going on and he needed that explaining to him. You really need to explore it enough to find out."

Ian stated that he needed to be able to rationalise it and then put it in its place. "This is crap but it will finish and then we will feel better about it".

> "So even though something is really bad now it might not be tomorrow, particularly if we deal with it, if we fix it. And I think giving him the tools to fix stuff is the key thing really."

So tools to fix and feel empowered again were favoured, rather than having limited coping strategies.

An indirect approach of change

> "The key with Mark was an indirect approach, because the direct approach seemed to be far too confrontational. The key to it seemed to be spending enough time to actually understand where he was, what he understood, how well he understood it, what kind of ways he had coped with things in the past and how could he change that. Over a period of years, if you have got the luxury of time, theoretically you can actually influence, you can change people."

It appeared that within these services, the longer-term interventions were commonplace, where as in many mental health services the emphasis seems to be on short focused interventions. Such short-term interventions do not allow for the relationship to develop and get beyond the problem or illness, to see the real person.

> "We are particularly lucky that we spend so much time with clients or potentially can spend so much time with clients that we can maintain that

> process as an ongoing thing and constantly adapt which is the key to working with client, because we did need to change and adapt."

Here Ian emphasised being creative and flexible, if something clearly did not work, to change strategies.

> "Basically we wanted to keep moving down the road. If we suddenly found we had stopped or diverted or, got stuck in a traffic jam, we would do our best to try and change things to move on. We did have some casualties on the way and we did have some strategies that didn't work. Basically revolving around issues that Mark didn't want or was unable to discuss with us. I think things that were quite personal to him and they still are. There are still areas that we kind of avoid speaking about. In the same way that we very rarely speak about self-harm".

Avoidance of other life issues and self-harm itself seemed to really help here. Mark seems to have dramatically improved and is in more control of his life. Clearly here Mark began to see himself purely as the self-injury (as staff seemed to as well) this in effect masked the underlying issues and the main therapeutic task of maintaining a positive longer-term relationship.

> "But we couldn't possibly with the best will in the world fix everything. We can only fix the bits we can fix. And if that gives someone a better ability to deal with stuff, we can say we have done a good job"

This is a refreshingly honest approach to helping from Ian. He reported that Mark was able to achieve a sense of pride in his life and build his self-esteem.

Maintenance work

> "But this is very much a work in progress. This process needs to be maintained and I think there is a temptation to kind of draw a line under things possibly too early. And say yeah that's all fixed now, you can go away. And it all just goes wrong."

Ian emphasised the maintenance role. He explained that this could be done by other people, non-professionals, self-help groups, "train spotters", sporting groups, the aim being to just maintain that trusting relationship with the client.

Ian reported that drug therapies were not seen to be very helpful for Mark. He stated that individual therapy with a psychologist was also not reported by Mark to be helpful.

Ian informed me that clients with a personality disorder label often ended up hating their psychologist or psychiatrist and thinking that they did not listen to them. He also suggested that clients often wanted a "magic key" to fix all their problems

> "I think the small interventions are sometimes valuable, but overall, there has to be an overall plan and a strategy for where you are going and what you're aims and objectives are. And those are largely written by the person you are dealing with".

An emphasis on true collaboration in co-designing any help.

> "I'm quite happy to learn and adapt with them. You have to not have pre-conceived ideas as well. I suppose taking people rock climbing isn't going to work for everyone. Writing poems might work, art, anything, its just finding what it is. Giving people self-worth, giving people a real achievement, that they have achieved and making sure that that happens. That they don't fail, failure just reinforces. That's where the risk comes in, you have got to be sure that you are taking the risk that they are not going to fail. The client is an individual and our approach is based on the fact that he is an individual. So anything you pick up about what we have done with client is really specific them"

2) Steve's Themes

Steve was a community psychiatric nurse. He had an RMN, a BA in economics, an MSc in practitioner research, a certificate in CBT, a certificate in experiential counselling and a further adult education teaching certificate. He was also five years into his Doctorate. He stated that he was a Community Psychiatric Nurse and care-co-ordinator. Steve stated that he was not responsible for Mary's actions at all. He did however recognise his influence on her, as she made these choices within a social context which he was a part of.

a) Following self-injury

Steve stated that Mary got quite embarrassed about self-injury. She informed him after the event. He was only involved almost immediately if she took an overdose and was admitted to hospital. He thought the more recent self-injury had been triggered by interpersonal relationships, with her feeling angry and frustrated when things went wrong.

Prior to the self-injury Steve stated that he did not notice any changes or feel any differently than normal. He explained that her mood often fluctuated, but he was not aware that she might self-injure. He clearly described not becoming more anxious as he was unaware that she was at further risk of self-injury. This seemed to link into Mary's impulsivity prior to self-injury. Steve stated that for her the self-injury was not planned or ritualised and he had picked up on the lack of an increase in anxiety levels for him prior to the event.

Steve stated that Mary used to self-injure a lot more but that had reduced in more recent years. This also seemed to have a calming effect on him, in that he could see that she was in the recovery process.

Surprise

Steve stated that he felt surprised about the self-injury, as there were no apparent changes prior to the incident.

Making sense

> "Why this time, what was different?"

He then began trying to gather information about what was different this time. His expressed thoughts in the interview were clearly linked to specific interventions that he could do with Mary. For his work with her he stated that he did not feel a failure as they were getting on well. This overall sense of achievement seemed really important to survive the other problems along the way.

Curious thoughts exploration of events

Steve informed me that he reviewed the events leading up to it and what was happening. Here he seemed to be acting out his initial thoughts "why this time, what was different?"

> "I tried to go through those things with her and get a handle on what she was thinking and how she was feeling"

It seemed a response here was to find out more information about what was going on prior to the self-injury. So Steve was initially in a process of knowing more.

Calmer reactions with less severe self-injury and an overall sense of recovery

Steve also stated that he felt differently with Mary than other clients he worked with who self-injure more severely. He explained that she cut less severely in safer places.

> "So it really isn't at all, like, kind of like, self-mutilation or attempted suicide. It really is for that release, cutting herself."

So here Steve viewed Mary's self-injury as different from self-mutilation or suicide and as a method of releasing tension. It was not perceived as severe enough to be life threatening. This seemed to help him remain calm

As a result of this he was less concerned about her and her safety.

He wanted to

> "Steer her back to the distractions she has adapted for quite a long time other than cutting."

So an important intervention here was to distract her away from the self-injury and to help her cope in a less destructive way. It seemed that by helping her do other things to cope, the self-injury gets utilised less often. Here Steve was using a clear behavioural strategy focusing on external experiences rather than internal experiences.

Increased risk involved increased self-doubt and emotions

> "And you do question yourself because of the risks involved and you can feel a failure if things you put in place still hasn't worked."

It appeared that with people who increase the risk of injury to the self or death, Steve was more likely to feel extreme emotions and self-doubt.

Long-term relationship

> "But with Mary much less so, because I've known her for a very very long time".

So here it seemed that the length of time seems to help him not to react in an emotional manner. The nature of Mary's self-injury also helped him not to be too concerned about his abilities as a helper. In addition to this he stated at that time their relationship was going well.

Doing the job well

> "At other times it was strained and therefore if something happened in the context of me not being able to engage her adequately in services, or with me, then obviously I would see it as a failure on my part."

Steve stated that he had done his job well and therefore did not feel a failure with Mary.

> "I had been doing enough at that time, yes. We were really getting on well you know. The relationship was good, I'd been supportive."

Steve stated that the relationship was good with him at this time. He seemed to see his role as achieving this relationship, but also helping Mary to engage with other services.

> "She'd actually been engaging with a psychologist as well and all sorts of user boards, trust groups and various other groups she's took things up and so the context of her package of care is very supportive and very progressive at the moment. But we still can't prevent her mood fluctuating"

So even with this support, Mary's mood was still fluctuating and this was triggered by her relationship with someone else. It seemed that the self-injury was prompted by interpersonal issues. It appeared easier to work through interpersonal issues that Mary was having with someone else, rather than in the nurse-patient relationship. There was no discussion of the type of issues here with this client. While the conflict was outside the therapeutic relationship, the helper can avoid responsibility. This is much harder within the relationship between Mary and Steve.

"Dichotomous thinking"

Steve stated that a key issue for Mary was her

> "Dichotomous thinking, it came out this morning and that's the way she thinks. People are all for her or against her."

Steve stated that extreme thinking about others causes clear problems for Mary. This then seems to lead to anxiety in other people. Although Steve did not express anxiety directly related to the specific event, he did recognise the following interpersonal process at other times.

"Walking on eggshells"

> "When her mood begins to drop, she first gets irritable, very brittle and people, oh it's a classic thing, its walking on eggshells and other service users aren't skilled in doing that. And so that causes problems. Sometimes other service providers aren't good enough either."

Steve stated that when Mary's mood changed, other people around her felt like they were walking on eggshells, this seemed very tense and with a large concern that at any point you could say something wrong to her. Steve seemed to be referring to the staff managing their own emotions at this time, although he did not define what the skill actually was. So here a process is described where the client experiences an external event and then processes this by thinking in extreme ways about other people and themselves. This then seemed to result in a fear from others that they would do something that would "break the eggshells", a sense of treading really carefully and observing everything. Anxiety levels in the observer have then been considerably raised, but they are uncertain what to do next. There also seems to be an inevitability about breaking the eggshells; it's just a matter of when this will happen. This seemed to link with the "sword of Damocles" experience described by Ian.

Breakdown of other helping relationships

Steve stated that untrained helpers would have had more problems with this anxiety than qualified staff. He then described how Mary had experienced problems with a variety of other helping relationships and then had moved onto another service.

> "She has accessed every service possible around here, but she's still with us. And that I think is because we are trained, skilled, where as some of those

> people that work in other agencies don't have the same level of training or experience"

Steve explained that trained and experienced staff were the people who this client needed. This is an interesting point in that often nurse training does not include training on working with people with a diagnosis of "personality disorder" or self-injury or interpersonal processes of this nature. Steve describes a sense of security following his training and gaining qualifications.

b) Interventions

Small teams

> "She has a kind of love hate relationship with the crisis team and the A&E CPN service. Because that's a service that's evolved, it was smaller and when there was only one or two people they knew her well and she was really comfortable with them."

Here a small team approach was emphasised by Steve, however he stated that the team grew and this became a problem.

> "But in a bigger service, its more people, she knows them less well, she trusts them a lot less and so her relationship is more strained."

In addition to this the staff member thought that by increasing the numbers of helpers in a team, this would increase the likelihood of negative attitudes towards people with a diagnosis of personality disorder.

> "They seemed to be very supportive, visiting her every day and reviewed her. And stabilized her"

After this Mary referred back to Steve. Here he increased support by different people when in crisis and then back to Steve when she had improved seemed to work well.

Self-injury to manage relationships

Steve explained that Mary was able to terminate the relationship she was having problems with prior to the self-injury. So here Steve thought that one of the functions of self-injury was to manage relationships.

> "I think she felt let down. And I think that he's someone that she has known for a very long time".

Steve thought that it was important to discuss with Mary about how she felt in this relationship.

Unconditional listening

Steve reported that a positive method of coping was also for Mary to be able to say anything to him and him not reject her. Steve and Mary both called this ventilation.

> "She knows I'll take any thing and there will not be any consequence you know"

This seems to be a really important containment function. Mary needs to feel that she is accepted without judgement and that she is able to verbalise emotions and thoughts without being rejected.

> "I don't mind letting her ventilate, I think it's safer if she does it with me".

So a useful intervention is to find someone who is suitable to do this with. The use of the word ventilation is interesting as this is used to air her internal experiences. It is also used to save lives and Mary perceived her self-injury as a method of suicide prevention.

Reflection on day-to-day experiences

Mary was then able to cope with her relationship with this person without rejecting them because she felt betrayed. Steve said that this was a significant improvement and movement away from dichotomous thinking.

> "So I use the day to day experiences as therapeutic learning for her and she is much further on now than she was a few years ago".

So again this suggests an ability to reflect and measure change.

"Containment"

> "It's containment. It's all about the strong emotions, the ones she can't really hold in herself. That led to either her lashing out at people usually verbally or lashing out physically, because she has cut"

Steve explained that by containing and expressing emotions with himself, this prevented further verbal or physical violence to Mary or others.

"Ventilation"

> "So its about putting that kind of containing structure around her that allows her to access people, to ventilate, to feel safe, supported, so that she can let the emotion dissipate".

Steve stated that this could happen with different professionals.

"Just be there"

Steve had informed me that he had written an article about patients with a diagnosis of borderline personality disorder.

> "They didn't particularly want anybody when they are an in patient or in A&E service to sit down and go through an hours therapy with them, but they needed someone there for five or ten minutes, just to give them that kind of like, listen to them, to ventilate or support them in some other way, just to be there."

The important issue for Steve was about being present for Mary without judging or rejecting her.

Safety in a crisis

The additional input from the crisis team seemed to help as Mary needed "to feel the service will respond when she's kind of in crisis". Again this is a testing of boundaries for her to feel safe enough.

"Support and nurturing" to avoid rejection

> "The service won't abandon her they will do the opposite, like come in and support her. It gives her that kind of, that's what she needs, that kind of support and that nurturing, not abandonment and not being ignored".

Steve reported that a responsive service in crisis was important and a service that will not ignore or abandon Mary.

Avoiding "rescue mode"

He stated that;

> "There are some people that you kind of get into a rescue mode with, and there are some people that you are really worried about."
> "There was this one woman who was quite at serious risk of killing herself as opposed to just self-harm."

Steve seemed to be stating that a lack of experiencing fear about loss of life helped him to contain issues when he was working with Mary.

Apologies for needing support

Steve talked about how Mary sometimes apologised for contacting him for support.

> "Sometimes she will do that and apologise and I don't want her to do that, I don't want her to apologise, I don't want her to feel guilty or feel desperate because she has contacted me, or that she's been bad or done the wrong thing".

This was quite an emotive response. Mary's coping strategy of apologising to staff seemed to be difficult for Steve. This may be about being angry with previous people in her life who have made her feel worthless and need to apologise to others for needing help.

Humour and being human

Steve also stated that he used a sense of humour with Mary a lot

> "That's why I use a lot of humour with her, cos I think as long as you know the person, you know where you can go with it. And it is appropriate".

This was an important intervention for Steve.

> "I know I can use it in a way that subtly kind of make her catch onto herself and say, look don't worry about that and then we have a discussion about what has gone on".

Professional training can often result in very serious, humourless interventions. The clients in this study wanted to get to know their helpers as human beings and really appreciated the sense of humour of the carers.

Staff perceived negative evaluation from client

Steve also expected Mary to negatively evaluate interventions a lot more than she actually did. This seemed to be a similar process to the clients interviewed, expecting others to negatively evaluate them in A&E. Although Mary evaluated some other interventions negatively, this was not associated with Steve.

Staff need to be proactive in conflict resolution

Steve thought that staff should intervene when clients are having conflict. He had supported Mary to make her own decisions about how to challenge this decision and whether to complain or not.

He also described events where other staff had challenged her in front of other service users, rather than separately. This challenges the therapeutic community type approach that is reported to work well with clients with personality disorder. Although this setting did not appear to be a therapeutic community, this is one of the underlying key concepts, that people are challenged within the group, rather than being split off.

> "If they criticise her it really reinforces all of that low self-esteem issue she has and that then means that she finds it difficult to continue in that group with all of the residents or clients".

It seemed that this has often resulted in Mary leaving the service and moving on to another, rather than being able to work through her conflicts. Here Steve seemed quite protective of Mary and had clear ideas about how other helpers should behave. This can then develop further into judgemental ideas about other helpers and a splitting of the team may occur. However this was not described here.

Acute mental health ward better than life at present

Steve then discussed other people's assumptions when working on an acute ward, he would ask the judgemental staff

> "Why are they here then? You know, would you want to be here if you weren't being paid?"

He informed me that he tried to use their empathy to understand how desperate clients may feel. He talked about acute wards not really being pleasant places to be. However he explained that the client's level of distress in the outside world can make an acute ward better than their life at that time.

A social exclusion "Badge of honour"

Steve also spoke about other community mental health teams having a "badge of honour", where they will not work with people who have a personality disorder. However, he thought that they really did engage with these people but did not accept that they did, in order to make themselves "more pure".

<u>3) Dave's Themes</u>

Dave was a CPN His qualifications were RGN, RMN and he had also completed the ENB998. He stated that he was the Care co-ordinator and Community Psychiatric Nurse for Angela. He stated that he was not

> "Responsible for her actions, but I would be the first person that the courts need to speak to if anything goes wrong".

Dave was very aware of how he needed to document everything.

> "Its awful how notes go missing etc and they sometimes seem more bothered about and what you have written than what you have done."

Even in the early stage of the interview, Dave explained that he was very aware of how risky working with Angela could be. He was also expressing some invalidation of his interventions as legally the managers were more concerned about documentation than how staff were trying to work with a client. So although he stated that he encouraged Angela to take responsibility, he was also aware how society needs to blame professionals when things go wrong. He stated that

> "I encourage her to take as much responsibility for herself as possible. She can be quite dependent you know though"

This was clearly an issue in that Dave was trying to help Angela make her own choices but stated that she was still quite dependant on him. He had been seeing her for the last three years and she was doing really well at present. He was also aware that Angela might find her endings with him difficult, as endings had been difficult throughout her life.

We focused on Angela's most recent self-injury. This happened about three months prior to the interview.

a) Before self-injury

Increased communication

Dave reported that he had noticed that Angela had begun ringing him up more often than usual. She was having a hard time. He stated that this was similar to how she was four years ago when she was first referred to him.

> "Her phone calls got worse and worse, wanting to speak to me seven or eight times a day. I would try and speak as much as I could".

Here Angela seemed to be desperately trying to verbally communicate to Dave, but was unable to express herself, or feel as though she had some sort of emotional resolve. She clearly needed to continue repeating this process. This strategy became unmanageable as the more he talked to her the more she was ringing him.

External containment with emotional expression

Dave stated that the team decided to change this agreement, as it did not seem to be working. It seemed that the more she tried to verbalise her distress, the more she needed to do this again. He explained that one strategy was that the reception staff would speak to her first and then put her through to the duty professional. This person was covering any emergencies throughout the day. Dave said that Angela would have someone to speak to if she was in crisis, but that if the other staff were engaged in other work, they could continue to do that. The duty professional would speak to Angela when she was in crisis and help her work this through. She was also

told that if she wanted to speak to Dave she could leave a message and he would ring her back later. However, he stated that she did not usually do this as she had some help resolving her crisis. This intervention seemed to contain the expression of internal experiences and the crisis well. The ability for a service to respond and be available for a client in need was clear. Dave stated that this person did not always have to be their usual member of staff. This seemed to help Angela express her internal world without regular repetition of the experience. This seemed to help Angela contain her anxieties, but also to reduce staff anxiety and stress levels. By one professional being "on duty" for crises, the staff perceived the work to be their priority for the day, rather than having to fit in very difficult phone calls around visits to other patients. The staff can then have a sense of completion when they have managed to help the client work through some of their issues and emerge out of immediate crisis.

Within the described incident of self-injury, Dave stated that Angela had rung, he had spoken to her and she was ok. His usual intervention was to try and get her to focus on the more positive aspects and emphasise that the team was there for her. He stated that this is what he did this time.

Anxiety

> "I felt slightly anxious, but I know that Angela often cuts and is not suicidal."

So here it seemed that Dave was trying not to worry too much and rationalising that she would often cut herself to cope. However, he then also stated that

> "There is always that doubt in your mind that this time it may be different, isn't there? So on one hand I have got thoughts around this being ok and she will survive, but on the other hand she may do something more and try to kill herself"

Dave expressed the concern was about Angela trying to kill herself, but not being totally sure whether she would self-injure to survive or become suicidal. For Angela there seemed to be very close links and at the time of the interview she also had recent periods of wanting to kill herself. It seemed that if Angela was unsure about why she needed to harm herself, then it was difficult for Dave to be able to work this out.

Worrying Thoughts helped by focusing on client positive changes

> "I was worried, but thought about all the times she has been ok, so didn't think much more of it. She has also been a lot better recently. She used to cut about 7/8 times a week and also overdose and strangle herself at times. She doesn't cut very often now and its occasional overdoses"

It appeared that Dave was able to distance some of his thoughts and emotions about the possibility of her killing herself in order for him to continue with his other work. This is an essential strength for a helper to do as they need to be able to contain their own emotions, especially anxiety and fear, otherwise they will become emotionally burnt out. This is where measurements can be useful for the client and also the staff to alleviate anxiety. A focus on the gradual process of recovery can help client and staff overcome short-term difficulties.

"Hopefully she will be ok"

This seems to be the thought that Dave needed to try and keep hold of in the face of adversity, a hope that she will survive. Staff may have considerable anxiety that the client will kill themselves, but if they have some confidence in their approach they are able to take risks and hope for the best. This clearly demonstrates how stressful work can be with this amount of uncertainty. Dave had looked at recent events in a positive manner and had tried to prevent his negative thoughts taking over. This also demonstrated how important measurement was to the staff as well as the client. If the staff member was clear that the self-injury or overdoses were reducing then they were more able to calm themselves down with comforting cognitions. If the staff have worked with people in this way before they are more able to ride the waves of uncertainty.

b) Following self-injury

Dave stated that he was not aware that she had cut when he arrived at her house to see her. He told me that Angela had a bandage on her forearm and her sleeves pushed up. She then told him what had happened. She had dressed her own wounds. He also told me that she was a qualified nurse and was therefore happy to do this.

"Let down", when she was doing so well.

> "I felt a little let down but then I was thinking about how well she has been doing recently"

Here it seemed that Dave was able to recognise his emotions but then rationalise that she was getting a lot better.

"Relief" that she survived

> "I was also a bit relieved that she wasn't too hurt"

This was important, given Dave's concern prior to the self-injury. Not knowing if Angela was suicidal or not and also possibly having some concerns about accidental death, as she would cut very deeply and also hang herself from time to time, her risk was high. Dave stated that Angela had found a release of emotion and relief that the self-injury was over and she had survived.

> "It's also like an injection at times, you know there is pain coming but you just want to get it over with"

It seemed that Dave had thoughts that the pain is inevitable and relief that it has happened.

Acceptance of self-injury and focus on moving on

Dave stated that he had accepted that she has done it and then moved on to understanding why and how they could move on. By accepting her behaviour without judgement and then moving onto other issues that she needed to focus on, it seemed that Dave was able to see the self-injury briefly and then focus on the person. Helpers can be

> "Blinded" by the self-injury and can't move on from this behaviour".

This can serve as a block to prevent a relationship developing.

c) Longer term consequences

Negative attitudes of other people

Dave stated that there were no longer-term consequences within the mental health team as they were used to working with Angela and other people who self-injure. However if she needed to go to A&E, the staff were not very good with her there. Dave stated that he recognised that Angela could be really sensitive at times, especially if she was emotional, but he also said that these staff seemed to have negative attitudes. This seems to be a common split between general and mental health professionals. This also has helpful functions in that it helps Dave feel better about himself and the work that he has been doing with Angela. It also seems to help Angela feel good about how the mental health staff are helping her and not judging her.

> "I remember when I was a general staff nurse years ago and attitudes have not really changed much."

Physical/psychological split

Dave said that staff in A&E seemed to

> "Focus on the physically unwell and can see people who self-harm as timewasters or attention seekers".

It appears that the physical illness is focused upon above the psychosocial elements. Physical pain seemed more important than emotional pain, also that visual damage

to the body is more important than emotional damage. It appeared that the message was that staff want to avoid emotional pain.

d) Interventions

Focus on positive qualities

Dave said that he tried to get Angela to focus on her positive qualities,

> "She is an excellent artist and very academically bright and really wants to help others"

He really seemed to like her. This seemed to be an important issue. If there is something likeable in the client, even if they are difficult the helper can try and find a way of supporting them through the challenges. However, this would be difficult if the client was not very likeable and also self-injures. This positive re-framing seems to help Angela following self-harm as she tended to feel really guilty afterwards and has lots of negative thoughts over doing it. Dave's focus here was on raising the self-esteem, when the self-injury could serve to decrease this. This seemed to limit the damage post-self-injury. This reinforced the need for a validating helper who did not judge. It seemed that Angela judged herself enough and needed some help to challenge some of these negative thoughts after the self-injury.

A sense of humour/ being human

> "I think being non-judgemental helps, using a sense of humour when it seems right to the client. We have often laughed together at things and she sees this as being helpful and human."

Dave stated that these were essential aspects in this relationship. It seemed to me that the "professional" aspects may take over as in professional roles it is rare that staff are able to feel confident about expressing their "humanness". This challenges perceptions that staff need to be "objective" and emotionless. It seems that self-injury provokes so many emotions in staff that it can be difficult at times to stay in touch with other emotions as well. Dave informed me that he needed to be able to cope with difficult emotions at times, but was also able to express emotions at the right time. Humour can be perceived as being avoidant, rather than supportive. It seems that here, humour can be used positively to make distance between difficult thoughts and emotions. It also seems to be generally a part of the therapeutic relationship and being genuine.

Team work

> "I think we also work well in the team here. They have been really supportive to me as the care coordinator"

This is an essential aspect to working with Angela. In order to take therapeutic risks each team member needs to feel fully supported.

> "The team have worked well and we have almost produced a template that we have created with Angela. We are now using this with other people as well. It's really nice that our team work well together and are able to look at how we are affected by some of the patients. I have even been offered advice and a lot of support from others members of the team."

Dave stated that an important element of teamwork was to look at how each team member was affected by Angela, but within a supportive environment.

Clinical supervision

> "Clinical supervision is also really helpful as you can talk through what's going on".

Dave explained that supervision was helpful in reflecting on what is happening in their relationship. He stated that he could express emotions about Angela and use them to understand what may be happening, but also help him to work out what to do.

Returning to work

> "She seems to be doing well at work, she seems to like helping others".

Dave informed me that Angela had been working creatively to help other people with mental health problems. This seemed to have increased her self-esteem.

Judgemental staff attitudes

Dave stated that Angela had not told him that any of the interventions were unhelpful. She had however said to him that the staff attitudes in A&E were unhelpful and that when they had judged her, this made her self-esteem lower and increased her guilt and shame. He said that it was also not really helpful to admit her to an acute mental health ward. This seemed to make her worse. He said

> "We try and keep her supported in the community now and that seems better."

For Angela community based interventions seemed more helpful. Both methods stated here as being unhelpful were about hospital admission or at least assessment.

Dave stated that he felt quite angry at how the negative staff attitudes in A&E seemed to affect Angela.

> "I just get really angry as she can be getting on well and then she cuts, goes to A&E and gets all her negative beliefs about herself confirmed. I then have a lot of work to help repair the damage done to her self-esteem."

So it could seem at times that other staff within the health service undermined some of the interventions that Dave was doing.

In summary of this chapter, all staff interviewed recognised that the clients' self-injury had been triggered by interpersonal issues. They all reported anxiety and dread before self-injury and a sense of relief afterwards. The staff were all able to work with the clients without asking them to stop self-injuring and positively re-frame the clients and their own personal thoughts following self-injury. They all emphasized the role of reflecting on these situations with another person after the self-injury. A central concept for all staff was to accept the person, rather than just focusing on their behaviour. This was also reflected in all the client interviews as well. For staff the reported anger was towards the staff in A&E who seemed to have negative attitudes towards the clients.

Following a focus on emergent themes from the client and staff interviews, I wanted to bring together a third level of understanding. I then integrated each client and staff account. These dyads are now synthesised and explored in the next chapter.

Chapter 6: Interpersonal issues between staff and client.

Following exploration of client and staff themes, this chapter focuses on the relationship between the client and staff interviews. The processes that each person experienced are highlighted, along with their reactions and coping strategies to the self-injury. Again these concepts are supported by direct quotes from the interviews and developed with relevant literature. During this process I printed out the transcripts of the interviews and read them side-by-side and noted themes. Some themes were similar and others were different. I kept all themes in rather than excluding the individual and/or focusing on the common themes. I then spent considerable time trying to make sense of these themes. Initially I avoided use of theory driven analysis, but in the later stages, theory assisted in presenting my interpretations in an understandable manner.

I wanted to bring together the client and staff narratives to produce a third description focusing on a possible interpersonal interaction that can often be missed in helping relationships, due to a focus on only the client's self-injury. I have presented the data in the order that this occurred within the interviews and have focused on client and staff reactions before, during and after self-injury for the same reported incident. Within the interview, I asked each participant about their emotional reactions, thoughts and behaviours. Within this chapter I have interpreted the interview contents in a subjective manner. In the spirit of reflexivity I have also added my thoughts about why I interpreted in this way and focused on my beliefs linked to the analysis and synthesis.

Please note the following staff issues are in purple, client issues are in red.

1) Mark and Ian

a) Before self-injury

Before the self-injury occurred Mark described feeling intense anger. –

> "I get angry at one person, I get angry with everybody."

However, Ian stated that he experienced anxiety.

> "It's always kind of a sword of Damocles so it's not usually a question of if it was a question of when."

When asked how he felt at this time, Ian replied;

> "Really dreadful to be honest, I feel a bit hopeless."

Anger vs. Anxiety and hopelessness

Ian had to endure the waiting time, with a sense of dread and a lack of power or control. Mark had extreme anger, but had the power to decide what to do, or not do. This put Mark in a stronger position than Ian.

Angry	vs.	Anxious
Had choice		Limited choice

Had power to self-injure	Hopeless
Empowered to take control	Decision to leave control and choice with client
Knowing	Not Knowing

So here Mark appeared to have more choice and control than Ian. Where other staff may have took the control back and restricted client choice, Ian was able to withstand this fear, lack of power and choice, in favour of Mark finding his own way to cope. Ian appeared to be able to remain in the present with Mark and coped with "not knowing". Simpson and French (2006) regard this position as essential to good leadership. Cultivation, listening, waiting and passivity are personal skills that are useful in leadership, but western society often emphasizes directing and doing. Ian had been able to let go of the sense that he knew what he was doing and focus on the present. Not knowing creates high levels of anxiety and uncertainty for Ian, but he was able to avoid invoking prior knowledge or theories about this situation. Eisold (2000) defined this activity as negative capability. This is the ability to tolerate anxiety and fear, to stay in a place of uncertainty in order to allow the emergence of new thoughts and perceptions. This is a theme for all three staff interviewed. Anecdotally, staff can feel the pressure to act, rather than reflect, linking history and judging and then having difficulties viewing the future, as they may not know what to do.

I interpreted this aspect in this way as there was a clear difference in the experiences of the two participant's interviews. I went through a process of empathising with both people and, using their words where possible, I tried to make sense of the interpersonal process. I thought about how it would feel to have the "Sword of Damocles" above my head. I believed that I would be frightened of the sword falling

and helpless to be able to stop this. I then began to think about how difficult it could have been for Ian to not stop this from happening, and how brave he was to remain in this risky position in order to empower Mark and not take the choice away from him. I really admired Ian's courage within this interview to think of Mark's needs first above his own. I believe that it is harder to experience the emotions and contain them, rather than move into a space of "knowing" I also thought that this was the right thing to do to help Mark. This was also supported within the interviews by both participants.

b) During self-injury

Ian was not on duty when Mark self-injured. Also for Mark the self-injury was a very private behaviour. So here he was able to deal with his anger by cutting himself in private. He stated that this had helped him take control of the situation. During Mark's self-injury there was no interpersonal function, as he did this alone.

Numbness	Not Knowing, unaware
Not Knowing	

The "After Sunday Lunch" feeling

Mark experienced a "buzz" directly after the self-injury. This seemed to be an altered state of consciousness. Ian also experienced different states of consciousness, especially if he saw Mark cut, or just after. So it appeared that as Mark's body relaxed, Ian's body went into autopilot. This affected both people by an avoidance of an uncomfortable internal experience. Mark seemed to automatically follow a set

routine before and during self-injury and Ian also seemed to do this afterwards. With all these strategies the body was used to change the persons' state of mind.

As I listened to Mark in the interview, and later when I transcribed it, I became aware of how I believed that self-injury could alter a persons' state of consciousness. Mark confirmed this with his description of the "buzz" he experienced. When I brought the interviews together, I became very interested in how Ian also needed to have different levels of consciousness in order to cope with seeing Mark directly after he had self-injured. Ian was incredibly honest about how he coped with this in order to help Mark. I previously believed that staff had defense mechanisms, but had not realised to what extent. I knew that self-injury was traumatic to experience as an onlooker, but the staff interviews helped me to explore this in more depth. As I brought the interviews together, I was confronted with some similarities of these dissociative coping strategies. Within the interview with Mark, I was aware of how patterns of behaviour before self-injury could limit risk; however I had not understood the process experienced by people during self-injury. This was challenging for me to ask about, but I believed that this was important to fully understand what was going on. All three clients had not previously verbalised this either. I was aware that during the interview I thought of the necessity of looking at a wound in order to clean it, which helps with healing. This is also something difficult to do, but I believed this was essential in the healing process. In the interviews I was aware that this process was easier for me than Ian, as I did not have a visual description of what Mark looked like during or immediately after self-injury, as Mark was not looking at himself. I was also not experiencing this in reality.

c) Following self-injury

After the self-injury, Mark felt better initially.

> "The anger just goes, disappears. It goes away in a second."
> "My body just went like a jelly and went dead relaxed. You are in a chair and you just can't move."

He had been able to temporarily halt the emotions and thoughts. After the self-injury, Ian did this as well. He coped after the self-injury by "not knowing";

> "I'd learned to switch myself off".

He stated that this had helped him not get emotionally involved. This then helped him have a pivotal role in helping Mark to re-evaluate and conceptualise the self-injury in a less negative manner. My interpretation was that Ian was able to move from "not knowing to knowing" and also take Mark along with him in this process.

Mark described the process of negative self-evaluation and also perceived negative evaluation from others;

> "They just look at you like; here you are again, a waste of space, wasting our time, wasting our services."
> "After the self-harming I feel down and it's just one long vicious circle."

This then made him feel worse and confirm negative beliefs about self or others. Therefore by Ian reacting in this way, he was more able to limit the damage and confirmation of negative beliefs about self and others.

Vulnerable vs. Empowered again

Reduction in power	Increase in power
Feeling stuck	Knowing what to do
Less control	Increasing control
Expecting rejection	Ensuring acceptance

So when Mark felt vulnerable and stuck in a cycle of self-injury, Ian stated that he felt more able to take control and reframe both experiences. This member of staff was able to positively re-frame his own thoughts and then help Mark do the same. Ian had found it was useful to think about the process like driving.

> "If we suddenly found we had stopped or diverted or, stuck in a traffic jam, we would do our best to try and change things to move on".

By seeing the situation as a challenge, this then had the effect of reducing the internal trigger events that often lead onto further self-injury. This seemed an essential function of a positive staff member as this was very difficult for the client to do alone. If this does not happen the cycle of self-injury can continue. This could be seen as a complementary identification (Racker, 1957), as staff responses complemented the clients.

Low mood	vs.	Low mood
Stuck		Feeling stuck
Feeling Hopeless		Increased hopelessness
Reduction of control		Lack of control
Increasing anger		Increasing anger and frustration

Thus while Ian had a similar internal experience to Mark, the self-injury cycle continued. This could be seen as a concordant identification. If both the client and the member of staff are unable to reconceptualise their experiences they may both succumb to their negative thoughts and feelings. If the staff are able to contain these projections and survive them and still help the client move on, then they are helping the client. Heinmann (1950) and Malin and Grotstein (1966) view this processing of the projective identification without acting on the engendered feelings as an essential part of the therapeutic process.

If the professional is able to conceptualise this experience in a different manner as above then they are able to model their ability to survive the trauma and the projected emotions with or instead of the client and then help them move on. If the staff can maintain this level of hope and recognise their power to change their own internal experiences, they can then help the client to do this. The self-injury can then become a learning experience rather than a repetitive cycle of self-abuse.

I had used Racker's work on projective identification to illustrate the complementary and concordant interpersonal processes. This was a useful method to analyse the narratives as I was able to include matching and competing processes. My beliefs that many interpersonal processes occur simultaneously helped in this analysis as I could use the theory to describe sometimes competing processes, without excluding parts of the interview. I accepted that Mark and Ian could have concordant and complementary processes within the same part of the same self-injury incident.

During this analysis I became aware of how important staff roles were in helping the client to reflect on their self-injury. All clients stated that they wanted to move on and sometimes forget the self-injury, but the staff were there to help them reflect on the process before and after self-injury. The staff stated that they thought this was an important part of the process of helping and I agreed with them.

d) Self-injury as a block to reflection and metallization

Before

Need to stop internal experiences vs. Need to contain internal experiences

During

Switched "self off" vs. Need to switch "self off" then "switch back on"

After

Anger, negative thoughts vs. Able to think and feel relief

Guilt, embarrassment, Blame

"I've coped", relief

So Mark had said that he started with a need to stop his internal experiences and Ian stated that he needed to contain his. He thought;

> "I'm not happy about this situation, so how can I manufacture something that is more appropriate or less upsetting? For me and for Mark and less damaging."

This would then help distract him from any difficult emotions that may have emerged.

Ian said that he needed to contain the experiences as Mark was unable to and needed to avoid.

> "I'm gonna get on with this and do what I have to do and then later on when nobody's watching, I'll just have a blubber."

If both people just avoided, then Mark would be unable to learn how to bear these painful issues and would continue to avoid and project in to others. Both parties needed to "switch off" their internal experiences to survive and then Ian stated that he needed to be able to get back in touch with his internal experience once the self-injury was over. So for the staff this was a time where they needed to be able to push down their own emotions in order to help the client.

Ian and Mark stated that they experienced difficulties reflecting during self-injury as they were avoiding their internal experiences to survive. This can be a period of using mechanisms such as de-realisation, depersonalisation and projective identification. Following the self-injury, Ian stated that he thought it healthy to reflect at a later date and express the emotions that had been suppressed, but he thought that Mark was still trying to avoid his emotions. So here for the client, self-injury helped them avoid their internal experiences. For Ian, he needed to avoid but then emphasised reflection on and expression of emotion.

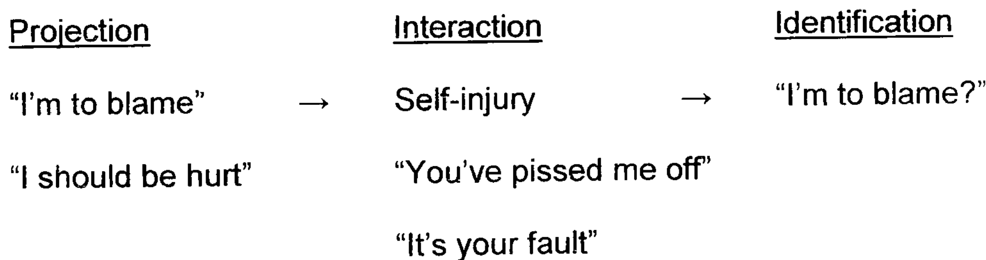
These observations confirmed my beliefs that reflection helped the clients learn how to bear the emotions and thoughts or recognise how they were coping with these experiences. I had not realised just how important reflection was. Self-awareness of

this nature, I believe was difficult for the clients during the self-injury, but they were able to return to this and view it with hindsight. This seemed a safer position. This in turn challenged some of my beliefs about retrospective interviews, in that although they are based on memory, this can also have a de-traumatising effect, as the person is no longer in the situation.

e) Not taking the blame

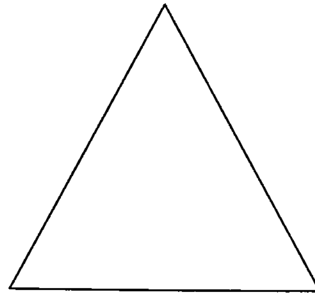
This occurred in the earlier days of the relationship when Mark was really angry most of the time and constantly self-injuring.

This is illustrated using Ogden's (1982) stages of projective Identification.



However, Ian said that he was able to challenge this projection of blame. He described the projection but did not identify with this. If staff take on this blame then they run the risk of joining a re-enactment process of shifting blame and responsibility to another person.

Using the drama triangle (Miller, 1994);



This member of staff was able to avoid taking on any of these roles and was then able to assist in the reflective process afterwards. This was all completed without focusing on the self-injury in any depth. So the challenge was to "avoid the old games" and collaboratively create a "new game", or method of relating to the world.
I used the drama triangle here, as it has been useful in my clinical work with clients, staff in supervision and educational sessions to illustrate this process.
This was selected as this fitted the content of the interviews from Ian and Mark. This only emerged as being useful as I was attempting to bring the narratives together.

Confronting conflict.

Ian stated that he clearly discussed conflict with Mark when it happened in their relationship. Thus he was able to model conflict survival strategies for Mark. He informed me that he had discussed the blame with Mark and stated that if he was responsible for Mark self-injuring then he could no longer work with him.

> "I took what he said at being absolutely true and said if that's the case then I had better get out."

Ian appeared to be demonstrating that he did not want to hurt Mark and would also not conform to the drama triangle positions above. This was quite a risk as Mark was perceived as being very fragile at that time and Ian had stated that the other staff had reported feeling as though they were "walking on eggshells". This anxiety may have served to help the staff avoid the confrontation until the client was stronger.

So the staff may have had a fear of making the client worse, which leads them to avoid confrontation and stay in a safer position, which can result in an increased risk of the staff identifying with the blame aspect that was projected. Thus if the staff remain in this "safer" position, everyone avoids the conflict and remains stuck in the self-injury cycle.

f) Polarised Thinking

Before

Polarised thinking from trigger	Beginning to polarise due to anxiety
Need to become angrier to self-injure	levels
Increase in polarised thinking	
During	
A lack of thinking	May have polarised thinking due to above
After	
Some non-polarised thinking	more able to have non-polarised thinking
But increase in guilt, shame and	think rationally and reflect.

Embarrassment which increased polarised

Thinking

After the self-injury, if Mark had to attend the accident unit, Ian said that he expected either a caring rescuer or punitive abuser role from the staff there.

> "He actually seemed to want a massive emotional response. Either an over the top caring one or an over the top angry one."

The flat emotional response seemed to help the staff depersonalise and switch their inner experiences off. While this was observed to be positive by Ian, Mark said that he saw the staff here as not caring and tended to see them as judging him and being punitive. While this expectation may have been based on previous experience, this did not appear to be the case here, when Ian thought they were just being professional.

> "Like a lot of Mark's opinions at the time, they were based on historical things, which very well might have been and as well his perceptions were slightly squed, but when people were being relatively objective and professional, he saw that as being negative."

Although the professional demeanour seemed to help the staff cope, it is obvious that Mark had difficulties with this.

Staff could end up in a polarised position, in that if they shut off their emotions and thoughts to remain professional, this may not help the client. However if they truly expressed their emotions and thoughts of the client, this may not help either.

> "I didn't expect anyone's reactions; I didn't want anyone's reactions. I wanted them to look at it like I hadn't done anything."

If Mark was working to avoid his own internal experiences usually immediately after was not the time for the staff to express theirs. So Ian reported that he needed to avoid becoming emotional in the crisis situation. He described a fear of emotions overwhelming him and a need to cut off from them in order to survive.

> "I've found that the best way is just to switch off and treat it as a thing. Not an emotional thing but just a thing. So as far as I'm concerned it's just a piece of meat. I know it's a horrible thing to say, but it's my defence mechanism."
> "Because if I started thinking that's really going to hurt, that's horrible, Jesus that's muscle under there. I tend not to be able to hide my emotions very successfully."

So by briefly depersonalising Mark's injuries, Ian was able to cut off from his emotions to survive the traumatic experience. This seemed to parallel the internal experiences of Mark before the self-injury. Through the interaction of the self-injury, the fear of overwhelming emotions seemed to be projected in to Ian. The staff role happening here seemed to be of containment of these emotions in any way that he could in order to cope with the current situation. This differs to the client's role of projection and avoidance, rather than containment and eventual reflection.

Ian described needing to cut off from the emotions, but had an awareness that he needed to return to them later and reflect on what had happened.

> "I kind of just a have a period where I kind of fall to bits a bit. I have to just let it out somehow. So I kind of pretend it's not happening but somehow or other I have to deal with that bit at sometime, but I'm not dealing with it now."

In order to survive Ian described a process of de-realisation where he needed to think "this isn't happening" "that's not really blood and muscle there". He also stated that he needed to think about Mark as a piece of meat rather than a whole person that he knew, a process of splitting the person in order to survive.

Self-injury can also act as a trauma that both parties need to survive. If the staff coped with self-injury by just avoiding internal experience they may not talk about it, become isolated and alone and become very angry at other people or themselves. This helps us understand how staff may cope with self-injury in a similar way to clients coping with their internal experiences. When this happens the staff disengage or reject the client and this can then lead onto them blaming, stigmatising and pathologising the client, rather than looking at their own internal experiences or coping mechanisms. Within this dyad, Ian was able to avoid this by being able to reflect, communicate and cope with his own stress by talking to others and not taking on roles of rescuer, victim or abuser. His sense of achievement in the recovery process helped him contain his own emotions and as he said "By-pass failure" He had an ability to endure extreme experiences and a belief that difficult experiences will come to an end. This seemed to help him through his survival process. He was also able to get the client to experience this through his interventions.

Externalised Anger

Mark stated that he often externalised anger to other people. He seemed to exacerbate his self-anger in order to self-injure.

> "Whilst I'm cutting I get angrier, for that reason because it helps me do it even more."

Although the anger was triggered by an external interpersonal issue, the self-injury process seemed to internalise his anger. During self-injury the anger stopped but returned soon afterwards.

> "The anger just goes, disappears. It goes away in a second."
> "But say a day after. So it was either, remain feeling down or remain feeling angry."

This was externalised again when he went to A&E and thought the staff were judging him.

> "They just look at you like; here you are again, a waste of space, wasting our time, wasting our services."

Fear seemed to be a reaction that Ian felt more than Mark. Mark only talked about fear in relation to hospital admission as a consequence of self-injury. Ian however discussed feeling fear before, during and after self-injury.

I had previously believed that anger had a key role in self-injury and that this may be turned inwards when the person self-injures. This confirmed my belief here, but I had not made a clear connection with how the anger became externalised following self-injury. This then lead me to think about the function and meaning of this process for the client, but also the staff who expressed anger towards the staff at A&E.

Keeping safe

Both Mark and Ian talked about keeping safe in these interviews. Ian stated that he wanted to keep Mark and himself safe and protected from his own emotions. This

resulted in him using various defence mechanisms. Ian also wanted to keep Mark safe by helping him go to hospital and working to get him to have more contact with other people following self-injury. Mark wanted to keep himself safe by coping with his internal experiences and also by using his rituals prior to self-injury to control the level of harm.

People think about traumatic experiences in different ways. If they perceive themselves as a victim, they are more likely to think that they deserved something to happen. So as Ian was able to conceptualise his relationship with Mark as a success then he was more able to help. If the staff can also think about the challenges of their role as complementary, because they are a good helper then this also helps their self-esteem survive. So when Ian was asked to talk Mark into going to the accident unit, he saw this as a "crap job" for a good person.

Crap jobs for good people vs. Crap jobs for people who deserve it

So by Ian being able to conceptualise his worth as remaining good, even though he was given a "crap job", this helped Mark challenge his own thoughts. By avoiding polarising his thoughts, Ian was still able to see himself in a positive manner and that some jobs, as he said "just go with the territory" Mark was more used to attributing negative events to himself and thinking that he deserved it.

g) Keeping the secret or respecting privacy: Knowing or not knowing

Both Mark and Ian stated that they were able to not focus on self-injury at great length. The physical wound care was sorted out and the emotional side avoided. This

"Don't talk about it to them, just be with them."

If this was the only intervention then Mark may have been unable to move on. As Ian was also working on endurance and surviving extreme emotions and discussing interpersonal conflict, this seemed to work well.

The process of avoidance could be perceived as keeping a secret, but it could also be perceived as maintaining privacy. Mark stated that he was well aware that he had other deeper issues to work on, but did not state what they were. He was able to see how much he had improved over the past three years and how he felt a lot safer. So privacy seemed to be important as this was what Mark wanted. If Mark feels safe enough he can talk about any secrets in the future.

For Mark the position on the body where he cut directly linked to whether he wanted other people to know about his self-injury or not, choosing to keep it private or public. While cutting was a private activity for him, Ian felt more anxious as he did not know what was going on. He was actually called in by his manager as he had a good relationship with Mark and they needed to know what was going on to keep him safe. This is a dichotomy to protect privacy, but to keep the client safe. While the self-injury is private the client has control over this and the power to be able to stop the hurt. He is able to keep any secrets and not disclose extreme internal experiences. He was able to have something going on that other people did not know about. He was being

hurt in private. This is how Mark preferred his self-injury and he used his rituals to remain safe whilst private.

However, at times this client's self-injury had become public. In deed when he went to A&E he had to admit to his self-injury.

> "I would clean it and then go up to the hospital, but its just hard work, going up there. Guilt embarrassment you know."

This is when he stated that he expected other people's reactions to be punitive, controlling, rejecting or caring. Being hurt in public exposes any secrets. Again symbolic links could be made here to disclosing abuse and the person being rejected, stigmatised and punished. When the person exposes their self-injury, they then have less control over the situation as other people can react in very different ways. So from being a method of taking control of the self, when this becomes public, other people's reactions will be unpredictable and could exacerbate the client's internal experiences at a time when they are most vulnerable. If self-abuse or abuse of others is in public, on lookers are more likely to take control and try and stop this. However if in private people will not know and the hurt can continue.

<u>h) Avoidance and self-injury</u>

Internal trigger → Self-injury as avoidance →Anger towards others, thus avoiding focus on internal issues

Self-injury as trigger → "objective professionalism" avoids internal experience → a focus on healing body part

By focusing on the self-injury the staff can avoid seeing the person as a whole and the underlying hurt. If the client's strategy is followed, focusing on the body healing first, then the emotional hurt can be explored in the future. However, most health services focus on the self-injury, either physically or psychologically. Mark talked about how all mental health services just focused on the self-harm and why he did it, rather than getting to know him as a person.

> "It got so bad at one point that all people wanted to know about was my self-harm, so I did it even more. I felt like, oh that's what people want. You know they don't want to see me. They only saw the self-harm."

This resulted in him self-injuring more.

If the client has intense self-loathing due to hurtful things happening, as they were bad/deserved it or were unlovable, this can be controlled through affective numbing (Pearlman &Saakvitine, 1995). Mark seemed to believe this in the earlier part of his relationship with Ian. He stated that he was also good at getting people to become aggressive towards him if he did not self-harm. He seemed to expect that the staff in A&E would think he was bad in the end. This process can result in the client having a hypersensivity to any evidence of the helper being critical or shaming in any way. This seemed to be the case with Mark, as Ian attended A&E with him and had a different perception about their attitude.

So while "Objective Professionalism" has the function of keeping dangerous staff emotions at bay, it also can interfere in the professionals' ability to develop a trusting relationship with the client. Therapist neutrality has been widely documented in the analytic literature. Originally this was developed to advocate an open-minded curious stance (Pearlman & Saakvitine, 1995). However a silent or neutral environment may feel unsafe for clients who have traumatic experiences in childhood. Silence and distance may be familiar coping strategies in the clients' early relationships. This may then make it difficult for them to differentiate between current and past relationships. Indeed for a professional to act in a neutral manner like this when a client is presenting with self-injury denies the self of the helper and their non-verbal communication. As stated in Mary's interview people who self-injure may view themselves as noticing the non-verbal communication of others especially when this is incongruent. Helpers may take on the role of a collusive parent (Pearlman &Saakvitine, 1995). This has also been described by Miller (1994) as a passive non-protective bystander. The client may think that the helper is inattentive, inadequately concerned or disbelieving. These attributions may occur as a result of this "objective professionalism". This way of relating to the client, although possibly helpful in the short term, can prevent the staff getting to know the client in a genuine way.

My beliefs of having a professional appearance whilst dressing a wound were challenged here. It seems that whatever the professional did, this would not have been right at the time. I believe it would be wrong for the staff to express disgust or shock at the extent of the self-injury, but this may have been a more familiar reaction to Mark and have confirmed his beliefs about other people rejecting him.

So in summary, Mark and Ian both emphasised keeping both parties safe and protecting each other. Prior to the self-injury Mark described anger and Ian described anxiety and helplessness, thus reflecting a complementary projective identification and a state of knowing. During the self-injury both people described a process of not knowing, either feeling numb, or Ian being unaware of Marks problems. Initially following the self-injury, Ian described needing to cope by also cutting off from his emotions and thoughts, in order to help Mark. Thus in the short-term a process of not knowing was important to survive. However Ian emphasized then need to reflect and know, later on. This was a process that Mark was unable to do alone. He learnt this through Ian's diversion techniques using sports. He was more able to reflect on endurance experiences and has developed a sense of achievement and self-esteem. Ian was able to positively reframe Marks experiences by using analogies. Mark expected a blaming, angry, rejecting response from others. Ian was able to avoid giving this response and thus challenged some of Marks beliefs about himself and the world. Mark and Ian shared depersonalisation, derealisation and avoidance as coping strategies to not know. However these were Marks main strategies, whereas Ian was able to use these at a difficult time and the return to knowing and reflecting.

2) Mary and Steve

Mary's self-injury happened very quickly and impulsively. Steve stated that he did not know about the self-injury until afterwards.

Before

Sudden onset of need to self-injure	**vs**	**Nothing different, unaware of client problems**
Impulsive		

No ritual

During

Felt relieved	**vs**	**Unaware**
Stopped thinking and feeling		

After

Relief	**vs**	**Surprise**
Made internal external		**"What happened?"**
"Respite"		**"I know I have been doing my job"**
Pain and cleansing		
"I can now look after myself"		

Positive relationships protect

Here Steve stated that he was unaware that Mary was in crisis or self-injuring. Both people were calmer if they knew the self-injury was not a suicide attempt but cutting to live. This seemed to especially help Steve contain his anxiety. The thought that he was doing his job well seemed to help him here. Thus he avoided personalising the self-injury. This was very important to Mary as her family often did this. Steve reported not feeling a failure as they had been getting on well; he had helped her engage with other services.

> "If something happened in the context of me not being able to engage her adequately in services, or with me, then obviously I would see it as a failure on my part. Because I we can only do so much, I always work with that perspective. But had I been doing enough at that time, recently yes."

The trigger situation was with someone else. So by focusing on external relationships, Steve was able to support his idea that they were getting on well. This may be more difficult if the conflict was within their relationship. He seemed to focus on positive elements in the relationship being supportive and getting on well. If they had a conflict he would not be able to use his comforting thoughts about his skills in the same way. This coping strategy did seem to work well with the client, focusing on external relationships.

Steve thought that trained and experienced staff were better than untrained and inexperienced staff.

> "She has accessed every service possible around here, but she's still with us. And that I think is because we are trained, skilled, where as some of those people that work in other agencies don't have the same level of training or experience."

He had a clear sense of achievement that this service had succeeded where others had failed.

My previous beliefs were that I would have agreed with Steve about trained and experienced staff being better at providing help. However within the interviews I became aware of how Ian naturally had worked with Mark in a different way, without years of training as a professional. He was also very able to avoid judging and see the person beyond the self-injury, or diagnosis. This then made me challenge my

beliefs about professional education. I began thinking about how helpers may be better off without training to diagnose or provide help in a "prescribed" manner.

Listening and ventilation

Both Mary and Steve agreed that listening and ventilation of emotions were really helpful. Acceptance without judgement was an important focus here.

> "Steve was always there for me and never judged me, or never, you know made me feel bad, he just made me feel like, well you've done it, like move on from it and he has always been like that."

The containing safe function was emphasised by both parties with Mary not being rejected. "Just being there" was a big comfort to her.

Apologising to staff

Mary spoke about how she needed to apologise to staff following self-injury, as she could not apologise to herself. This seemed difficult for Steve as he stated that he was quite angry about this. He stated that he did not want her to do that.

> " Sometimes she'll do that and apologise and don't want her to do that, I don't want her to apologise, I don't want her to feel guilty or feel desperate because she has contacted me, or that she's been bad or done the wrong thing."

Mary expressed a need to get forgiveness from others and that she was guilty and to blame for what she had done. Steve however stated that she had done nothing to be blamed for. He was conceptualising the self-injury as a coping strategy, rather than a negative behaviour that should be punished. This could have triggered a rescuing or punitive response by Steve, but he was able to avoid this. Steve seemed angry that

she blamed herself and was possibly angry that other people had blamed her and she had taken this on board.

I empathised with Steve at this point in the interview, but then became aware of feeling angry myself. I noticed how the anger had seemed to move between Mary, then Steve then myself, all blaming other people. I thought about how the process continued even with me as a researcher and how this was still an emotive process even when I was interpreting the interviews at a later date. These thought processes helped me move to a position of thinking about how staff expressed their anger within the interviews.

Not being "good enough"

Steve seemed keen that he was a "good enough" helper and that Mary thought this also. Mary would then complain about herself or other people from outside of the therapeutic relationship. This way Steve was protected from thinking that he was a failure. Other people are the ones that she had conflicts with. This is a common feature in close therapeutic relationships. The client wants to be a good client and the therapist wants to be a good helper. By projecting inadequacies on to others, the client and staff can remain in their positive therapeutic relationship. Whilst this might help the relationship continue, the client may be unable to be assertive in the "here and now" relationship for fear of hurting the staff, or being rejected by the staff. If this is possible, this helps the client be honest in the therapeutic relationship and work through interpersonal conflict.

Conflict resolution was a key issue in this relationship but focused on other relationships outside. This had the function of having a very positive perception of their relationship.

Both Steve and Mary stated that other helpers in A& E were not "good enough". Whilst this can clearly be the case, it also has the function of projecting anything negative out of themselves and into others. This can then lead to splitting between members of staff. Although Steve intellectually talked about this he also blamed outsiders for negative behaviours.

On looking at the transcripts, I became aware that I too have become angry with either mental health staff on the ward, or staff in A&E, who had seemed to make clients worse, who I had been working with in therapy. This then caused me to think on a wider perspective about how this commonly occurred within groups that I had taught. The group then moved to a blaming response, but about other staff outside of the room. This seemed to be occurring within the pairs of interviews. This helped me take a wider psychodynamic perspective within my discussion chapter.

Pleasing others

Mary stated that she became angry with herself for hitting her parent who was hitting her. She seemed to have developed a skill of subjugating her needs in favour of other peoples. Thus I believe that she would find it difficult to be angry with Steve. The avoidance of this issue would help her feel safer and it would also protect Steve. If she thought that she deserved to be hurt instead of her parent, then this would protect the parent from thinking they were not good enough. Thus in her current

relationship with Steve, if they work on external relationships and solving problems and emotional expression about others then Steve could remain the good helper. Unfortunately this could mean that Mary would then take the blame if anything went wrong in that relationship, as she had done with her mother. There was a tendency here for Mary to internalise anger. She would think it was her fault, but Steve tended to avoid blaming Mary and focused on other people and what they had done. This again served as a protective mechanism.

Before	
"I'm not worth looking after"	**"You are worth being looked after"**
After	
"I've hurt, so I can now look after myself"	**"I'm looking after the client"** **"I'm trying to help her make sense"**
"I'll apologise to staff"	**Anger at others "She shouldn't have to apologise"**

Steve was working on increasing self-worth with Mary. She then only seems to be able to look after herself following self-injury, as she has been hurt. Here the self-injury helped Mary to sanitize her angry thoughts towards others unless they were related to her self-injury. Anger at others for how they treated her following self-injury was acceptable to her and Steve. If other people are angry with her self-injury she could still think that she was to blame, as she has carried out the self-injury. Steve was focusing on not judging the client. However, it becomes more difficult to not

judge the other staff. By helping Mary value herself, Steve helped her to accept her anger at others and not always internalise this towards herself.

Again I became aware of how I had done this with clients in the past. I tried to avoid judging the staff, but my priority was not judging the client. I was also aware of negative real experiences that clients had reported to me in the past.

Keeping self-injury private

By self-injuring in private this was one of the few times that Mary could put her needs first. She also really found ventilation useful, as she did not need to think about Steve's emotions and protect him. She seemed quite comfortable that he could cope with her expression of emotions. This could be a time when Mary could get angry with Steve, but this was not explicit in the interviews. By keeping her self-injury private, she was able to not have to think about other peoples needs. She was able to inform the staff when she felt ready to go public. Again the hardest part reported by her was going to A&E, but most of the time her cuts were not that bad so she did not have to go.

So in summary, both Mary and Steve were protective about each other. Before the self-injury Mary was angry and reacted impulsively and Steve was unaware of the situation. During the self-injury Mary felt relieved and as if she had experienced "respite" from her internal experiences. So she had achieved not knowing through the self-injury. At this time Steve did not know about the self-injury. Afterwards, when he knew, he reported feeling surprised and began to think about how he could help Mary. She initially felt better and then felt guilty and ashamed, especially when the

self-injury became public. Steve coped by thinking that they had a good relationship and he was helping Mary. While the trigger event for the self-injury was external and the staff making her feel worse were also external to this relationship, anger could be projected on or in to them and Steve and Mary could continue to please each other by doing well in the therapeutic relationship. Whilst this is clearly helpful here, Mary may have difficulties being assertive with Steve. The containment function was expressed by both parties as being useful and Mary also enjoyed expressing her emotions about others to Steve. By keeping self-injury private, Mary did not have to think about other people's reactions. Her self-injury was her method of doing something purely for her, without thinking how this could affect others. In this sense this was a method of assertion for Mary. Steve was also helping her ventilate which was also helping her express emotions without having to think about Steve's reactions and protect him.

3) Angela and Dave

a) Before self-injury

Angela stated that she cuts her body to control her mind; Dave employed interventions to control his anxiety. Angela reported feeling angry prior to self-injury, Dave reported feeling anxious. He reported an increase in phone calls from Angela prior to self-injury, it seemed to him that no matter how much he supported her she needed to talk further. So a duty professional system seemed to work better where someone was on call for anyone in crisis. This seemed to help Angela contain her anxieties. While Dave could not give her enough time, as he was scheduled to be doing other jobs, the duty professional system ensured that person could give Angela all the time she needed

Feeling unsafe	Feeling unsafe
Anxious	Anxious
Out of control	Out of control
Lack of power	Lack of power

So here Angela and Dave were experiencing similar reactions (concordant identification)

I had experienced similar issues in my previous clinical work, where a phone call from a client in crisis would result in anxious feelings and resulting in my worry about what I should do to help. I had been aware previously how my internal reactions were similar to the client involved. I had also had this belief confirmed many times in my teaching sessions with staff.

<u>b) During self-injury</u>

Took control by cutting	Unaware
Had some power	Lack of control and power
Initially felt safe again	Feeling unsafe
Buzzy feeling/ numb	Anxious
Relieved and shaky	

So during the self-injury and initially afterwards Angela felt more in control and safe. However Dave did not know what was happening so was still struggling with the

above emotions and negative thoughts. Thus he had experiences of fear and Angela did not.

Again this was a familiar experience from my own clinical work and educational practice. I believed that the staff were sometimes left with the emotions and their task being to contain these, rather than trying to control the other person's self-injury. I really admired Dave for being able to contain these difficult emotions and remain engaged helping Angela.

c) After self-injury

After the self-injury, Angela reported feeling relieved, but that her emotions of anger and hurt soon returned along with shame and guilt.

> "But for me, yeah, there is a certain amount of relief. I think that's because you have just done what you have been planning, you've finally done it. But it doesn't make me feel good. I still feel angry, I still feel hurt, I still feel disgusted with myself."

Dave also reported feeling relieved that Angela had survived.

> "Well I felt a little let down but then I was thinking about how well she has been doing recently. You get used to the emotions a bit and she has done much worse than this you know, so I was also a bit relieved that she wasn't too hurt."
>
> "My first thought was I wonder if it is ...., I haven't heard anything yet, so hopefully not, but you just never know. Sometimes with ...... as she is feeling better she does something. But hopefully she will be ok."

Here Dave was able to challenge his thoughts immediately as they arose and end with a comforting thought based on faith that Angela was getting better. However there was still the element of doubt there.

Reading the interviews, I revisited my awareness of the comforting thoughts that I would use to help contain my anxiety. Theories on containment were useful to inform my comforting thoughts; such as I need to contain these emotions in order to help them. I was quite surprised how quickly in the interviews that the anger became re-directed towards the A&E staff.

Angela and Dave expressed some quite negative views about the staff in A&E.

Blaming others

"I'm to blame"	"They are blaming her"
"I shouldn't have done it"	"They are making her worse"
"I'm ashamed"	"Just when we were making good progress"
"I don't deserve help"	

This view was especially difficult for Angela and Dave as they were both general nurses. Again they both thought they had a really good relationship, but that the main problem was with how A&E staff treated her. Pearlman & Saakvitine, (1995) recognise that clients may anticipate humiliation when experiencing certain emotions in public. To be seen as wanting or desiring anything is enormously shaming. So here as Angela was looking for help and understanding in A&E, this seemed shameful for her, especially when linking it to her coping strategy of standing looking into the corner whilst in the waiting room.

> "And then you sit and wait for two hours while you are sobbing your heart out in the middle of a waiting room, while everyone is staring at you and I can

> never sit down. So I'm often stood for two hours, you know with my face against the wall."

She seemed to see crying or expressing fear in public as humiliating and dangerous.

Although these experiences of rejecting staff were based in reality, they also had the function of keeping good aspects with the staff or client and the bad part aspects with the A&E staff. Dave was trying to get Angela to accept her good qualities, but she found it difficult to keep these in focus. Both parties felt they were "loosing the battle" in A&E.

> "Well I just get really angry as she can be getting on well and then she cuts, goes to A&E and gets all her negative beliefs about herself confirmed. I then have a lot of work to help repair the damage done to her self-esteem."

Here the blame was externalised to the A&E staff. Again this can link into a parental countertransference. This serves to externalise the anger outwards, rather than to the self. Parental countertransference is common when working with clients who self-harm or who are chronically suicidal (Pearlman & Saakvitine, 1995). A parental countertransference was common in all three staff accounts however, this was not always clearly expressed. They all seemed to want to repair the damage done, re-parent and make up for the injuries that the client had suffered. Feelings here included protectiveness and fear and anxiety for the client. Here Dave was responding to Angela as an adult responds to an abandoned hurt child. This type of countertransference can be helpful but also problematic. If the helper models appropriate parenting for the client, this can be helpful in the healing process. The helper can convey that the client is a person of value who is entitled to care and respect. This seemed to be challenging Angela's self-beliefs. Indeed this was an ongoing process within the relationships of all the staff and clients interviewed.

However re-parenting impulses on the part of the helper may infantilize a client and deny the adult functioning part of the client (Pearlman & Saakvitine, 1995). This role in the therapist may invite transference to the therapist as all knowing, all-powerful and all nurturing. This however was not reported with the staff interviewed. They had all managed to use the positive aspects of this countertransference response without having recent problems with this.

I reflected upon my experiences of becoming angry at other staff when working with clients who self-injured. I believed that the work I was doing with the client was the right way to help them. I became aware of other staff who began rescuing clients, but had less of an awareness of how I would do this in more subtle ways, such as blaming other staff. Within the research process I was also aware of how I still want to help people who self-injure and how difficult this is. When Angela spoke of her humiliating experience standing in the corner in A&E I too became angry that she had this experience. It challenged my beliefs that everyone should be treated with dignity and respect.

Reconceptualising self-injury

An important aspect was the positive re-framing following the self-injury after the event. Angela stated that she would feel very guilty following self-injury and Dave seemed to help her reflect on the situation and not get focused on her negative thoughts about herself and others.

Laughing and being human

This was emphasised by both parties. This really helped the relationship grow. Being genuine was valued highly by Angela. She liked to see some emotional reactions from Dave. The use of humour helped to re-focus on Angela and her underlying issues rather than on the self-injury. Although this may help avoid the self-injury, this could have helped Angela and Dave distance themselves from difficult emotions.

Angela was also aware if Dave felt disappointed after her self-injury. She did not have a problem with this and seemed to want him to be genuine in expressing his emotions.

Reality checking

Both Angela and Dave stated that they were aware of her tendency to polarise. She said that she used Dave to check out reality, to see if she was getting into extreme thinking about an issue. This seemed to work well for them both.

Private hurt and public humiliation

Angela self-injured in private as much as possible. She emphasised that it was just her that should hurt, no one else. She was frightened that if other people could see she was hurt then they would be angry with her. She really was pre-occupied with other people being angry with her. She wanted to protect other people from hurt, but could not protect herself from hurt from others. This was very clear when she described attending A&E when other people's reactions really affected her. She really struggled going to A&E as she wanted her self-injury to remain private and avoid feeling shame, embarrassment and guilt, but as her wounds were so deep she had to go. She often did not like the staff informing Dave, she did not want him to

know for fear that he would be angry with her. This had never happened, but she still expected this reaction from him.

Both Angela and Dave also expected negative reactions from A&E staff.

Felt let down	**Felt let down**
Disappointed	**Disappointed**
Relieved	**Relieved**
Glad it's all over	**Glad it's all over**
Expecting negative A&E staff reactions	**Expecting negative A&E staff reactions**

Overall Angela and Dave both described fluctuations between extreme emotional states of numbness or not knowing and hyperarousal. Kohut (1977) calls this "transmuting internalisation". In this process the therapist may feel abandoned or assaulted and they are left alone to guess what the client is experiencing. This was clearly described in Dave's interview, where Angela would ring up to communicate her need to self-injure and Dave would be left guessing whether or not Angela was suicidal or self-injuring to survive. Here Dave held the affect with Angela. If she went off and self-injured Angela would be able to stop her thoughts and feelings temporarily, but Dave would still be experiencing his emotions and thoughts. This was common in this relationship when Angela had self-injured and Dave knew he held the anxiety, fear, anger and helplessness, while Angela felt numb. Here Dave was aware of Angela's internal state by reflecting on his own. Dave reported how he had found a method of containing these internal experiences and making them

manageable for him. He spoke about feeling and accepting emotions and thoughts and then moving onto focusing on how he could help Angela.

> "Well, I felt slightly anxious, but I know that .... often cuts and is not suicidal, but there is always that doubt in your mind that this time it may be different, isn't there? So on one hand I have got thoughts around this being ok and she will survive, but on the other hand she may do something more and try to kill herself."

Dave often experienced an internal battle between the comforting thought that she would be ok, but also the frightening thought that she would kill herself this time.

> "I just tend to accept that she has done it and then move on to understanding why and how we can move on."

Here Dave demonstrated that he pushed his internal personal experiences down and focused on how he could help her.

This confirmed my beliefs and previous experience of what had helped me continue to support clients who self-injure.

Loss and fear of abandonment

Within Angela's interview she discussed her devastating loss. Less apparent however was her fear of abandonment. This became clear in Dave's interview when he described the intense phone calls when Angela was in crisis.

> "Her phone calls got worse and worse, wanting to speak to me seven or eight times a day. I would try and speak as much as I could."

Here, Angela seemed to be unable to keep Dave in her mind and imagination. She tried to deal with this by repetitively ringing him at difficult times. She may have also needed to ensure Dave's mindfulness by evoking worry, concern and anxiety in her helper, to ensure she was not forgotten.

Blame

Angela thought she was to blame. Although Dave was aware he was not responsible for her actions he was aware that if she killed herself society would look to blame him.

> "I would be the first person that the courts need to speak to if anything goes wrong."

> **"They will blame me"** **"Society will blame me"**
>
> **"I'm to blame"**

These beliefs about blame can also be reinforced by other people. Angela discussed how a paramedic blamed her for the influence on her family.

> "The ambulance appeared, which I didn't order, that was just a bit of a mix up and the ambulance man finally persuaded me to get in the ambulance and thought I was about 18 and said, no then have you had a row with your boyfriend? I looked at him and said, do I look like I've had a row with my boyfriend? Well have you considered how this must hurt your children? Well yes, I've considered it many times. In the end, I said if you are not going to take me to the hospital, I'll walk there on me own thank-you. And I got out of the ambulance and walked."

Angela then empathised with the professionals;

> "They get to this stupid woman that's come in again with a cut. I can understand why they would get frustrated."

Angela was angry at this treatment and the projected blame that came from the staff. She then responded by empathising with them and took the blame. She had an internal belief that she was to blame, this was reinforced externally and she was left believing she was to blame with more conviction.

Dave also described feeling blamed by other staff during internal investigations.

> "I need to be really careful about how I document everything as the managers would be on my back if anything went wrong."

So here, Dave was taking therapeutic risks with Angela, but also had to contain his own anxieties about organisational systems that could turn the blame on him at any point. Thus the blame is projected from staff to Angela and also could be projected on to Dave if anything went wrong. Again here there are similar reactions between staff and client, expecting and receiving blame (concordant projective identification).

I remember the fear of blame and litigation well from my clinical and educational work. On thinking about these interviews I became angry at other people's need to blame, especially blaming health professionals. I then became aware again of my own process of projection of blame on to others and keeping Angela and Dave in this positive helping relationship. I too was taking part in another projection of blame. Shared with Angela and Dave, I was able to have periods of empathy with the "others" and then periods of anger. This confirmed some of my beliefs that these processes can be projected around to observing others in roles such as clinical

supervision and research. This can also be part of a process for the reader of any research or thesis.

Dependency issues

Dave was very aware that Angela had difficulties trusting. Whilst they had managed to build a trusting relationship he was aware that this would need to end in the future.

> "I am trying to work towards discharge with her, I have been seeing her for the last three years and she is doing well, but I think she will find endings difficult."

Whilst reading the transcripts, I began thinking about how Psychiatry seems to dislike clients that become dependant, yet also focuses on a trusting therapeutic relationship as a treatment strategy. Angela thought that "Every time I trust others leave me" this was related to her previous experiences. This would be confirmed when Dave would need to stop working with her. A better way forward for both parties would be for Angela to withdraw at her own pace. This is what Dave was trying to do.

Staff coping strategies

In order to cope with anxiety, Dave thought the following

> "She often cuts"
> "She will survive"
> "Overall she is getting better"

These thoughts had a positive containing function, reducing his anxiety levels. This ensured that he could support Angela and contain his own emotions. However if he thought the following, his anxiety levels and fear rose.

> "This time may be different"
> "She may do too much damage"
> "I don't trust managers"

"Everyone will blame me"

Angela was unaware of the function of her self-injury at times and this only became apparent following reflection on the crisis afterwards. This then made it difficult for Dave to assess risk and prevent further harm. This then raised his anxiety levels considerably. This was contained by the team working together to take increased risk and not admit her to hospital. At this time Angela would be feeling unsafe with a lack of control and power and Dave also felt the same. Here he worked with the team to contain the emotions, rather than act them out to control Angela.

Dave often talked about the process of not knowing what was going on. He was able to contain his anxieties about this and continue to engage with Angela. Pearlman & Saakvitine, (1995) state that it is common for helpers to find themselves in a position of either knowing or not knowing. Here the helper needed to be able to tolerate "being in the dark", which is exactly what all three members of staff interviewed were able to do. With Mark, Ian was able to clearly tolerate not knowing about self-harm, but instead focused on developing other activities and aspects of their relationship.

In summary, both Angela and Dave had negative views about A&E staff. Angela expressed shame and guilt, then anger at the staff. Dave just expressed anger at the staff. Again as with Mary and Steve and Mark, although the anger may be just and directed appropriately, another function of this is that the anger is projected on to others and thus protects the therapeutic relationship and the self. So here parental transference was reported, but seemed to work well. Dave was able to explore conflict within their relationship as well as with other people. Angela would feel guilt and shame following self-injury and Dave had an essential role of helping her reflect

on this and challenge some of her thoughts. Both parties expressed an emphasis on humour and genuiness. Prior to the self-injury, Angela felt angry and Dave felt anxious. This was conceptualised as a complementary projective identification where both people were very aware of their internal experiences. At times both Angela and Dave would both feel anxious and this then was conceptualised as a concordant projective identification. During the self-injury, Angela had taken control and self-injured. Dave was either unaware that she had done it, or would feel anxious, as if he was waiting for something to happen. Dave was able to recognise these emotions and thoughts, but not be compelled to act on them. Thus he was able to embrace "not knowing" what to do, and just manage his reactions. He did this by using comforting thoughts, but was still aware of possible negative outcomes. Both people felt relieved after the self-injury and Dave then worked on helping Angela with her shame, guilt, hurt and anger. Both parties expected blame from other people. Angela also had a fear of abandonment possibly linked to her loss issues. This seemed to link into her expectations of angry responses from others and then possible rejection or abandonment.

Following analysis of the interviews in pairs some interesting themes have emerged. Dissociation was prevalent for clients and staff. Re-enactment of abuse or trauma was also a strong theme. Experiencing shame, hurt and anger appeared to trigger self-injury, but self-injury was also reported to have caused further shame and guilt afterwards. A key theme here was also the use of projective identification and projection for the client and staff. It was common for the clients and staff to be angry with the staff in A&E. The staff interviewed were able to cope with "not knowing", cope with their internal experiences and remain in the relationship.

These issues will now be expanded upon in the discussion chapter.

Chapter 7: Discussion

This chapter discusses emergent themes identified from the interviews. Self-injury is viewed as a cycle of shame avoidance and shame induction. Defense mechanisms such as dissociation, splitting and projective identification were used by clients and also staff. These processes are then related to organisations, society and the blame culture surrounding self-injury.

The concept of shame was a key issue within all of the interviews; the evidence is described in this chapter. Shame infiltrates through all people and systems, the client, staff, team, organisation and society at large and can result in a culture of blame. Clients and staff used a variety of psychological defense mechanisms to cope with their internal experiences. All interviewed utilised splitting, projection, projective identification and dissociation at times. The staff also emphasized reflective processes that helped them re-engage with the client after the self-injury. Clients recognised the staff role in this process, but did not report doing this themselves. Instead they preferred to forget about the self-injury after it had happened. Devalued and devaluing representations, associated with shame have been utilised to describe interpersonal and organisational issues. These positions appeared to be projected between client, staff and institution and are also a central component of the blame culture within society.

Within the staff interviews it was noted that they had various methods of coping with their internal experiences linked to the client's self-injury. Traditionally within the professional literature, psychological defense mechanisms are associated with

clients, rather than staff. However if the staff countertransference is the focus, the existence and impact of staff defense mechanisms are recognised (Alexandris and Vaslamatzis, 1993; Pearlman &Saakvitine, 1995; Gabbard, 1993). The similarities between the client and staff psychological defense mechanisms were clear from the interviews, however the staff returned to a state of mentalization or reflection following these actions, but the clients did not report doing this themselves. The staff had a pivotal role in assisting the clients in this process.

When a client is experiencing self-destructive thoughts and behaviours, the cumulative effect on the helper is significant (Pearlman &Saakvitine, 1995). The helper needs to hold on to hope in the face of despair and helplessness. All three staff, to some extent witnessed brutal behaviour towards someone they cared about and were trying to help, this was traumatizing in itself. Here the staff seemed to be a helpless witness to a brutal assault. This may be a process that clients have experienced if they have had traumatic childhood experiences (Miller, 1994).

The helper could become a victim or a helpless witness to trauma (Pearlman &Saakvitine, 1995). They state that transference around the client's identification with the aggressor has two forms, the client may enact assaults or seductions on the helper, or they re-enact the trauma on themselves in front of the helper, ensuring the staff become a helpless witness. The latter was described by Ian and he had to find a way of coping with this experience, using psychological defense mechanisms. This process of being a helpless witness may happen during self-injury or afterwards. This can be a behavioural demonstration or a description using words. It is still difficult after self-injury for the helper to have not been able to help the client to prevent self-

injury. However, the staff interviewed did not set themselves up to prevent self-injury. Instead they accepted that this might happen. This approach seemed to help them avoid feeling a failure and thus experiencing shame. The clients interviewed all explicitly stated that they did not want to know the negative effects of their self-injury on the staff interviewed. This implied that they feared a negative reaction from other people about their self-injury. All clients reported a sense of protection that they felt towards the staff interviewed. If they became aware that their self-injury had hurt the staff in some way, they may have felt that they failed to protect them. Two staff reported experiences of feeling like a helpless witness while the client was self-injuring or shortly afterwards. Bateman and Fonagy (2006) state that self-injury can serve to create a "terrified alien self" in the staff helper. So depending on the staff internal state, they can experience a terrified state or a helpless bystander state. Both these experiences can be perceived by the helper to be shameful.

Experiences of shame

Crowe (2004 b) states that the signs of shame include;

> "The person's description of themselves with negative global evaluations, such as I'm bad, faulty or inferior.
>
> The person feels a need to hide themselves away from others who they see as evaluating them.
>
> The person may express hostility to others who they perceive to be evaluating them.
>
> The person expresses a sense of powerlessness or worthlessness.
>
> The person may be sensitive to the opinions of others."

Clients interviewed expressed all of these signs of shame after self-injury and some as a trigger. Staff experienced some of these signs, but not consecutively and reported feeling a failure in earlier work with the client, or with other clients who self-injured. The interviews will now be discussed in the context of shame. The client and staff interviews have been discussed together in order to integrate the experience, rather than reinforce separateness.

Wheeler (1996) defined shame as a belief in the unacceptability of personal needs, characteristics and desires in a social relationship. Shame has a focus on a belief that the self is bad or defective, whereas guilt has the focus on the behaviour being bad or defective. Thus the person and the behaviour are inseparable with shame and this can result in increased emotional impact (Buckbinder and Eisikovits, 2003). Within the client interviews, some people were more explicit about their experiences of shame than others. Angela stated that she thought, "You deserve to hurt" "I am doing stupid things" "I'm useless" These statements are self-blaming, self-critical and are common expressions of shame (Wheeler, 1996). All clients expressed ideas that they "deserved to feel pain" as they were bad. The staff described less overt messages about shame. All three staff spoke about helplessness, feeling a failure, but did not link this to beliefs about themselves being a failure at the time of the interview. This is discussed further later in this chapter.

None of the clients used the word shame to describe their internal experiences prior to self-injury but all linked shame to the process of self-injury and also were very explicit about the shameful experiences following self-injury that exacerbated their

previous internal experiences. Shame leads to a desire to escape and hide, to shrink into the floor and disappear (Lewis, 1986). This was clearly described by Angela after her self-injury when she would stand in a corner in A&E, sobbing and avoiding eye contact when she thought that everyone was staring at her. Gilbert (1997) states that people develop methods of avoiding shame and described these as safety behaviours. Self-injury could be conceptualised as a safety behaviour to avoid the experience of shame. However if this is the case it is a self-defeating behaviour as it was reported to result in further shame.

All three clients interviewed had experienced traumatic childhood events. Many trauma or loss survivors learn to fear the experience of affect (Andrews, 1998). This can be also accompanied by self-loathing and fears of abandonment and annihilation. The child may have also learnt that showing feelings makes them more vulnerable to harm. In all the clients interviews anger was reported as the immediate emotion prior to self-injury. Attributions such as "This has happened before, so it's my fault" commonly lead to shameful responses (Andrews, 1998). These attributions can occur as a result of a variety of childhood experiences, but are commonly reported as a result of physical and sexual abuse (Andrews, 1998). Whilst one client reported what could be perceived of as physical abuse and one client hinted at past difficult experiences, one client clearly informed me she had not been abused, but had experienced significant losses. The attributions were present in the interviews, but the clients past experiences were not always clearly linked within the short time of the interview.

All the clients reported wanting to avoid their internal thoughts and emotions, which were reported to be triggered by anger. However anger can often mask shame (Kaufman, 1989). Some shame researchers argue that anger and rage are subsequent responses to shame, but that they can be activated so quickly that a person may lack conscious awareness (Retzinger, 1991). Thus the clients may have actually felt shame, but activated anger pre-consciously to bypass shame. Anger and aggression can be triggered to cope with or conceal shame (Gilbert, 1997). This was often the case for Mark, when he reported anger at other people as a trigger for his self-injury. He stated that he preferred to use self-injury to cope with his anger, rather than aggression as this was more effective and within his control. Mark differed to the women in that he initially stated that his anger was directed at other people, hence his other coping strategy of causing a fight and getting others to injure him. Eventually Mark stated that he was angry with himself and also spoke about a process during his rituals prior to self-injury where he reinforced anger towards himself. He stated that he needed to do this in order to self-injure. The women were clear from the trigger that they were angry with themselves. This supports the idea of women tending to internalise anger and men tending to externalise it (Harrison, 1994). The staff also reported anger rather than shame, but this was directed towards external staff teams, such as A&E or other mental health services with "untrained" workers. They too could have unconsciously activated anger, to avoid feeling shame. Client and staff appeared to be more comfortable expressing anger rather than shame.

Participants may have also felt too ashamed to express shame in the interview. Macdonald and Moreley (2001) found that shame was the emotion that clients in

psychotherapy were most ashamed of disclosing. All clients interviewed in this research did not disclose shame prior to self-injury only anger. Angela most clearly expressed shame in the interview, but after the self-injury rather than before. She stated that she felt "worthless with added shame on top". Angela remembered self-anger and thoughts of being useless and personally to blame prior to her self-injury. She had self-blame prior, and blame towards others after, self-injury. So she had some signs of shame before self-injury and bypassed this emotion with anger. All clients were able to express shame and guilt following the self-injury, but this was often linked to other people's reactions of disgust, superiority or rejection and a sense that they were unattractive to others due to the self-injury or that they were inheritantly bad. These reactions were both expected and experienced. Self-injury here also seemed to have a function of helping the client verbalise shame and guilt afterwards based on perceived negative reactions from other people. Andrews (1998) and Seidler (2000) emphasise that when a person is experiencing shame they are often unable to verbally express this emotion. Shame may be concealed from conscious acknowledgement or not disclosed due to experiences of further shame on describing a shameful experience. This could have been why the people interviewed did not often use the word shame to describe their experiences. Self-injury could assist in verbalising shame if people were unable or unwilling to talk about shame. Retzinger (1991) states that people also lack the verbal schemas needed to articulate that they feel ashamed. So the clients may or may not have felt shame before the self-injury, but this was not verbalised. However, following self-injury and an interaction with another person shame was overtly described. As such it seems that the initial experience was too difficult to verbalise. This only happened when other people took the position of devaluing other and reinforced the shame. Staff

interviewed also may have found shame difficult to verbalise. This may have been compounded by my job and professional training and a need to impress me. They may have feared negative evaluation from myself as the interviewer. Indeed to be a failure is one of the most difficult experiences for staff in helping relationships (Roberts, 1996). Clients may have been more able than staff to verbally express shame. Staff were keen to inform me of their helpful interventions but were less forth coming about interventions that did not work. However, all staff were able to state that they felt a failure at times, either in the past with this client, or with another client.

Shame is often described as acute arousal or fear of being exposed, scrutinised and judged negatively by others (Fischer and Tangney, 1995). This was clearly reported by all clients in their interviews about attending A&E following self-injury, but also in relation to self-injuring in private and remaining alone initially afterwards. In shame, the self is considered to be both the agent and object of observation and disapproval, as shortcomings of the self are exposed before an internalised observing other (Andrews, 1998). As such, shame can be experienced interpersonally and intrapersonally. An external observing other need not be present, as the person holds that experience within, based on previous experiences. Thus when Mark perceived a punitive response from the A&E staff this seemed to be related to his previous experiences of rejection and humiliation, as Ian observed the interaction with the staff and did not perceive this to be negative or rejecting. This was further compounded by a visit to A&E where the patient is expected to expose himself physically and mentally, whilst having a fear of being exposed and judged negatively by others.

Crowe (2004a) states that impulsive acts such as self-harm may discharge emotions, but that they also may contribute to further shame. In the client interviews, the self-injury helped them avoid shame, rather than discharging or communicating this to other people. This may be because all clients chose to self-injure in private, rather than public. Mark and Angela described purposely cutting where they could hide the scars. In order to seek help at A&E they were required to expose these wounds for assessment. They were also required to talk about why they self-injured and what had happened. So a physical and psychological exposure occurred at the same time, when feeling vulnerable and ashamed. This would be difficult enough if they were able to trust, or were doing this within a trusting relationship. However this exposure happened within a context of difficulties trusting new staff helpers who the clients were expecting to reject them and think that they were "disgusting, inferior and worthless". Staff were asking the clients to expose themselves further when expecting a shameful response. This appeared to be a re-enactment of the processes of the self-injury, but in public, rather than private. The clients reported feeling ashamed whilst seeking help in A&E and then they were expected by staff to expose their wounds and experiences to an observing other, who may judge them in order to receive help.

In assessment staff may expect clients to know why they self-injured. There may be an expectation that the client knows why they self-injure. If self-injury is a method of avoiding shame and anger, staff then ask the client to confront and verbalise these internal experiences when seeking help in order that we as staff can "know" Mark stated "they wanted to talk about it, I didn't" He recognized the pressure he felt during this process. All clients expressed a need to "just move on" and forget about

their self-injury. This was difficult in A&E with staff they did not really know, but they seemed more able to do this with the staff interviewed as they had a close, longer term relationship, the clients did not report needing to avoid talking to the staff who were interviewed. Avoidance of the previous internal experiences are understandable, especially if internal experiences related to the present treatment (further shame and anger) are being experienced. Unfortunately in the long-term if the clients and the staff choose not to reflect on their experiences of self-injury and recognise the mental states of both people they do not just disappear.

It could be argued that shame traps the person into feeling a failure and worthless. This in turn may generate an experience of self-rejection and rejection by others. This may then lead to a sense of helplessness, inferiority, vulnerability and loss of control. These were all described by the clients before and after self-injury. Angela summed this up when she said that self-injury

> "Just perpetuates the feeling that you are worthless and then you are worthless with added shame on top."

Shame involves a sense of exposure and then disapproval from sources outside of the self (Tangney et al, 1996). This was clearly the process described by all clients interviewed. An exposure of their wounds of self-injury in the hope of a caring response became a devaluing and humiliating experience. However, in the interview Angela described considerable empathy to the nurses in A&E and their negative attitudes to her; she stated that she was unable to do this whilst she was experiencing anger and shame. So at the time of experiencing further anger and

shame in A & E empathy with staff was difficult. However, this was a useful ability later when reflecting on her previous experiences. In the staff interviews, they may have felt exposed when the clients needed to go to A & E for treatment, but this was not verbalised apart from that A&E staff didn't understand their work. Mental health staff can expect general staff to be unable to understand their psychosocial, rather then physical interventions. Clients experienced shame following self-injury. If seeking help at A & E devaluation was often expected and/or experienced from the staff, thus confirming their devalued self-beliefs, "worthless with added shame on top"

The effects of shame

All three clients were aware that they tended to assume negative reactions from other people. Although they all had a sense of pride about being good at picking up non-verbal communication, only one client described how she could empathise with the nurses in A&E as she had been a staff nurse. Indeed Tangney et al (1996) stated that when people feel shame their self-efficacy is affected and their awareness of others negative reactions (expected or experienced) is highlighted. This seemed to be the case with all three clients, but Ian reported an observed difference in perception to Mark when they attended A&E together. Thus for him at this time it could have been an expected devaluing reaction linked to the professional behaviour he had previously experienced.

Shame tends to be disorientating and producing disruption in thought (Benson, 1994) All clients expressed emotions more than thoughts, prior to self-injury. Crowe (2004) states that the shame affect is intrinsically linked to a person's ability to express their

own emotions and read the emotions of others. Although these were expressed in the interviews, this may not have been possible immediately prior to self-in jury due to the shame experienced. In addition to this Crowe (2004 b) describes a disturbance in reflective capacity, which can lead to polarized perceptions of other people. So here the experience of shame is thought to lead to difficulties leading to splitting as a psychological defense. This was reflected in the clients' interviews. The polarised thinking was initially self then other directed.

Mentalizing is a concept that has a focus on mental states in oneself or in others to explain behaviours (Bateman and Fonagy, 2006). People with a diagnosis of BPD are believed to have problems understanding their own thoughts and feelings and also those of other people. Again this would help in understanding difficulties prior to self-injury but also perceptions of other people's internal states following self-injury. Lewis (1986) argues that episodes of shame have a panic like quality to them, where the capacity for rational thinking steps aside. This was the case in the client interviews. They clearly spoke about anger and anxiety, but did not clearly make the link to shame prior to their self-injury.

A tendency to hold anger in a ruminative fashion, when experiencing shame was also noted by Tangney. This was apparent in all of the clients' interviews. They all had self-rumination anger that they stopped by using self-injury. Bateman and Fonagy (2006) state that self-injury can be a method of bringing back the ability to mentalize when the person was having difficulties thinking. Thus if the clients were ruminating about anger, this could prevent them understanding other peoples' mental states.

Fonagy (2004) has speculated that for physical violence to be possible the aggressor has to not think about the person being violated as having a mind, either thinking of them as a physical object (depersonalisation) or a member of a large alien group. With self-injury, the person is the aggressor to themselves. Thus, this behaviour would stop the person's ability to mentalize as they need to focus on the skin as a physical object and depersonalize. In the client interviews this was reported as the main reason for self-injuring, to stop the thoughts and feelings. Mary stated that she needed to make her internal experience visible. However, this had changed for Angela. She reported needing to feel and think when she was severely depressed and started self-injuring. This function confirms Bateman and Fonagy's ideas that self-injury brings clients minds back to the point where it was lost. In this example self-injury is thought to reinstate a mentalizing mind. However, the recent incident of self-injury that each of the clients chose to focus on assisted in avoiding or stopping mentalization. It seems that self-injury can be used as a method to stop mentalization or avoid thoughts and feelings or as a method of inducing mentalization and focusing on and communicating internal states.

The staff were more able to reflect on their relationship and interventions with the clients. They were able to mentalize their own mental state and also the clients. They were able to embrace the differences of experience for themselves and the clients, rather than assuming they would react in the same way as them. However they seemed unaware of their difficulties mentalizing when they became angry with the staff in A&E.

Managing shame

Scheff (1997) links shame and humiliation in an affect program. Lewis (1998) writes about how unacknowledged shame can become humiliation fury and the guilt for forbidden anger. This can then create a "feeling trap" where the person oscillates between shame and anger, each state rekindling the other. This is the cycle described by all of the clients in the interviews. They described anger prior to self-injury and shame and humiliation following self-injury, then externalised anger to others before experiencing self-anger, blame and shame again. They have all used self-injury to try and avoid this position, but it can also unfortunately serve to compound the position further.

The clients all reported feeling ashamed following self-injury, either when other people found out, but also when they had to go to A&E. Shame could also have a large role to play in keeping the self-injury a private matter. Shame has been framed as an individual vulnerability that interacts with didactic organisation and alienation, resulting in a mutual persistent cycle of shame and humiliation coupled with destructive rage (Balcom, 1991; Scheff, 1997). This cycle mirrors the experiences described by the clients in the interviews. The experience of shame and anger lead to the self-injury, which then resulted in a trip to A&E where they felt publicly humiliated. Coping with shame requires ongoing withdrawal and escape aimed at gaining existential space, but achieves only paralysis and further chaos (Meifen et al, 2005). This seemed to be the case with the self-injury described here. The self-injury is a method that helps the client withdraw and escape, this also helps numb internal experiences (like an internal paralysis), but this behaviour often then creates further chaos and dependency on a coping strategy that is shameful. Thus the initial private

self-injury becomes a public humiliation in A&E (or wherever the person goes to seek help with the wounds).

Humiliation involves focus on the other person as bad, whereas shame has a focus on the self as bad (Gilbert, 1995). There is an internal attribution of harm and a sense that this is right. All three clients had a perception that they were bad and should be hurt or punished. They all also had a sense that the A&E staff were to blame for the humiliation, linked to their attitudes and behaviours. However they all also experienced shame and had a sense that they were to blame. Thus the shame could have been projected from client to staff and/or from staff to client. We can feel shame when we have done nothing wrong, but be aware that we have created an unattractive image of ourselves in the eyes of others (Gilbert, 1995). Indeed Mark clearly described self-injury as the right way of coping for him, but still felt low afterwards. One can be scarred, damaged or contaminated by others, but then feel ashamed of having this scar or damage revealed or seen (Gilbert, 1997). All three clients reported self-injuring mostly where other people would not see the scars. It was only as they became more desperate that they did not care where they injured. There was a conflicting relationship with cuts or scars needing to remain hidden, but a sense that they were reassuring for further pain experience if required.

So for the clients in the interviews, they reported expected humiliation and shame in A&E, with the expected devaluing staff and also experienced humiliation and internal shame related to previous self-injury. In addition to this, the act of self-injury serves to expose wounds, both physically and emotionally. Mark limited the exposure of his emotional wounds by not wanting to talk about the self-injury, or having the focus of

his treatment on his self-injury. Instead he preferred that staff get to know him as a whole person. Although this is an understandable point, Mark's injury was also part of his self as a whole. It seemed as though there were still aspects of himself that he could not accept. If staff could accept the injury and also the rest of the person as an integrated whole, this would demonstrate acceptance and validation.

Private self-injury to avoid further shame

All three clients reported wanting to keep their self-injury private if possible and avoid this experience of shame and humiliation. They seemed to understand the shame inducing role of self-injury. Mark reported a tendency to hide himself following self-injury, as other people would know that he had self-injured. He also did not like talking about the self-injury and emphasised that most professionals wanted to focus on his behaviour only. Bateman and Fonagy (2006) state that the process of finding meaning to self-injury and a focus on behaviour, rather than mental state can be shameful in itself. However Mark seemed to want to avoid discussing the self-harm by just being with the person. So this state of not knowing about the meaning of the self-injury would have been helpful to Mark.

Kroll (1993) emphasises the public demonstration of self-injury wounds with the expectation of eliciting a response, usually support from others. Whilst this may be the case for some people who self-injure, this was not reported in the client or staff interviews. The clients reported the necessity to show self-injury in A&E to receive treatment that they wished they could do themselves or receive in private and thus reduce further shame and humiliation. So the self-injury helped the clients avoid shame and anger, but was not reported to be intended to get a caring response from

others. However due to deep wounds afterwards, help was required. Kroll argues that psychotherapists focus on the private statement and avoid the public statement. This seems a simplistic view and assumes a conscious need for attention. This was not confirmed in the clients' interviews. However, the clients' reported a focus on self-injury as a behaviour rather than their private or internal experiences. Both elements need to be understood and integrated for staff and clients. For the clients, self-injury was a private affair with public exposure for treatment. However this exposure may have affected the staff and judgements may be made about the client's motivation being a "cry for help" Staff responses were not the main aim for the client's self-injury within this study. However they received responses anyway, especially if they attended A&E. The problem is if the staff assumes that self-injury is a "cry for help", as they may move into a rejecting punitive role, as they could have asked for help without self-injuring, or alternatively they may take on a rescuing role (Gabbard & Wilkinson, 2000).

Reconciliation and repair

There are reports of using behaviours to repair shame, such as secrecy. All three clients interviewed had tried to keep their self-injury a secret, or at least private. This served to keep their external environment stable and also limit damage to other people. Angela and Mary were very concerned about protecting other people from their self-injury. Mark was less focused on protection of others, but he still required privacy. They all went to considerable lengths to ensure that they were alone prior to self injury.

Apologies to others following experiences of shame, demonstrate submission (Gilbert, 1995). He argues that people experiencing shame may lack reconciliation skills as well as opportunities for reconciliation. Mary reported that she always apologised to others following self-injury as she was unable to apologise to herself as she was not worthy. So here her sense of unworthiness and devalued self externalised the good to other people, when she believed them to be superior or worth more than her. This interfered with her ability to reconcile with herself. Although this could be viewed as a positive way of coping and repairing the relationship with A&E staff, this appeared to make Steve angry. He thought that Mary had "nothing to apologise for".

A positive aspect of shame is it is thought to be an appeasement gesture (Gilbert, 1995). Its function is thought to lead to reconciliation after social transgressions and to reduce interpersonal conflict. By feeling ashamed, the person accepts that they may have done something wrong. If self-injury is utilized to cope with shame, this process of reconciliation is halted in the development of further interpersonal conflict. The expression of shame can bring on a sympathetic response from others, which in turn can motivate an altruistic helping response in others (Eisenberg et al, 1989). However if self-injury is used to cope with shame and the resulting anger and anxiety, this helping response can become a rejecting response, as the method of coping is not acceptable to others. If shame could be expressed following self-injury this can lead to a more positive helping response. If shame is expressed prior to anger, anxiety or self-injury, then these reactions would not need to occur.

Shame was overtly evident in the client interviews and more covert within the staff interviews. The concept of the devalued self and devaluing other representations appear to change for clients and staff at different times in the process of self-injury and treatment afterwards. Different issues were identified for clients and staff but similar coping strategies were evident.

Psychological defense mechanisms: splitting, dissociation, projection and projective identification.

These concepts are introduced and defined within Chapter 2. Within this chapter these concepts are utilised to develop the discussion.

Dissociation

Associated with the experience of shame is a sense of loosing control and letting something out. However, within the client interviews self-injury was reported to numb the internal experiences and make them more manageable, rather than letting something out. Actually the clients let blood out of the body, rather than their internal experiences. The three clients reported that they wanted to disconnect from their internal experiences, rather than communicate these to other people. Self-injury appeared to be a method here of containment, rather than communication of internal experiences, which is more commonly reported in the literature on self-injury (Babiker and Arnold, 1997; Miller, 1994; Connors, 2000). Mary was the only client to report a communication of pain element to her self-injury at times. She thought that other people understood physical pain more than psychological pain.

All three clients described self-injury as a process of dissociation. Mark and Angela reported a "buzzy" feeling, immediately after the self-injury that appeared to be a type of dissociation. For Mark this state was described as "sitting in a chair and staring at the roof for hours" He equated it as being similar to a drug, but different in that the "buzz" was not a feeling of being high, but relaxed and numb. He described this as the "after Sunday lunch feeling". Mary described a process of "respite in the head" where the self-injury stopped her thoughts and feelings and then when the pain occurred later, this then functioned as a distraction from her internal experiences. Dissociation is often a response to an internalised mandate not to know (Pearlman & Saakvitine, 1995). This state was clearly described by all clients when they stated that they self-injured in order to stop their internal experiences and become numb. This mandate requires them to split off parts of their experience and self, to avoid at all costs the integration of their thoughts, feelings, memories and bodily sensations (Pearlman & Saakvitine, 1995). Self-injury, in turn reinforces this split. The person focuses on the bodily sensations as a method of "numbing" their internal experiences. It allowed the person to achieve disintegration by not experiencing the emotion and thoughts. This is a move into an altered state of consciousness, a state of "not feeling and not knowing", but also a state of "not me" or depersonalisation. Here, self-injury may be understood as shame avoidant behaviour. Baumeister (1990) labelled shame avoidant behaviours that are used to numb the internal world, as "escape from the self" and an aversive state of high self-awareness (shame experiencing). By "not knowing" the person is experiencing a state of "not being me". Mary reported that when she was depressed she did not "want to be in her own skin" and therefore could not look after herself physically. Following self-injury she was able to "give herself permission to look after herself". So following a dissociative state

induced by self-injury, Mary emerged from a state of "not knowing" and "not being me" She was then able to give herself permission to care for herself as she was physically injured. Staff could work with Mary to give herself permission to self-care and thus reduce the need to self-injure.

Shame and further dissociation often follow a return from a dissociative state (Pearlman & Saakvitine, 1995). In addition to this, Hahn (2000) recognises that people experience an excruciating sense of badness and inadequacy following avoidance of shame. This occurrence of shame, badness and inadequacy was most strongly reported by all of the clients following self-injury. If people experience spirals of shame internally, then interventions need to help them focus externally (Kaufman, 1989). Thus self-injury is initially a positive coping strategy as this helps the person focus on the skin, the cut, the external. Mary also used Witch Hazel to clean her wounds, this helped her to continue her external focus on bodily pain. Self-injury was described as a method of inducing a dissociative state and the experience of shame could occur as they returned from this state. The clients all described a sense of internal shame and then further shame induced by external interpersonal experiences. All clients had a sense that self-injury was helpful and the right thing to do, but later Mary reported feeling she had "let herself down" and that it was not "appropriate to cut" Mary had made an internalised judgement on herself that she also heard externally within family members and staff. Mark stated that he "felt down" but was not able to describe any thoughts associated with this process following self-injury. He did state that he felt "guilt and embarrassment" a few days later even if he did not attend A&E, suggesting internalised shame as well as shame induced by others perceived reactions.

The staff described a variety of psychological defense mechanisms utilised to cope with their work with the clients. Dissociation was one of these methods Therapists have been known to dissociate in response to traumatic issues discussed by the client (Pearlman &Saakvitine, 1995). Ian clearly described a process of dissociation when he saw Mark directly after his self-injury. Here he described thinking about Mark as "a piece of meat" in order to manage his intense emotions. He was then able to process this later and reconnect with the client. He did this in order to help Mark and himself survive the trauma of self-injury. However, when he informed me of this strategy in the interview, he seemed to feel ashamed and thought this was not "politically correct". Countertransference examples of dissociation are regarded to be experiences of not knowing, not noticing, not remembering and not connecting (Pearlman &Saakvitine, 1995). A dissociative event is when the person detaches from some aspect of the self or environment. Countertransference dissociation includes, depersonalisation, trance-like experiences and inability to think. When a therapist focuses on content to the exclusion of process, they may be dissociating meaning and knowledge. Helpers may focus on behaviour with the exclusion of emotions and thoughts. This can parallel the client's previous or current family context. The intrapsychic functions of dissociation in staff are; not to feel, not to know and not to be oneself (Pearlman & Saakvitine, 1995). Ian described not wanting to know about the reality of Mark's

injuries, not wanting to feel and had a sense of being different than his usual self at this time. Following this experience of dissociation, Ian emphasised the need to reflect later on what had happened and to be able to re-integrate Mark with his wounds and see him as a whole person again. Bateman and Fonagy (2006) state

that the therapist needs to reflect and retrieve his own mentalizing ability quickly when working with people who have a diagnosis of BPD. Mentalizing occurs well when out of an emotional state of mind. So here, Ian dissociated to remove himself from the emotional state of mind and later was able to reflect on his own and Marks state of mind. Thus for staff to always mentalize when clients self-injure would be an impossible task. As long as the staff are able to mentalize and reflect later the projected mental state will not take over. One staff also reported feeling anxious if he thought the client would self-injure and he had a need to avoid becoming pre-occupied with this. He blocked out negative thoughts by focusing on positive achievements with this client improving.

Staff reported the use of dissociation, but could also have specific responses to the client's experience of dissociation. When the clients were feeling angry or, initially after self-injury the helpers described an increase in anxiety if they were aware that the client had self-injured, staff could feel abandoned as a response to dissociation (Pearlman &Saakvitine, 1995). For example, Dave spoke about Angela's phone calls about the need to self-injure or kill herself and being left with anxious feelings about whether she would survive or not. As a consequence of Angela's phone calls, Dave stated that he felt helpless and anxious to be helpful and back in control. He was able to reflect on these experiences and work with colleagues to plan a duty professional system to ensure that Angela had telephone contact with staff when she needed this and Dave was able to continue with his other work. The staff were able to help Angela contain her internal experiences until she could see Dave. When a client dissociates from their emotions these are often left with the helper while the client feels numb (Pearlman &Saakvitine, 1995). The helper may be left with profound

anxiety, grief, rage, helplessness, shame, despair and powerlessness, while the client achieves a state of dissociation following self-injury.

Projection and projective identification of shame

When shame is experienced, internal representations become polarised into devalued and devaluing introjects (Lewis, 1971). When feeling shame, people are often unable to contain these competing aspects and tend to project one off through projection or projective identification (Hann, 2000). Whilst projection reinforces separateness, there is a desire in shame to re-establish ties. Thus Projective identification becomes the chosen strategy when experiencing shame (Hahn, 2000). This means that the internal representations are projected into another and then there is an interpersonal behaviour towards that person that encourages them to identify with the projected representations. This then creates a sense of reunion and helps ease feelings of abandonment and emptiness which are associated with shame (Hann, 1994).

Nathanson (1989) stated that people who have experienced shame tend to have two routes for managing these feelings; (1) Through interpersonal withdrawal, a shrinking, withdrawing, hiding from the shame eliciting situation, or (2) reactivating their impaired self through other-directed anger and externalising the blame onto others.

The first route seemed to relate to the reported use of the self-injury in these interviews. The self-injury facilitated a withdrawal, as for these clients it needed to be done in private. The self-injury also resulted in the numbing experience which helped

them hide from the shame. The self-injury then induced a blaming and devaluing reaction from others that confirmed the clients' self-beliefs. Self-blame was a prominent trigger for self-injury for all clients. It was only afterwards that blame was expressed towards other people for making them feel worse.

The second route of managing shame seemed to occur after the self-injury, when the anger was turned outwards towards the A&E staff. This was also reported towards the carer with Mark when he would previously blame Ian for "making him self-harm" Angela described how she became really angry with everyone else following her public humiliation in A&E previously described (in chapter 4). The staff interviewed also used the second route by expressing other-directed anger and blame towards the staff in A&E.

In the interviews, initially the self-injury had a positive function. However, longer-term internal or external experiences compounded the thoughts and feelings that triggered the self-injury. Angela also described this rumination process after self-injury when she attended A&E and was angry about staff interactions with her. She was understandably very angry that staff left her to bleed, cry and shake in the waiting room in front of other patients. So humiliation and shame were exacerbated by a sense that staff were devaluing her. This was at a vulnerable time when she was seeking help and exposing the damage she had done to herself. Both these activities were shameful in themselves. The A&E staff then took the position of the devaluing other and Angela was devalued. She coped with this by then becoming the devaluing other and expressed anger towards the A&E staff for treating her in this way. This resulted in a continuation of her shame and humiliation spiral. The staff interviewed

mentalized well when describing the client, or their work with the client. However they were all angry at times with the staff working in A&E, due to the previous experiences of the client. This is when staff judged the external staff as "not being good enough"

Staff will have felt shame from some of their life experiences. When the clients devalued or devaluing representations resonate with the staff's unresolved shame, this can result in countertransference identifications and enactments (Hahn, 2000). Gabbard (1993) views countertransference as a joint creation where the therapist's past conflicts and the client's projected aspects create patterns of interactions in the therapeutic relationship. So in this example, the staff's personal experiences of shame exist alongside the client's projections of shame that are experienced by the staff. Within the staff interviews some possible countertransference responses were noted. According to Racker (1957), concordant countertransference identification occurs when therapists identify with the experienced self of the client, so for shame this will be the devalued self or the devaluing other, depending on what is externalised (Hahn, 2000). Complementary countertransference identification occurs when therapists identify with a disavowed aspect of the client's experience, so for shame this will be the devalued self or the devaluing other. As it is difficult for people to contain both devalued and devaluing representation, one of these is externalised through projection or projective identification (Morrision, 1989). So depending on what the client experiences as their sense of self, the other representation may be externalised. For example, if the client feels devalued (helpless, hopeless, worthless) then the devaluing other (judgemental, critical, punitive) may be projected into staff.

Hahn (2004) argues that people internalise devalued and devaluing mental representations when they experience shame. Devalued representations contain a sense of worthlessness and inadequacy, whereas devaluing representations criticize and condemn these experiences. As a child these aspects are experienced as originating from within the self and also from others. Indeed, Crowe (2004a) views this position of an observer and judge as a form of dissociation when experiencing shame. As it is difficult for people to contain both devalued and devaluing representations, one of these is externalised through projection or projective identification (Morrison, 1989). This can then result in the perception that others are involved in a devalued-devaluing dynamic. Morrison states that in prototypical shame the devalued mental representation remains internalised and the devaluing representation is externalised. Thus the person has a profound sense of inadequacy and others are perceived to have the power to judge and condemn. This is supported in the client interviews when the clients self-injured. Immediately after the self-injury they expected a negative reaction from others and thus preferred to hide away and keep the self-injury private. This expectation of judgement and condemnation was amplified in the staff at A&E. Alternatively, the devalued self may be externalised. Hahn (2004) states that when the devalued representation is externalised, others are perceived to be inadequate and unworthy. This has the function of the person focusing on the inadequacies of others, rather than a focus on their own feelings of being "not good enough" or worthless. All three clients reported experiences of staff in A&E being "not good enough" and not really helping them. Whilst this may have been the case in reality, this can be further compounded by externalisation of the devalued representation.

So after self-injury the clients went through a process of externalizing the devaluing other to A&E staff, thus fearing negative evaluation from them. This then changed into an externalisation of the devalued self when the client devalued the staff. These processes may occur interchangeably or simultaneously. This was a defense mechanism also present within the staff interviews.

<u>Devalued self – Not being "good enough"</u>

When the devalued representation of being worthless and inadequate is internalized by the staff, they may feel helpless, inadequate and worthless as a helper. This is concordant countertransference identification if the client also felt this. The experience of helplessness was reported by Dave when Angela would ring and inform him she was going to self-harm. He did not seem to take the projection of the devalued self, on as his own, apart from in extreme anxious moments. He seemed able to accept failure at some things without seeing himself as a failure. In addition to this it has been reported that when a person's thinking function fails, projective identification replaces this to relieve tension (Alexandris and Vaslamtzis, 1993). In the interviews, the supporting staff members coped with "not knowing" and helped the clients following their self-injury. However the anger, blame, shame and devaluation needed to be projected elsewhere as the staff and the clients could not contain devalued and devaluing representations at the same time. The devaluing representation was projected by client and staff to the staff at A&E. This seemed a more comfortable place for these internal experiences to go as the clients and staff were working in a closer therapeutic relationship where the staff was perceived as being "good enough" or valued. Staff reported previously experiencing the devalued self and feeling a failure, but in the more recent experiences of self-injury, did not feel

a failure, or devalued by the client as their relationship developed. However the staff may have been unable or unwilling to express this openly to me in the interview, due to possible shame of "not being good enough"

Here the devalued aspect of shame was externalised by both client and staff to the external team. Thus at this point clients and staff may have been unaware of feeling ashamed and not being "good enough". Thus, the A&E staff were perceived as being inadequate and unworthy. Angela and Dave meandered between empathising with staff and then devaluing them, demonstrating abilities to understand the other person's mental state intermittently. Non-mentalization is revealed in a bias towards generalisations and labelling (Bateman and Fonagy, 2006). For example when staff think about clients in terms of a "Borderline personality disorder" diagnosis, or a "self-injurer" rather than an individual, they may not be mentalizing. Staff and clients also demonstrated this non-mentalizing stance by thinking about other groups of staff as punishing, rejecting or maltreating the clients. By using absolute terms to describe another person, there is no longer a need to find out that person's state of mind

Alongside difficulties mentalizing, staff may experience their own psychological defense mechanisms. Hahn (2000) argues that concordant countertransference identification occurs when people self-injure to cope with shame. For the clients, self-injury is an external action orientated response and in turn, staff become action orientated in response to their own helplessness. All staff reported actions or interventions following self-injury. This seemed to be a more comfortable time for the staff as they had an idea of what to do, in contrast to the helplessness reported prior to the self-injury if they were aware that it was taking place. Hahn (2000) also states

that staff may become behaviour focused in order to avoid the internal shameful experiences of the client. This is common within health and social care settings, a focus on behaviour change and a need to stop self-harm (Linehan, 1993; Conterio & Lader, 1998). Staff may offer advice, suggestions and recommendations with the stated purpose of helping their clients. However they may be preventing themselves from feeling helpless and a sense of disconnection, suggesting that they have a need to "fix" rather than understand. One staff interviewed was keen to be "knowledgeable" and an "expert". He was also very focused on his use of techniques and interventions. This is often encouraged in current mental health services, especially in the guise of evidence based practice and cognitive behavioural therapy (Stickley and Freshwater, 2009). However, if understanding is avoided in favour of actions, the interventions may not be useful for the client. The functions and meanings of the client's self-injury need to be examined alongside the client's emotional and cognitive experiences within a given context. If only one theory or school of thought is adhered to, the client may not respond to this .The focus on staff technique and intervention are usually linked to a specified school of thought in order to provide evidence of effectiveness and rationale for choice. This allegiance to one type of therapeutic intervention or school of thought, may then result in making the client fit the theory, as apposed to making the theory or theories fit the client. Making clients conform to theories helps staff defend against their own shame about being wrong about their own beliefs. This has been referred to as Ideological countertransference (Retzinger, 1998). This is a danger as if staff take the position of "knowing" or being an expert, then it is shameful to not know, or have theories challenged. Bateman and Fonagy (2006) advocate a "not-knowing" stance for staff when using mentilization approaches. This is where the staff and client share their points of view, without

asserting who is right and wrong. This is a useful collaborative method of interacting and seemed to be used by all three staff interviewed. "Not knowing" is also important prior to making sense of what seems to be occurring (Bion, 1962). So this occurs before the staff "know" what their views are. Unfortunately Western cultures place a high value on rationality as a core element of "normal" behaviour (Crowe &Carlyle, 2003). They state that rationality assumes that there is one "true" meaning and this can obscure an ability to just "be" and then create meaning that is acceptable to staff and clients. This results in rationality and action being favoured over "not knowing" and "being". The latter then can become taboo or shameful activities. Staff need to empathise and give genuine human responses, but may get caught in personal or ideological transference. If staff were able to cope with not knowing for a period of time, before jumping to theories to understand behaviours and then do the associated interventions, then real empathic relationships and understanding could develop before a focus on change. Internal experiences in staff could be used to empathise with the client's internal experiences. Staff may find security in a connection with the client, rather than in technique or intervention

In addition to concordant countertransference identifications for staff, complementary countertransference identifications can also occur with the devalued self. The staff may not be aware that they are experiencing shame, as the devalued representation remains with the client and the staff feel unworthy and inadequate. This was reported in the staff interviews, but with other clients who self-injured, rather than the client interviewed. At this point, the staff may be in danger of rejecting the client, or believe that they do not want help, cannot be helped or are beyond help (Hahn, 2000). This would be a possibility for staff reactions in any setting when the client was difficult to

engage, however the staff interviewed had already engaged with the client interviewed. Another, more complex reaction than withdrawal is attacking the self. Hahn (2000) states that self-injury fits into this category and that this method is utilised often by people who have shame but also have overwhelming fears of separateness or disconnection. Hahn (2000) believes that attacks on the self stem from a sense of unworthiness with a fear of rejection. This sense of being unworthy is not necessarily supported by the perception of others. The clients reported unworthiness and a fear of rejection. Angela still did not want staff in A&E to disclose her self-harm to Dave even though she mostly thought she could trust him, for fear that he would become angry with her. She knew on a rational level that this was unlikely to happen as Dave had not expressed anger about her self-harm before.

The feelings of numbness described in the clients' interviews, were a disconnection from the physical body and shame. Once the relief had been experienced the body and sense of self could reconnect. At this point the therapists' concordant counter identification can become action focused, thus avoiding their own feelings of helplessness. This occurred with all three clients interviewed. The staff were able to become active following self-injury, to help the client feel better and avoid further shame. Being helpful assists therapists in avoiding their feelings of helplessness by fixing, but may be at the expense of understanding.

The other representation associated with shame is the devaluing other.

Devaluing other "they are not good enough"

Another characteristic of shame is to hide from the pain by splitting the good and bad parts of the self (Hahn, 2000). This was evident in staff and client interviews, especially relating to external helpers. The staff in A&E were often blamed by staff and clients for reacting in a punitive rejecting manner that induced shame in the client. This has a function of projecting the "bad helper" into another department and then the "good helper" could remain within the close therapeutic relationship.

Whilst one nurse in A&E may have demonstrated behaviours that rejected the client, the other staff in A&E may then have become engulfed by blaming generalisations about helpers, e.g. general health staff vs. mental health staff, or qualified staff vs. unqualified staff. Overall staff interviewed demonstrated excellent mentalizing ability with the clients, but had more difficulties when talking about other helpers. This had the effect of assisting the staff to protect their self-perception of being a "good helper" and assisted in avoidance of shame. The valued self is the disavowed representation of the client that is projected into to the staff interviewed as the ideal helper. This is complementary countertransference identification.

As helpers like to be valued, this is often a type of countertransference that is overlooked as it produces positive, rather than negative emotions. The closest staff becomes to being the "always good" helper, the staff in A&E become the "never good enough helper"

So the process of staff and the clients joining together in devaluing A&E staff served as a shame-avoidant behaviour for all of them. This defense strategy also helps the client view the closest member of staff as being a "good helper" and the other staff as

being "bad helpers", thus reinforcing the split. Here we see an example of how the intra-personal process of splitting has become the inter-personal process of projection and or projective identification. The client perceived the A&E staff as negative, punitive and rejecting and then reported this to the helper in a "close" relationship with them. The helper in turn became angry with the other staff for being a "bad helper" and projected the devalued aspects over to them and became the devaluing other. This was a concordant countertransference identification. The staff were identifying with the clients devaluing representation. This resulted in a perception by the client and staff dyad that this staff was a "good helper" and thus was valued, and the other staff were "bad helpers." and therefore were devalued. If the process changed from projection onto the staff in A&E to projective identification, when they identified with the devaluing other, they would then have become judgemental, punitive, critical and rejecting. In addition to this, as the "good helper" was valued, the A&E staff may have felt devalued in comparison as they could never live up to the idea of a perfect helper.

All staff interviewed expected very negative evaluations from the clients about their interventions, they too expected a devaluing response from the client. So here the devaluing representation was projected on to the client. When asked about negative professional interventions, one helper stated; "I bet they came out with a list as long as your arm." This may have been based on the client complaining about other services however, the clients did not have a bad word to say about their chosen interviewed carer. Angela even admitted that Dave was "annoyingly right even when she didn't want him to be". By thinking about Dave in this way, Angela was able to confirm her perception of him as a "good helper" However, if the perceived good

helper becomes perceived as bad, this could result in breakdown of the therapeutic relationship. However this was not a focus in the interviews and the staff appeared able to remain engaged with the clients.

A common reaction to shame is to turn away or reject the person (Retzinger, 1998), this has been reported in the literature about people who self-injure and is also supported within the client and staff interviews (Favazza, 1989: Pembroke, 1994; Babiker and Arnold, 1997; Rayner and Warner, 2003; Rayner et al, 2005). Staff may behave in a way consistent with the client's externalised devaluing representation. They may identify with a representation of critical and condemning other. They may be unaware of their own shame and perceive the client to be inadequate, disgusting and shameful. Thus staff interventions may be overly confrontative and critical. This was not reported in the client or staff interviews about the staff, but could be happening in other relationships with helpers, such as in A&E.

The devalued self and devaluing other can be projected from the staff as well as the client in response to shame. This can then take the form of concordant or complementary countertransference identification.

Like people, institutions develop defenses against difficult emotions (Halton, 1996). Descriptions of how clients and staff used defences such as dissociation, splitting, projection and projective identification to cope with the shame associated with self-injury have been discussed above. In turn in the staff's place of work, either health or social care services, similar defenses can also be utilized. Some of these responses are helpful and assist staff in completing their work, other responses interfere with

the primary task of the institution. In this case the primary task seemed to be the care, treatment and control of clients.

People in helping professions have often had the role of caretaker in their own family and tend to be motivated by reparative wishes (Roberts, 1996). An important aspect of being a helper may be a deep seated fear of helplessness and loss of control, with an attraction to omnipotent expectations of personal ability to "cure". This then makes working with clients who are helpless and out of control difficult for the helper to engage with as these people awaken common fears among staff. As such, clients can then become labelled as "difficult", when the staff are having "difficulties" with their own internal states. Feelings of anger, shame, helplessness and hopelessness may be denied in staff, but projected towards the client, or alternatively other groups or agencies within the institution or externally. These people can then be judged, criticised and devalued.

This devaluation was reported in the staff and client interviews relating to staff in A&E and also for one staff interviewed, other "un-trained" mental health workers in external agencies. Indeed for staff to be judgemental or devaluing of clients is socially unacceptable behaviour for working in the helping professions, thus it appeared that this devaluing process needed a different focus to avoid staff shame. Thus a projection of badness or devaluation to other staff was necessary in order to protect the self-image of illusionary goodness and idealisation. This seemed to be occurring in staff and was also supported by the clients who thought their interviewed carers were excellent. This worked well within the staff client dyad as both were united in their projections. However, for the institution, this process produces a rigid

culture where growth and integration between teams of staff is inhibited. Each group then thinks that it represents something good and external others are viewed as inferior (Halton, 1996). There tends to be a lack of dialogue between the split staff and thus no change or development is likely to occur. Although the staff were angry with the A&E staff and this seemed to be an ongoing process for their clients, they did not describe any contact that they had made with them to improve the situation. Only one staff interviewed spoke about attending A&E with the client, and he was less angry with the staff and also noticed that the client's perceptions of the staff were different than his own, so there was less evidence of splitting and more ability to mentalize at this time. It is through this process of splitting and projection, or projective identification that one group can act as a "sponge" for all the anger, guilt or shame in the other staff group (Halton, 1996). This team could then carry these emotions for the institution as a whole. It seemed that A&E could possibly fit this role within this research. The clients interviewed here were still reporting negative experiences in A&E, but positive experiences with staff from mental health and social care settings. A&E may have carried the blame, shame, and representation of the devalued and devaluing other for the health service as a whole, in relation to clients who self-injure at present. However, these splits can also take place within teams or between different mental health professionals. If staff can tolerate these feelings and self-states with the client for long enough to reflect on them and contain the anxieties they stir-up, it may be possible to bring about change. When the teams can work together to reflect on these experiences and processes, then the split may have a chance of integrating. The clients spoke about the split between physical and mental health not being useful, but also the split between general and mental health services not being useful. They wanted to be treated as a whole person, rather than one

"symptom", either psychological or physical. Staff need to move towards a position where every point of view is valued and emotional responses are available to all people, staff and clients alike. We also need to re-integrate the psychological, social, and spiritual with the biological parts of the person and also the associated services, rather than the fragmented current service provision.

Staff can often hold emotions for clients without discussing them (Darlington, 1996). Death and fear in clients and staff produce the most anxiety in institutions. Although self-injury described by the clients interviewed was usually in avoidance of suicide, there was an overlap at times if they became suicidal. Fear and anger were expressed by clients and anxiety by staff in the interviews. Thus these reactions can be difficult for the institution as a whole to contain. Obholzer (1996) argues that the health service is a "keep death at bay service" So while the stated primary task is treatment of illness there is also an unconscious task of providing members of society with the fantasy that death can be prevented. Thus death as an outcome is often denied. This can be in direct opposition to clients who are suicidal. Hopkins (2002) argues that with the development of a "scientific and technological" approach to mastering the body, a belief has emerged that if people take the correct action all health problems will cease to exist. Within general health services there are some acknowledgements that there are chronic or terminal illnesses that will not cease to exist (Hinkka et al, 2002). However this is not the case in mental health services. Even when working with clients who are consistently suicidal, staff are still expected to be able to "treat" them and "make them better". This unrealistic request could then link directly into a blaming culture if death cannot be prevented, the assumption being that suicide is preventable, therefore someone has done something wrong.

The current focus on service provision to consumers misses the important function of containing emotions for patients, staff and society against death (Stokes, 1996). The large stable institutions of the past seemed to be more able to contain these emotions. However in more recent years health and social care settings are less stable and therefore do not contain as well. When staff are working with people who self-injure, the staff can often be left to contain their own and the client emotions that may have been projected to them. This can be an overwhelming task and staff may need to use their own psychological defense mechanisms to cope. When organisations become fragile and unpredictable, the uncomfortable emotions tend to be projected into intergroup and interpersonal conflict rather than conflict with the managers (Stokes, 1996). Therefore institutions need to become aware of these processes and attempt to manage them by integrating departments or teams and using interprofessional practice.

As these projections occur within the institutions, similar aspects are noted within society at large.

Privacy and dignity in opposition to shame

Dignity is about being in control of oneself (Gilbert, 1995). Thus self-injury serves to help the person regain their dignity. Pride is regarded as the contrasting affect to shame. Pride involves achieving things other people will admire. Self-injury seems to be more about dignity rather than pride in the client interviews. However there can be a sense of pride associated with self-injury in that the person has regained control over their internal or external world and this would be perceived as a positive quality

by others even if the method may not be socially acceptable. There was also a sense of pride when two of the clients spoke about their rituals prior to self-injury and the other one spoke of cleansing rituals after self-injury. Two clients spoke of getting cutting implements together, cleaning them and getting towels or dressings ready. This was completed in a controlled ritualistic manner. These behaviours seemed to have a positive function of establishing a degree of control when they felt out of control of their internal and external experiences. Wyrostok (1995) thought that rituals demonstrate a predictable social order rather than the chaos of social disruption. Thus within the client interviews, the rituals seemed to have a focus on the external with a predictable order, that was reported to help the clients by avoiding their internal experiences and also helped them calm down and sometimes even avoid cutting. The rituals before self-injury or the self-injury itself could be understood as a method of ensuring transition from shame into empowerment. The ritual could also have a placebo effect (Shapiro, 1978), when there is some relief that something is being done to relieve the discomfort. Thus a predictable social order is created that regains dignity. This could explain the use of rituals prior to self-injury when Angela stated that sometimes she no longer needed to cut and simply put her cutting pack away. Within anthropological studies, altered states of consciousness have been reported to be part of the ritual experience of self-injury (Freeska and Kulesar, 1989). Thus a union of opposites may have occurred, either in terms of polarized thinking, or the devalued self and devaluing other representations.

Dignity is an issue often overlooked when working with people who self-injure (Pembroke, 1994). Staff talk of "dying with dignity", but the challenge may be helping people who self-injure to live with dignity, rather than shame. Miller (1996) states that

obsession is related to maintaining dignity by controlling internal feelings and impulses, keeping things in order and place. This seemed to be linked to the rituals that two of the three clients reported. Success in this is a source of dignified pride. Angela and Andy reported their rituals with a sense of pride and positiveness. Both also stated that staff did not often ask about their activities during self-injury. Thus staff seem to focus on why the self-injury occurred and the negative consequences, but not the positive functions of the behaviour.

Behaviours aroused as part of shame can be an immediate hiding of a shameful event. This was reported in the interviews, where the clients went to self-injure in private but also wanted to remain alone afterwards and had some concern about other people finding them. There can be a continuing desire to keep hidden what seems shameful. So the shame attached to the self-injury, seems to make the clients want to remain private during and following self-injury. Whilst this was often possible for the people interviewed, for patients admitted to hospital this may be sought, but not achieved. Angela described her anxiety at having to have an empty house while she self-injured in order to protect her husband and daughter. She was also able to delay her rituals and self-injury until this happened, most of the time now, but had not always been able to achieve this is the past.

The experience of feeling ashamed is linked to ideas of being worthless, weak, wanting to hide, being damaged and rejected (Leeming & Boyle, 2004). These ideas are thought to be at least partly cultural. Twitchel (1997) argues that what is shameful in western cultures has been determined by religious and capitalist values. These values include self-help, self-discipline, self-respect, self-control, self-improvement,

self-reliance and self-interest. Therefore by using self-injury a person may be judged by others to lack abilities to help themselves; be undisciplined; lack self-respect as they have damaged their body; lack self-control as they "couldn't help it"; be devaluing the self; relying on others and lacking in interest of the self. In just one behaviour the person who self-injures actively challenges all of these values. However self-injury can be perceived as a method of self-help and self-discipline, to avoid suicide, a method of re-establishing self-respect, self-control, self-reliance, self-interest and self-improvement following interpersonal issues that resulted in an intolerable internal mental state. This alternative position can only be understood by listening to the views of the people who self-injure, rather than the devaluing other who may observe them. All clients interviewed were clear about the positive aspects of their self-injury and how this initially helped them feel more in control and was a method of self-help. However they were also acutely aware of other people's reactions to their self-injury. They all expressed a need to be unaware of the effects of their self-injury on their closest professional helpers. They all expressed a need to protect the staff from the effects of their self-injury and this lead to them preferring to be alone when self-injuring and remain alone afterwards. They also appeared to be aware of being stigmatized for self-injuring by others. Self-injury can be perceived as a lack of self-control and helplessness. Within beauty norms, self-injury can be viewed as making oneself ugly and unattractive or as making the self sick. (Favazza, 1996).

Making the self sick is a difficult concept for staff in health care settings to cope with. Stockwell (1984) stated that patients are expected to fit into the sick role, which involves doing everything possible to get better, rather than making the self sick. In

her study she found that nurses did not like patients who did not help themselves. As the self-injury appears to be self-defeating, in terms of health for the patient, this increases the likelihood of being perceived as the "unpopular patient" The staff interviewed clearly liked the clients they were discussing, so this did not seem to be an issue for them. However this could relate more to the staff working in A&E.

Socially acceptable self-injury forms a recognised religious or social system (Kroll, 1993). As such it is regarded as meaningful and understandable. If this element is missing the person is often pathologised as the self-injury does not appear to have an easily understandable meaning. Kroll argues that the public display of self-injury appears to violate the norms of western society. He makes the point that staff often attempt to understand self-injury as a method of coping with childhood sexual abuse as this has been clearly linked in the professional and lay literature. He argues that professionals have institutionalised self-injury as the socially meaningful and legitimate way to express distress about abuse. This helps judgements soften, but creates an expectation that people who self-injure have experienced sexual abuse. Angela reported this after the end of her interview. She stated that she had not experienced any form of abuse in her childhood and found staff expecting this to be the case because of her diagnosis of BPD and her self-injury. Here shame can be a more effective method for understanding self-injury (and other elements of BPD) as this may occur from a variety of experiences including childhood abuse and loss, reported by the three clients.

The clients reported experiences of being stigmatized and negatively judged by staff in A&E, confirmed their devalued self as "worthless, disgusting attention seeking"

people. It also confirmed that their internal representation of the devaluing other was also correct. Thus on repeated visits to these departments the clients and staff expected a similar devaluing response from others. When stigmatized, the stigma represents the person and the whole self becomes defined by the stigma (Lewis, 1998). Hence people who self harm are often labelled as 'self-harmers' in the professional literature. This then prevents the interpersonal relationship developing as they are perceived as a behaviour rather than a person. This was clearly emphasized by Mark when he stated that he did not want people to focus on his behaviour, but him as a person.

Blame and Shame

A person is stigmatised by possessing characteristics that do not match the standard (Lewis, 1998). Other people may blame and stigmatise, but the person may also blame themselves. This seemed to be the case with the client interviews as self-blame was evident. The idea of responsibility and perceived responsibility is central to stigma and shame. Controllability of a condition influences other peoples' responses. Thus if other people believe a condition is controllable then a resulting reaction from others may be anger rather than pity. As self-injury is done by the self to the self, other people believe this to be a controllable condition. Therefore it is more likely to result in angry rather than pitying responses from others. Lewis states that the amount of self-blame and blame from others that the person has for their condition, the higher the levels of shame. This is certainly the case reported within the interviews. All clients reported self-blame and expected and actual blame from others following self-injury. The staff interviewed also expected negative evaluation, but from the clients or managers about their interventions.

Negative self-evaluation is described as internal shame (Gilbert, 1995). Fear of negative evaluation from others is also commonly reported with shame experiences, this can be described as external shame. The clients had a fear of negative evaluation based on previous experiences in A&E or health services, but also possibly linking to other childhood experiences. They expected the staff to devalue, criticize and judge them, as this had happened before. A fear of negative evaluation may also link with the clients' statements of not wanting to know how their self-injury affected the staff interviewed. They seemed concerned that even their closest carers may change into the devaluing other. They seemed to want to protect the staff from the negative effects of the self-injury. If they became aware of staff negative reactions to their self-injury, they would no longer be protecting them, but possibly damaging or traumatizing them.

Scheff (1995b) argues that shame about shame varies cross-culturally. Based on analysis of historical documents, he demonstrates that shame has become especially taboo within modern western cultures and as such has gone "under cover". He states that it is unacknowledged or denied shame that is the problem as subsequent feelings of rage or hostility towards the perceived "shamer" are likely to damage social bonds (Scheff, 1995a). So if shame has been stigmatized and has gone "undercover" this makes it a difficult emotion to recognise and verbalise for clients and staff. Indeed, Turner (1995) suggests that it is our attempts to deny it, disavow it, sweep it under the rug, blame it on others or ignore it that does the damage. This seems to be confirmed within all interviews for this research. Self-injury and suicide raise anxieties within observing others about death. If the self-injury results in death,

or socially challenging injuries staff within health and social care services are often blamed. This is the projection of the devaluing other in response to shame. Society thus has a need to stand in judgement, stigmatise and blame the person who self-injures, the staff who have failed to help them, or the institution where the incident occurred. While the institutions of health and social care still have the role of "keeping death at bay" they will be blamed for not preventing death. However the assumption here is that all death is preventable and therefore, someone or something is to blame.

It could be argued that when blame seeking, society moves into a non-mentalizing state. Bateman and Fonagy (2006) state that non-mentalizing is; having excessive detail with the exclusion of motivations, thoughts and feelings. Its is also a focus on external social factors, physical or structural labels, and a pre-occupation with rules. Non-mentalizing occurs when there is a denial of involvement in the problem, blaming or faultfinding. These aspects can all be experienced in internal and external investigations following the death of a patient. One staff interviewed was very concerned about these issues based on previous experiences within the team. Investigators may focus on the detail of what happened, what actions were taken and especially how these occurrences were documented by the staff involved. A pre-occupation with the rules of the institution, especially around risk assessment often occurs. Staff can become misguided in the thought that the ability to adhere to the risk assessment procedure can control the behaviour of others (Crowe and Carlyle, 2003). Additionally external staff may deny any involvement with the client unless this is documented. There is often a lengthy discussion about staff following procedure. The focus here is on behaviour, which results in staff, clients and family having their

internal experiences overlooked. Investigators can then express certainties about the suicidal intent of the client in hindsight and have concerns about whether the staff may have missed these signs. When staff or the client is blamed, often judgements are made about that person and they are devalued. They may be perceived as inadequate or a failure, worthless, helpless and hopeless. The same could also be said about the way the institution is perceived by society, encouraging the staff to join the client in the fear of the criticising observing other confirming their shame. However, at this point it is difficult or impossible for the staff to empathise with the client or visa versa.

By continuing to humiliate, blame and devalue people who self-injure, this forces them to remain within this shame experiencing role. This is useful for other people as they can project their own shame to them, and avoid their internal experiences. By blaming the client, or staff, the institution does not need to focus on its own limitations and inadequacies. The same could be said about society at large. By blaming clients, staff and institutions, the problem is externalised to others rather than experienced in the self. A shamed role for one group member may be necessary in order for the group to uphold a moral code (Leeming & Boyle, 2004). So by shaming and blaming people who self-injure or the staff who engage with them, the observing others can uphold moral codes and illusions of being in control, adequate and/or being able to prevent death.

Self-injury could be perceived as a reaction to shame and also as a method of coping with shame, or avoiding shame. The experiences described following self-injury in A&E were shame inducing and the clients found ways to cope with this shameful

experience that further compounded their previous internal experiences. The self-injury assisted in the oscillation between knowing and not knowing about internal experiences. For staff they also oscillated between knowing and not knowing about their own and their client's shame. The devalued and devaluing representations then could be contained in identified staff teams in that institution. The staff and clients then supported each other in projecting the devaluing other or devalued aspects of themselves towards the staff in the external team. This consistent process of projection and re-projection of shame may become passed between staff and clients. Whoever ends up with the shame of being the devalued, becomes the one to blame. This may also occur within a setting of society wanting "experts to know" and move into action to avoid internal experiences and possible contagion of shame or suffering.

These experiences of shame and associated psychological defense mechanisms have influenced the implications chapter that follows. Here consideration is given for educational issues, practice and also research.

Chapter 8: Implications

This chapter explores the implications for education, work with clients and research, following completion of this study. These areas have also been linked into the overall themes apparent within this thesis.

1) Education

Education for health professionals seems to focus on interventions rather than relationships (Stickley & Freshwater, 2009). There is limited lime for ethics, communication skills or self-awareness development in many contemporary academic programmes of study. Education needs to develop staff self-knowledge and link this clearly to client issues or problems, rather than keeping these as separate issues. Helpers need to be educated to embrace complexity, rather than seek simplistic truths. Staff need to increase awareness of their own internal experiences in order to work out which issues are their own and which are specifically related to working with the client. In my own work as a lecturer I have incorporated more self-awareness orientated experiential learning within the modules that I teach. For example on the self-harm module, I begin with a focus on how staff react to people who self-injure and help the students explore their own countertransference reactions in order to understand the interpersonal process of self-injury. Bateman and Fonagy (2006) state that the helper needs to feel what the client wants him to feel, but at the same time be able to preserve a part of his mind that mirrors accurately the clients internal state even after projective identification. So the helper needs to take on the projected internal state, feel it and be aware of how

this relates to the client. They also need to be able to keep a part of their mind for observing and reflecting and another part for making sense or knowing. If helpers can recognise common strategies shared with clients they may be able to remain more genuine within the relationship and increase empathy with the client. So within my teaching, I now promote learning and understanding about projective identification and splitting and help students to develop a more reflexive way of working with clients. In such an approach, they would be more likely to be able to feel the emotions and think in a way that is congruent with possible projections, but also have an awareness that this is an interpersonal process and these experiences are not always of their own making. In so doing, it will be easier for the student to begin to think about their own thoughts and emotional reactions. Clinical supervision is emphasised as a venue for working out these complex relational issues.

Generally in education there needs to be a recognition that just being with the client and getting to know them as a person is essential to positive care. The focus on interventions or action can result in the clients missing out on the human relations element of the helping relationship. This is especially important when people self-injure as the focus tends to be on the self-injury, rather than the person (Pembroke, 1994; Harrison, 1994). If the focus remains on the self-injury, then a therapeutic relationship with the person is difficult or impossible at times. A reductionist model of understanding the behaviour only, without internal experiences eliminates the person and the context from the conceptualisation. By understanding these hidden experiences, the helper is then more able to have an understanding of the client's mental state and thus make sense of self-injury in a different way, that prevents further rejection. In my teaching of formulation in psychotherapy I now bring in the

context and the interpersonal relationship. So within a cognitive behavioural formulation, that I may teach about, the self-injury may the focus of a cycle of confirmation of negative self-beliefs. However when the students view their own thoughts and emotions when working with this client, they are often able to recognise shared elements increasing empathy with the client. Just using a simple CBT formulation of thoughts, emotions and behaviour for the client and then also themselves, brings the formulation into the interpersonal domain. This has proved successful when I provide clinical or psychotherapy supervision and also in teaching sessions with students on pre-registration and post-qualifying programmes.

Increasing empathy between staff and clients, having a focus on mental states and experiences of shame need to be considered within staff education at all levels. Staff need to be aware of their own defense mechanisms and coping strategies. They also need to be educated about shame and become aware of their own personal shame reactions including experiences when working with clients. If staff are educated about the devaluing other and devalued positions within shame they can then become able to reflect on this during and after work with clients on how these roles may have been re-enacted with them, other staff or carers. They then need to be encouraged and supported in discussing the devalued and devaluing aspects with the client, when appropriate. On completion of this, staff may be able to demonstrate the ability to integrate these two aspects of shame, without using defense mechanisms. By encouraging clients to reflect on these interpersonal processes, staff can help them to reclaim their externalised shame and cope with this is a different way. If staff do not recognise countertransference at this point, they will be unaware of the complexity of the interpersonal process. Then the externalised aspects of shame will

not become integrated in the client, as they are not integrated in the staff. Helpers need to lead by example and be able to recognise and cope with their own shame reactions in a positive manner. This will then prevent any externalisation of their own shame and re-enactments of devaluing and devalued self. Within my own educational practice, I now provide sessions on pre-registration and post-qualifying programmes for nurses and other professions on shame and mental health and the processes of projective identification. The students I have worked with have really grasped the concept of the devalued self and the devaluing other. As part of these sessions I encourage students to look at their practice with clients, relationships with other staff and also other departments or teams.

Educational approaches need to re-frame shame as a healthy emotion that reminds the staff that they are human and as such may fail at times. This can then be a source of creativity and learning. Staff need to be able to embrace the idea that it's ok to fail and be "not good enough" some of the time and recognise that this does not make them a failure in life. The important aspect is to be able to demonstrate to the client that they can survive this and it makes them a stronger person. Being able to admit mistakes made by staff to clients is noted as an essential activity for the helper; so that they are not bound by their shame of doing something wrong. Staff need to become aware of how they cope with failure and which psychological defense mechanisms they may use. Projective identification, transference and countertransference need to be part of all professional education and clinical supervision. If students are taught about these interpersonal processes, the focus is often on how their thoughts and emotions affect their relationship with the client. However, as demonstrated in this study staff need also to become aware of how

these countertransference reactions may also effect interpersonal relationships with other teams, members of staff, family members and carers of the client.

Education on self-injury needs to move beyond just understanding motivation or function. Ideally recognition of the emotions or feeling stuck needs to occur then moving into a full exploration of what was happening for client and staff (if involved) before during and after self-injury. This is the approach taken on the self-harm module. This needs to be viewed without judgement and the positive consequences of self-injury or behaviours in the process need to be considered alongside some of the problems. There needs to be a clear recognition that each episode of self-injury can be different for each person and also affect each member of staff in a different way. This interpersonal aspect also needs to become part of the conceptualisation of the work with the client. There may be some linked issues or similar processes, but staff need to move beyond assuming one consistent reason for self-injury, such as experiencing childhood sexual abuse.

<u>2) Work with clients</u>

There needs to be a focus on staff having the space to reflect prior to making sense of a given situation in order to avoid ideological countertransference. However this challenges the focus on action that we often have in western culture. There needs to be an acceptance that a period of not knowing needs to occur before theories and explanations are constructed in order to empathise with the client, truly observe what is occurring and only then move towards creating a collaborative meaning of events. Eisold (2000) supports this idea by emphasising negative capability in staff, where they can tolerate uncertainty to allow the emergence of new thoughts and

perceptions. Staff need to develop an ability to understand the client's mental state and also their own. They need to be able to empathise with the client and recognise how the client makes sense of their experiences and thus why they are behaving in this way. Everyone has temporary failures in understanding other people's mental states, but staff need to recognise when this happens and return to an ability to recognise other peoples mind states. This process also needs to be mirrored in education using experiential approaches, where often students at first sight, do not understand the learning of the session. However, the understanding emerges later on in this work and the learning becomes clearer as they make the connections themselves. By presenting students with information in a traditional lecture, they do not tend to experience the process of "not knowing" and then moving towards creating their own knowledge. If this process is not experienced in education, then this personal development of knowledge will be difficult to bring to bear in client or family focused work that they may complete outside of the educational setting. Experiential learning methods such as Problem Based Learning or Flexible Learning can assist in this process as the student engages with a process of not knowing then searches to find knowledge and then explores in the group before a deeper level of knowledge emerges. Students can experience difficulties with this process but with support from the facilitator can learn that is it part of the learning process to cope with uncertainty and the personal emotions that emerge. Warne and McAndrew (2008) emphasize that emotionality and learning need to be linked in an experiential process of this nature.

Client work needs to focus on how shame experiences can reduce immediately following self-injury and also how staff interactions or interventions may be perceived

by the clients' as inherently shameful. Staff need to recognise the role they play in the cycle of shame. Interactions need to focus on the person as a whole and not just their self-injury. A mixture of avoidance or diversional interventions need to be integrated with deeper exploratory methods of working with their experiences of shame. Gilbert (2005) has some useful ideas of how visualisation can be used with clients to visually imagine their critical self and recognise the thoughts that they have causing them shame. Then he moves on to recommend that a further visualisation is practised with an imagined compassionate self, to combat the critical self. Challenging thoughts can then be planned to answer or prevent the critical self increasing shame. He also advocates the use of role play and empty chair work where the client becomes the critical self and then the compassionate self. I have been using this work with clients recently and it has worked well to reduce shame. The above work by Gilbert had a large influence in the discussion chapter of this thesis (Chapter 7) relating to shame.

Managers and staff within practice settings, need to become more aware of the interpersonal processes of systems and blame culture. They need to link the experiences of shame within organisations at different levels. So from the client and staff relationship, through to relationships within the immediate team, within different staff teams and between organisations and society in general. An emerging theme from my research was that managers also need to be supported in developing organisations that can contain and respond to emotions, rather than ignoring them. The role of shame in the workplace and how projective identification may occur between departments or from staff to manager, or from manager to manager are key elements of this research that need to be explored within a leadership or

management context. Therefore leadership and management courses should incorporate psychodynamic and systemic theories on organisational dynamics and shame in the workplace. Managers and leaders need to access supervision that also effectively addresses these issues. The provision of such supervision is dependant upon there being sufficiently qualified and experienced practitioners available. Nationally, it is not always easy for organisations to recruit such practitioners. Where this is the case, alternative models of supervision might need to be considered.

Hahn (2004) advocates that when a client discloses a shameful activity, this needs to be accepted in order to address the underlying shame. The activity needs to be accepted at face value with no demand that the client stops engaging in it. Confrontation at this stage and a request to stop self-injury can be experienced as condemnation (Pembroke, 1994). The goal in therapeutic work is to accept the clients striving for autonomy without communicating disapproval condemnation or defensiveness (Livesley, 2003). Staff need to be aware of their verbal and non-verbal responses to clients as these may show evidence of these expected devaluing reactions. Eventually the devalued and devaluing representations become less polarised as a result of this accepting and reliable relationship. Staff also need to be aware that the client may expect the devaluing other role even if the staff do not take this role on.

Staff need to recognise when they externalise shame to others, even if based on patient experience. Otherwise, they join together in condemning external others and becoming the devaluing other. This can result in an impression of an alliance, but is actually shame–avoidance. Instead the true alliance needs to explore the underlying

shame. Staff need to be able to recognise when they experience shame and express this in supervision. This experience can then be utilised to understand the clients' internal experiences of shame. Clinical supervision focusing on staff thoughts feelings and behaviours can reduce countertransference identification and re-enactments. However, even if staff receive clinical supervision these interpersonal processes may not be discussed and the focus can remain on their use of the tools and techniques of interventions with the client. However the clinical and psychotherapy supervision that I provide for nurses and psychotherapists contains recognition of the interpersonal processes and experiences of shame. This has been evaluated as highly constructive by these members of staff.

Bancroft (2007) views the healthcare system as changing from secrecy and blame to systematic approaches to safety and quality. If this is to be the case, in the pursuit of excellence health care systems need to focus on how the system reacts to shame and how the employer can support staff to heal from a shameful experience, such as a mistake or a client complaint. It becomes increasingly important that individuals feel supported rather than devalued and blamed when investigations occur. In order to reduce blame, the employer needs to promote a healthy organisation and understand the role of shame and blame within the organisational dynamics.

The organisation needs to be in agreement about its primary task, care, treatment and control (Bolton, 2005). It also needs to be aware of the emotions that it must contain to adequately function. There needs to be an acceptance that some negative emotions will be felt by staff due to the clients and the issues they are working with. There needs to be recognition that illness produces difficult emotions in people and

these may always be present. Rather than just pursuing the constant need for the "best treatment" that will help us all avoid death. The organisation needs to be clear of its function within wider society and whether or not this is achievable. Mental health services cannot fulfil the function of being a "keep death at bay" service. It could be argued that in general health services staff focus on organs, rather than people to defend against person contact (Obnolzer, 1996). In mental health services, a focus on behaviour with avoidance of the clients internal state, could be achieving the same avoidance of real personal contact.

With the increased recognition of the role of shame on clients and staff in their interpersonal relationship, staff can attempt to avoid secondary shame interactions. They can also use interventions in a more productive manner as shame re-enactments are less likely to occur. Organisational leaders can also recognise their role in re-enactment of shame dynamics and maintenance of blame cultures. Education and supervision of managers needs to occur where they understand self-injury as part of an interpersonal cycle of shame. Some of the staff that attend the self-harm module are leaders and managers or follow this route after completion of the programme. However it is important that leadership and management programmes have educational input about interpersonal issues and shame, even if the course is not clinically focused.

If self-injury can interfere with staff and managers' ability to reflect and be aware of their own and others internal states, they need to be taught how to recognise when this is happening and how to cope with this. Crowe (2004b) linked the experience of shame to difficulties reflecting and also the polarisation of perceptions of other

people. This was supported within this research by the clients and also the staff. Staff and managers need support in being able to "switch emotions off and then back on again" The switching off of emotions may be incorporated into a "professional" stance. However staff and managers need to be able to do this and also "switch them back on" when reflecting after the event. If staff and managers can use clinical supervision or reflective practice to access their internal experiences of an event after it has happened. They then may be more able to increase their own reflexivity within the immediate therapeutic encounter. Clinical supervision and reflective practice are essential components in this process. If staff consistently switch off emotions and are unable to reflect this could lead to increased stress levels.

The focus in practice needs to be on the communication and acceptance of client and staff internal experiences, rather than the common pre-occupation with self-harming behaviour. Acceptance of shameful activities is a crucial step in addressing underlying shame. So by accepting the self-injury without judgement, the staff can then focus on the person, rather than be diverted by the behaviour. If the staff reject the self-injury and state that the client needs to stop this prior to any therapeutic activity, then this is further condemned as a shameful activity and the helper then takes on the role of the devaluing other. If staff can engage with clients to understand the shame cycle of self-injury, the client becomes more able to reflect on this process and conceptualise shame as a predictable part of this. From this position, staff can help clients reduce the shame experience following self-injury. So when staff do not take on the role of the devaluing other, the client only needs to cope with their own internal representations of the devalued and the devaluing other, rather than actual

devaluation plus expectations of being devalued. Staff can also focus on the cognitions that the client has such as "I deserve to be punished".

A move towards decreasing external control, and rigidity when working with people who self-injure would help to reduce further shame. The act of removing potential instruments of self-injury is shaming in itself. Staff also need to look at cycles of blame and shame that surround any current self-injury with the staff team and family, or significant others.

The expectation that staff will ask about why people self-harm can cause considerable shame to the client, even though this intervention may be commonly thought to be helpful and assists in assessing risk. The staff may be wanting to "know" or have knowledge about why the person has self-injured. This can then make them feel trusted and powerful. Employers and legal systems also further endorse this position of knowing and it is a clear focus of risk assessment. The client may find this difficult as they are required to re-tell a shameful experience whilst expecting negative evaluations from the helper and possible further shame or external control. Whilst this is an important intervention, this needs to occur within a context of relating to the client personally, rather than as a risky behaviour. This also needs to occur over a period of time, rather than immediately after self-harm when the client may be experiencing shame.

Alternative methods of externalising focus could be useful when working with people who self-injure. An example of this would be to complete an activity together. Mark's experience of healing challenged the concept that understanding behaviour is

essential to reduce the need to do it, or that self-injury needs to be an initial treatment target (Linehan, 1993; Conterio et al, 1998). Here neither client nor staff focused on self-injury, but developed their relationship by taking on sporting challenges. He was able to focus on the relationship whilst achieving a sense of pride in surviving extreme external environments and a sense of achieving new skills. This is an example of ignoring the behaviour and the internal experiences, but focusing on improving self-esteem. This can be a useful intervention in early stages of the therapeutic relationship, or with some people in the team, whilst others are focusing more on exploration and communication of the internal experiences. Thus by recognising the avoidant function of self-injury staff can respect the clients' psychological defense mechanisms but create more positive effects by changing the activity.

Self-soothing or cleansing and dressing the wounds after self-injury could be another useful method of externalising the focus. One client interviewed really used the cleansing process following self-injury to avoid her internal experiences. She used the pain to focus on. Spa rituals or massage may be useful external activities here that also can bring on a sense of dissociation and separation from emotions and thoughts into a deep relaxed state with a focus on the skin. Staff may need to work on the clients ability to give themselves permission to self-soothe, as this may also trigger shameful experiences if they think they are worthless or do not deserve this.

Rituals were helpful for the clients interviewed by reducing risk and also externalising attention prior to self-injury. Staff could work with clients to identify rituals or patterns of behaviour that could enhance a sense of safety. Crisis checklists can be useful

when the client works their way through a list of strategies and diversional activities when they feel they may need to self-injure (Linehan, 1993; Babiker and Arnold, 1997). This could be a useful ritual. The rituals that occur prior, during and after self-injury need further research. Research on the positive aspects of this behaviour could lead to new more positive rituals for clients to use, either to keep themselves safer whilst self-injuring, or as a diversion technique.

3) Research

Further research focused on shame and self-injury is required in order to explore this issue further. It would be useful to find out what people who self-injure and their professional helpers think about using self-injury to cope with shame, but then also the role that self-injury may have in the production of shame experiences and confirmation of the clients' self-beliefs. Further research exploring how organisations cope with shame and to find more specific methods of avoiding the devaluing process is required.

Given that organisations are made up of people and people make up families, further research on how families cope with self-harm and shame would also be useful; both from a perspective of how they cope with a family member self-harming, but also about if they experience the self-harm as a shameful activity. There is also a lack of education for families of people who self-harm. If they can attend a course on this, then they may be able to continue to support the person without re-enacting the interpersonal issues of shame. I have gained re-approved the self-harm module to be suitable for carers or family members to be able to attend alongside professional helpers. Since undertaking this PhD, a couple of carers have joined us and found the

module really useful. The impact of education on carers or family of people who self-injure, might also provide a new focus for researchers.

The focus on dispositional shame is limited when viewing shame associated with self-injury. If research focuses on understanding shame about something, rather than being prone to shame, interventions would become more informed. Self-injury could be conceptualised as a context for shame. This helps to normalise the shame experience, rather than pathologize this in the clients. If clients are experiencing shame staff will have their own reactions to this, linking into their own experiences of shame. If staff are taught more about the role of shame in mental health and also health care settings, then further research would be required to find out how this would impact staff interventions and also dynamics within staff teams. Research studies on outcomes of interventions based on reducing shame after self-injury, or the effect of staff shame education and supervision on client care would be useful.

Research generally needs to continue to embrace reflexivity and recognise the effect of the researcher on the research process and outcomes. Just as practitioners use reflexivity as a concept in client intervention, it would be useful to also focus on their use of reflexivity within the research process. New methods of research need to continue to develop based on individual projects. Researchers can rigidly use previous methods that do not fit the current project. They need to have the confidence and support to adapt methods without shame to ensure new understandings are created.

The key elements that embrace practice, education and research all relate to understanding ourselves as helpers, teachers and researchers as part of the interpersonal process, rather than a separate entity. By incorporating my self as data in the bricolage it helped me reflect on my own experiences and reactions within the process as a researcher. Through my own learning about myself, I am more able to help future clients, staff and students to do this also.

Following my own reflection on the study, some of the limitations are considered in the next chapter.

Chapter 9 Limitations to the study

This chapter considers some limitations of the study.

One limitation that could also be considered a strength is that the study is not generalizable. It was never intended to be. The strength in this research is embracing the uniqueness of the persons experience within their context and thus would be individual. However people can have a tendency to want to transfer findings onto other people, or to devalue qualitative methods that are not transferable or buy into a positivistic paradigm.

This study will not account for people who self-injure in public, or who seek out a reaction from other people. This clearly was not the intention of the people interviewed. They were self-injuring in private for themselves. It would also not be very relevant to someone who self-injures and does not have a close relationship with a professional helper or carer. Here self-injury may not take on interpersonal processes. Indeed it also may not be relevant for people who have only self-injured a couple of times. One of the key arguments of this study is that each self-injury is unique, each persons understanding or interpretation of events is unique and must be embraced as such. Thus knowledge of why other people may self-injure or what happens in the interpersonal process, can be useful but each self-injury and each person needs to work on creating their own meaning, rather than searching for generalisations.

This study may also not account for staff who have been unable to form and maintain a close therapeutic relationship with a client who has self-injured. All staff interviewed had been very able to achieve this, some for many years. If people are self-injuring and find themselves rejected by carers or services, they may find themselves in a different interpersonal process. However this may also link into the devalued self and devaluing other dynamic.

By asking for thoughts feelings and behaviours, I may have missed out on other parts of the lived experience. This was a useful way to assist in understanding this process, but could be perceived as reductionist and a cognitive filter linked to theory. Vague feelings and words and ideas on the margin of consciousness may have been overlooked.

The interviews of both the clients and staff would have been influenced by recognition that the other person may become aware of their interview. This may have reduced the expression of negative emotions towards the other person in the dyad. There was an obvious lack of any negative feedback from the clients about the staff; the staff actually expected negative evaluation from the clients about their interventions. The staff were able to talk about difficult emotional responses more openly than the clients, as they had less to lose in the powerful helper/helped relationship. They were providing help rather than seeking it and thus were in a less vulnerable position.

All of the participants may have been influenced by expecting me to judge them, especially the clients who had a fear of negative evaluation from the devaluing other.

Staff may have also expected me to judge them and their reactions towards the clients especially following self-injury. My role as a researcher, lecturer and clinician could also have restricted certain viewpoints or experiences, especially expression by staff of judgemental ideas about the clients.

By taking on the findings of this study and use of projective identification, staff may begin to see this process with many of the clients they work with. Whilst it is hoped that this will help in their relationship with the client, these theories may distort or limit the staffs view. They may ignore other experiences and focus on this aspect and experience ideological countertransference too. I too may have been limited by my focus on this useful concept. Replacing one theory with another, does not help the helper to embrace not knowing. It is hoped that the outcomes of this research will help the staff to embrace not knowing and use this time to really empathise with the client and together make sense of what appears to be going on before moving towards using theory to understand or into action or intervention.

These are some of the limitations of this study. No doubt, more will emerge with time, however all research has its limitations and these assist in creating new directions for further research activity. Some of these ideas are now considered in the conclusion chapter that follows.

Chapter 10: Conclusion

This chapter explores the concluding remarks of the thesis. Initially I will discuss how the aims of the research have been achieved and then I move on to focus on three main outcomes of the research and critique the literature in light of this. I then move to a focus on what I hope to achieve next and then reflect on the research and completion of the thesis.

The aim of this research was to provide a rich description of the process and outcomes occurring between a person who self-injures and a professional helper in order to generate and enhance existing theory and to capture and present the client and the staff perspective of the effects of the self-injury. I have explored the effect professional behaviours have on the clients emotions, thoughts and behaviours. I have used this data to inform health and social care provision.

This thesis has generated and enhanced existing theory by linking self-injury to concepts of shame, linking client and staff experiences within the context of an interpersonal relationship and has moved well beyond a depersonalised focus on the functions of self-injury. It has demonstrated how staff and client psychological defense mechanisms can be similar but with more reflectivity in staff accounts. Splitting, projective identification and dissociation of the representations of shame; the devalued self and the devaluing self were clear in staff and client interviews. A sense of "not being good enough" passed around clients, staff and the systems that they worked in resulting in experiences of helplessness and worthlessness.

The three most important aspects of the thesis that add new knowledge to the area follow as headings and literature is critiqued with these outcomes in mind.

1) The integration of the client and staff interpersonal processes before during and after self-injury.

This integration of client and staff experiences led to recognition of shared defences and coping strategies as well as some differences. Many separate accounts of self-injury are published focusing on clients/patients views of self-injury (Adler & Adler, 2007; Calof, 1995; Conterio & Lader, 1998; Fallon, 1983; Favazza, 1989b; Klonsky, 2007; McCallister, 2003). There is also some recognition on staff responses to self-injury (McCallister et al, 2002; Hopkins, 2002). However there are few articles or books that connect the experiences of both client and staff in relation to self-injury (Rayner et Al 2005, Connors, 2000). This remains an area for further exploration and clarification. This thesis fills this gap by providing an integrated approach to the interpersonal relationship when working with people who self-injure. While Connors (2000) writes about staff and client perspectives separately in different chapters of her book, I have integrated these perspectives by focusing in detail on clients and staff thoughts feelings and behaviours before during and after self-injury.

From a wider perspective, without connection to self-injury staff countertransference has been the focus in literature (Warne & McAndrew, 2006; Alexandris and Vaslamatzis, 1993; Pearlman & Saakvitine, 1995; Gabbard, 1993). However staff experiences are often viewed separately to client's experiences or narratives.

It could also be argued that a similar fragmented process occurs when viewing the literature on shame. Client experiences of shame are in different articles or chapters, rather than integrating the client and staff experiences of shame and viewing an interpersonal cycle of shame. Client narratives are well covered in the literature by many authors (for example Andrews, 1998; Buckbinder & Eisikovits, 2003; Gilbert, 1995; Kaufman, 1989; Lewis, 1986; Macdonald & Morley, 2001; Meifen et Al, 2005; Milligan and Andrews, 2005; Nathanson, 1989). Staff experiences of shame are less commonly the focus (Bancroft, 2007; Hann, 2000) As shame may have been conceptualised as an experience of an externalised devaluing other and a devalued self (Hann, 2004), this implies at some point that shame involved an interpersonal interaction to learn about shame. Therefore the experience of further shame requires either an external onlooker or an internalised view of the onlooker. As the client may view the helper as devaluing at some point, the interpersonal process of shame needs to be explored in a manner that considers client and staff experiences and also some recognition of how they meet in the interpersonal relationship. This area has only begun to be considered by a few authors but with limited depth (Hann, 2004, Crowe, 2004a &b).

A fully integrated approach to the interpersonal processes surrounding self-injury for staff and clients was not evident. This omission formed the rationale for this study. This thesis is quite unique in that one specific injury to the self is the focus, with different narratives from the client the staff and the researcher contributing to an understanding of projection and projective identification processes related to self-injury.

2) Self-injury as shame avoidance and shame inducing strategy

Within the data analysis that informed this thesis, self-injury has emerged not only as a shame avoidance strategy but also as a shame inducing strategy. Previous studies revealed that limited links are made with self-injury and shame in the literature. Wegscheider Hyman (1999) reports guilt, anger, anxiety, disgust frustration, hate, depression, helplessness and fear of loss as emotions prior to self-injury. Guilt, blame and shame have been emphasised by McAllister (2003). Shame has been recognised as an emotion occurring prior to and following self-injury (Connors, 1996). When people feel shame they are more likely to feel observed by others and are more concerned with others opinions of them and thus feel more isolated (Crowe, 2004a). This has been a response commonly reported by people who self-injure, but not necessarily expressed using the word shame (Pembroke, 1994; Babiker and Arnold, 1997).

Authors such as Klonsky (2007) describe the function of self-injury as "affect regulation", but do not fully describe which "affects" the person is attempting to regulate. A focus on relieving stress, rather than shame appears to be a more socially acceptable function. However, the role of shame prior to self-injury is recognised by some authors. Huband and Tantam (2004), for example, make the emotions explicit by stating that guilt, shame and anger are experiences prior to self-injury. However they didn't explicitly name these as reasons or triggers for self-injury, just state that they occur prior to the behaviour.

Shame is explicitly linked with other issues associated with self-injury. Andrews (1998) argues that shame is a mediator between childhood sexual abuse,

depression, eating disorders and posttraumatic stress disorder (PTSD), but does not link this with self-injury. However links between childhood sexual abuse, depression, eating disorders and self-injury are prevalent in other literature (Farber, 2000; Babiker and Arnold, 1997). Miller (1994) also links self-injury with these issues and also PTSD.

The diagnosis of Borderline Personality Disorder (BPD) is linked with shame (Crowe, 2004a, 2004b) and "never being good enough". She advocates that the characteristics of BPD are better understood as a chronic shame response. She states that shame is difficult to articulate in words and thus may be conveyed to others through the body and gives an example of self-harm. She describes self-harm as an expression of shame.

Milligan and Andrews (2005) recognise a significant relationship between shame, anger, childhood abuse, suicidal behaviour and self-harm. This was statistically significant in their research with women who have offended. However this was in a group of women where 60% of the sample was both suicidal and also self-injured. They found a significant correlation between experiences of shame and anger following self-injury, but did not record any reports of this prior to self-injury. They found that women who expressed suicidal or self-harming behaviours also expressed shame about their behaviour, character, body and appearance.

What has not been clear in the literature and research so far is how shame may trigger self-injury and also occur following self-injury. Pembroke (1994) seems to be the nearest in describing this cycle when she writes about her own experiences of

self-injuring then attending A&E and this making her want to self-injure again, following staff reactions to her. However, she doesn't refer to this as a cycle of shame and she also only focuses on her own perspective.

Shame is more explicitly recognised following self-injury, although this has attracted limited attention. However clearer links are made with these experiences following suicide attempts. Wiklander et al (2003) interviewed 18 patients about their experiences of hospital care following a suicide attempt. 13 of these patients described shame reactions. Some patients reported a positive experience that did not exacerbate shame, but others felt too exposed to others or experienced negative staff reactions, which exacerbated their feelings of shame. In the above study, explicit questions about shame were not asked, but participants reported this as an emotional experience when asked about events and experiences such as their thoughts and feelings whilst hospitalized following the suicide attempt.

The strongest links between self-injury and shame are documented by Connors (1996) when she refers to the "wall of shame" surrounding self-injury.

Connors recognises self-injury as a shame inducing behaviour and comments on how staff can help to reduce this shame and isolation. She also describes how people may feel shame about self-injuring and keep this behaviour a secret. In addition to this she also acknowledges that people may feel further shame about self-injury, based on the rejecting responses of professionals at previous disclosure. However, although Connors recognises strong countertransference feelings of guilt,

rage and helplessness in staff, she does not link this to an experience of shame in staff.

This thesis clearly links self-injury as a shame avoidance strategy that may also be shame inducing. I have also synthesised client and staff experiences of shame triggered by self-injury.

3) Staff ability to avoid rushing into action and cope with "not-knowing"

The role of staff "not-knowing" and being able to contain their anxieties prior to understanding are essential abilities to working with some people who self-injure. The ability to be "with", empathise and observe what is happening without jumping into theories is an essential aspect of truly understanding the person. Whilst not a new concept (Bion, 1962), there has been more recent re-emergence in current literature. Stickley & Freshwater (2009) state that countertransference in staff can be overlooked in favour of staff skill enhancement and a focus on action. Thus a focus on what to do, rather than how to understand a given process or issue tends to dominate practice, training or education. Warne & McAndrew (2007b) emphasise the space between knowledge and knowing, stating that it contains a place of "not knowing" This is where "emotionality can be challenged, compromised or strengthened" (Warne & McAndrew, 2008 P108). They link emotion and learning in this process, as do Simpson and French (2006). Freshwater and Stickley (2004) recognise the emotional restraint of the nurse when emotions may be expressed by the client. This was reflected in the actions of staff interviewed in this research and also echoed by the clients who at times wanted professionals to avoid expressing their own emotions and listen and contain theirs. Although these concepts are being

promoted within wider nursing practice and leadership, they haven't yet been clearly connected to self-injury.

Mental health nursing can be understood in terms of interventions and tasks, with a focus on action, rather than understanding (Mereness & Taylor, 1982). This work draws connections with the work of Menzies-Lyth (1990), who emphasised the focus of attention on tasks or interventions to avoid experiencing the emotional nature of nursing. As self-injury may affect staff in an emotive way (Rayner et al, 2005), it is unsurprising that helpers may focus more on interventions to help, rather than experiencing difficult emotions. However I would argue that the ability to contain emotions and be able to cope with the anxiety of "not knowing" needs to be an essential aspect of helping people who self-injure and also generally with people who are mentally or physically unwell. This skill has not been clearly connected in literature associated with self-injury or shame.

These three most important aspects of this thesis influence future areas of work in terms of research, publications and education.

<u>What now?</u>

Research

Further research needs to focus on the role of shame and blame in self-injury; finding out if shame is a trigger emotion to self-injury for more people; asking how self-injury helps the person deal with shame and if further shame is experienced following self-injury. For the staff: asking if they experience shame when working with people who

self-injure. The role of shame and blame in organisations would also be another interesting area to consider.

I would like to observe the relationship when a person self-injures and interview client and staff for their perspectives on what happened following the self-injury. I would then compare these explanations to my interpretation of what happened.

I would also look at the role of ritual in self-injury, either before, during or after in specific cleaning procedures.

The value of research is not based on whether it is replicable or not, but rather how it adds to our substantive knowledge (Hesse-Biber and Leavy, 2006). Unfortunately non-positivist research can be devalued and also become enmeshed in the shame dynamic. The qualitative researcher can take the position of the devalued and the positivist the devaluer. These roles may also be reversed. This could also be another area of research interest.

Publications

I am currently working on a research paper to highlight the findings and process of my research. Following this I would like to publish a book around interpersonal issues and self-injury. I would also like to write a paper on the role of shame in self-injury. A further article focused on self-injury and the staff ability to embrace "not knowing" before moving into theory driven understandings and interventions and also a specific paper on projective identification and self-injury also needs to be published.

A wider article to produce would be around the importance of integrating client and staff perspectives when focusing on interpersonal issues.

For education publications I would like to write about how essential academic and personal knowledge is about interpersonal processes and shame within helping relationships.

Education

I have already changed my teaching sessions for many of my pre-registration and post-qualifying education based on the outcomes of this research. I have included sessions on shame and mental health, shame and self-injury. I have also extended my sessions on transference and countertransference to include aspects of projective identification and especially the representations of the devalued self and devaluing other. These have all been evaluated well by the students of different abilities and levels of education. I am currently expanding my teaching on interpersonal issues in Cognitive Behavioural therapy as well. I have worked hard to bring together client case formulations with staff countertransference formulations. This has been quite an unusual method of integration for CBT approaches to therapy that have been focused solely on the client. These ideas could be presented as conference papers and some additional publications.

What would I have done differently?

When reflecting on the process of my research I have some ideas of what I may have done differently, however this was learning that I needed to experience, so I actually

wouldn't change anything. I would have liked to ask participants what they thought the interpersonal effects of self-injury were. I would have liked to ask the clients how they thought their self-injury affected the staff. I would have asked the staff if they thought the clients were aware of interpersonal consequences of self-injury. I would have liked to discover bricolage earlier in the research process, but then again, I needed to think about other methodologies to encounter then and then reject. I would have targeted clients for recruitment first, rather than staff.

How have I changed whilst writing this thesis?

I have widened my perspective on self-injury and weakened the link between experiences of childhood sexual abuse. Although many of the clients I have worked with in therapy have reported this to be the case for them, I am now very aware of how my professional work has been limited to clients within health and mental health settings. This group of people may be more likely to report experiences of trauma in childhood, but this is not necessarily the case for everyone. Angela's interview was very clear that she had not experienced these issues, but had experienced very significant loss of a parent and also further invalidation as a child. Instead experiences of shame appeared to be a clearer common ground with her and the other clients.

I now think of self-injury more of a method of coping with shame and then inducing shame, rather than as a communication method to others about the person's internal pain. The clients interviewed focused on the ability to numb their internal thoughts and emotions, rather than communicate these to other people. For some people who self-injure, however this may be a reason for self-harming.

I am able to cope more without knowing in terms of research processes. I was more familiar with doing this therapeutically with clients, especially when taking risks with people who self-injure. However this was a challenge for me in terms of often thinking I did not know enough about the research methods. With the help of my supervisor I was able to embrace the process and bring theories and literature back to my data later on in the process. Otherwise I too could have been more in danger of letting my research methods dictate my findings. Through this process I was able to reflect on how my own shame reactions of not having enough knowledge were influencing the research process. I would like to end this thesis with the poem below that embraces the ability to not know and become enlightened.

What is enlightenment – not-knowing

No past

No future

Open Mind

Open Heart

Complete attention

No reservations

That's all.

Morrision (2000)

Chapter 11: The Researchers Story

Whilst I have tried to demonstrate my reflexivity through out the thesis, I also have more to add. This chapter explores my beliefs, attitudes and emotions, as these have been shaped through completing the research and associated thesis. In the context of a research project such as this PhD, personal reflexivity is a way to acknowledge and reflect upon the ways in which the researcher's beliefs, experiences, gender, environmental context and other influences have affected them within their research (Townsend and Grant, 2006). I have explored these issues, before, during and after the research and have also linked these areas where relevant to parallel processes between myself and the research participants, or common themes of the thesis. I have also added aspects of an epistemological reflexivity where I have focused on questions related to the underpinning theories of research and the research process. During the research process I kept a reflexive diary and this has provided some of the material explored below. Other beliefs were explored in supervision and discussions with my personal tutor and also with colleagues who I have presented the research to.

Before the research: How is it that I am here?

In chapter 1 I explored the life events that influenced my decision to design and complete this research and thesis. Linking to my roles as a nurse, counsellor and psychotherapist, I believe that self-injury in helping relationships needs to be explored rather than avoided. I had experiences of staff avoiding discussion about this and this appeared to exacerbate the client's self-injury. I also believed that sometimes staff rejected people who self-injure as this was difficult for them to

accept, due to their own beliefs. However I also believe that staff paradoxically do want to help clients and relieve suffering. My belief of the importance of talking about difficult issues seems to link back to my nurse, counsellor and psychotherapy training, where the emphasis is on relieving suffering by talking. Some of my core beliefs are that people are generally good and want to develop, I am a good helper and want to help people develop, the world is a difficult place, where you can experience positive and negative events. I believe that good mental health is about adapting well to the environment that you are in and having both positive and negative beliefs. I also think that you need to explore suffering in order to feel better. I was aware of my beliefs that devising a plan and putting actions into place can help people. A focus on action is very much part of a western culture and also is a part of nursing, counselling and psychotherapy training.

During the research process and reading my reflexive diary, I became aware of my need to have a "tidy" theory about why people self-injure. Due to hearing client narratives in mental health settings, I began to link childhood sexual abuse strongly with a need to self-injure for the client I had worked with. My understanding was based on their stories and how they made sense of their experiences. I also believed that self-injury was for a variety of sometimes competing reasons, but that it was often to cope with helplessness and relieve tension. I also thought that this method of coping seemed to be difficult for professional helpers, which could result in rejection of the person or a focus on the self-injury behaviour, which sometimes resulted in an avoidance of the human relationship. I believe that self-harm is a functional part of being human and that people in different cultures have different ways of expressing this. I have also believed in the past that people who self-injure must have a need to

talk about this in order to "make them better". Thus this belief implies a link between self-injury and being unwell, rather than an expression of mental well-being. However I also recognised that self-harm can be a way of expressing yourself or experimenting with the physiological effects of the body. Some artists use self-injury as art and a form of expression. So these last two beliefs are somewhat competing, but I think that I became very influenced by the clients that I had worked with in mental health settings. I try to avoid judging people, but due to common co-created understandings of self-injury, I may have begun to have more fixed theories of self-injury than I had realised. These beliefs are important to reflect upon as they underpinned this research and also became modified during the research process and the writing of this thesis.

In terms of interpersonal processes I believed that when working in a therapeutic relationship that both staff and client have an equal influence. I also thought that both staff and clients could have psychological defense mechanisms. I believed that projective identification and splitting can occur within this context. I also thought that staff did not focus on this issue enough and tended to focus on tools and techniques of change. The aims and rational for this study were embedded in these beliefs.

In terms of epistemological reflexivity, I now turn to a focus on my beliefs about the research process. I believed that research was about learning from the participants and generating new knowledge. I believed that research needed to follow set methodologies in order to be valid. Information given within the research process needed to be confidential up to a point and consent given for where the information was shared. Research needed to not do any harm to the participants.

I chose interviews as I wanted to hear how the participants had made sense of the situation. I broke down the stages of the self-injury into thoughts emotions and behaviours before during and after the self-injury. This was quite a reductionist view but in hindsight I think it was my method at that early stage of my study, of organising a complex issue. However the clients seemed to relate to this well and two even stated that they had not spoken about what occurred during self-injury with anyone else. These questions helped me to link the client and staff interviews together. However I didn't explicitly ask the participants what they thought the interpersonal effects of self-injury were. So this structure did limit the expression of participant's understanding of the interpersonal process. Clients and staff did talk about the effects of self-injury on themselves or other people and the clients seemed to want to avoid thinking about how they had affected the staff interviewed.

<u>During the research</u>

I have written about the effects of the ethics committee in Chapter 3 and linked these into the ongoing themes of the thesis. My belief in keeping contents of interviews confidential influenced my decision to interview staff and clients separately. I initially considered interviewing staff and clients together, but thought that this may have reduced the level of disclosure by both parties, even though this may have been quite a therapeutic intervention for them. I also had this belief in mind very much as I completed the analysis and also the writing of the thesis. I reflected upon my decisions and thought processes about the interviews and separated the need to be a nurse/therapist and help the client and staff have a therapeutic intervention from my need as a researcher to understand the interpersonal processes. Thus I decided

to conduct separate interviews as I considered this to be more productive for the aim of the research.

The research process affected me in that I was a lot more anxious than usual and I was also paying attention to my boundaries of researcher and nurse/therapist. I think that I was more anxious as the role of researcher is less familiar to me than my role as a nurse or therapist. I was keen to explore the issues, but these were very similar to questions that I would ask in these other roles. I wanted to find out the participants story but was keen that the research did not harm them, as self-injury can be a difficult issue to discuss, especially with a stranger. However in my preparation for the research I remembered how much better people had felt after verbally exploring their self-injury with myself as a nurse/therapist.

In the analysis, my beliefs of Psychoanalytic theory and Cognitive Behavioural theory emerged as a method of making sense of the interviews. I used these theories to help describe what seemed to have occurred. This clearly would affect the outcome of my analysis and discussion. Although I was encouraged by my supervisor to not be theoretically driven, I was influenced by those theories that fitted into my own belief systems already. These models helped the completion of the research in that CBT did assist in the interview process and then the organisation of the dyads before, during and after self-injury. The psychoanalytic theory, especially projective identification assisted in exploring and linking the responses of each pair. Other theories would have shaped the analysis in a different manner. However many of the psychotherapy models do have a method of understanding different levels of the interpersonal process described using different names.

After the research

Following the completion of the research I have identified how some of my beliefs have changed.

In regard to self-injury I do not link childhood sexual abuse as closely as I once did. This belief was challenged during the interviews, especially with Angela, who was keen to dispel this connection. Her childhood issue was related to loss and bereavement. Shame was another concept that may be useful to link different experiences for clients. However I am aware of my need again to have a "tidy" theory for self-injury. This is another concept that may be useful for some people who self-injure. I am also aware of my thoughts that each episode of self-injury is unique for each person and how this contradicts a need to generalise common themes. This need to generate common themes was challenged when taking a phenomenological perspective that focuses on the uniqueness of each experience.

On some levels I was aware that staff would have similar defence mechanisms, however I was surprised how similar these were. I am now more aware of how staff use projective identification, depersonalisation or dissociation when in an interpersonal therapeutic relationship. My belief that you need to experience "not knowing" before you jump into action has been confirmed. This has challenged one of my beliefs about helping people to change. Sometimes you need to actually just be with the client in the emotion, or lack of emotion. I have tried to stay with this unknowing experience myself in the research process; to hold and experience the uncertainty before theorising.

An unexpected part of learning was in my beliefs about research. I hadn't realised how much I believed that set methodologies needed to be adhered to. The use of bricolage helped me challenge this idea and bring together competing methods and philosophies in the same way that I often combine therapeutic modalities as an integrative psychotherapist. Another challenge to my beliefs about research was that I believed that research was focused on the participant's narrative alone. I was aware at some level that I would influence the research, but I was not familiar with how much of myself as researcher would be disclosed whilst being reflexive. This process has been very refreshing genuine and honest. I was amazed at how at times of difficulty I kept returning to theorising and literature and set models to ease my anxiety.

Writing up the thesis

During the process of writing up the thesis I was aware of my psychological defense mechanisms. I moved between knowing and not knowing and embracing anxieties about the ethics committee and the viva. I became very anxious despite previous experiences of conference presentations, interviews and teaching sessions with challenging students. My avoidance strategy at times was to immerse myself in literature. Whilst this was an essential part of the learning I became aware of how I could continue with this activity in order to avoid writing up. Towards the end of the writing up period and the viva, I had many dreams of forgetting something or being unable to find something, but knowing it was there. Although I was not unduly concerned in the waking hours my anxieties came through my dreams. Shame seemed to be connected here, in that whilst presenting my work I had a fear of

negative evaluation from others. Gilbert (1995) refers to this as external shame. Although entirely normal in this process it did make me think about some of the themes of my research. I became aware of how much the study of a PhD confirms Twitchel's (1997) concept of western values. Self-help, self-discipline, self-respect, self-control, self-improvement, self-reliance and self-interest are all elements that the PhD tests out. He argues that shame occurs if these are not achieved.

Although at times during the process of completing the thesis I have had doubts of "not being good enough" I also had beliefs of being good enough as well. At times I needed reassurance that I was right, or applying the methodology in the correct manner, but now believe that I found the "right tools for the job" in the true sense of bricolage.

These modified and new beliefs will help me with my further research activities and also publications. I still hold the belief that the participants narrative is the focus, but also very much more include my own subjective experience and my own person as part of the bricolage and research process. I have become much more aware of my beliefs around research. The different beliefs about self-injury and the interpersonal realm are very much influencing the content of my teaching and also the teaching methods becoming more experiential. I am aware of my need to categorise and have an ideal theory to explain self-injury. I am also aware of how students may have this need also and have difficulties embracing competing theories about self-injury. I believe that my role is to provide as many narratives as possible to reinforce the idea that self-injury is different things to different people at different times.

Appendix 1

"An Interpersonal process of self-injury" – Gillian Rayner
Patient Participant information sheet version 3 – Jan 2006.
Local REC project number:
Participant Information sheet.
Study title – "An Interpersonal process of self-injury"
Researcher – Gillian Rayner.

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 other people if you wish. Please contact me if there is anything that is unclear, or if you would like additional information. Take time to decide whether or not you wish to take part.
Thank-you for reading this.

- **What is the purpose of the study?**

The study aims to explore the interpersonal process that may occur between people who self-injure and their professional helper. Completion is planned for 2008.

- **Why I have I been chosen?**

You have been chosen because a mental health professional from your team thought you might be interested in taking part and you have recently self-injured

- **Do I 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 decide to take part, you are still free to change your mind at any point, without giving a reason. 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 agree to take part?**

If you agree to take part, I will contact you or the staff to arrange a mutually convenient time to meet. This confidential meeting may occur in a hospital or university setting, depending on where we both find agreeable. You will then be asked a series of questions, which will be noted using a tape recorder. If you have receipts of travel costs to the venue, these can be reimbursed. You may also be asked to keep a diary of further self-injury, this will be discussed at the interview (depending on how often you self-injure)

- **What are the possible disadvantages and risks of taking part?**

The interview will consist of questions relating to both good and bad experiences, which may be emotionally painful to talk about. However you can talk at your own pace and stop the interview at any time if required. If you reveal that you are of significant risk of hurting yourself or someone else, or inform me of a child at risk of abuse, under the rules that govern my professional conduct, I will have to

speak to a member of staff. I will discuss this with you first and encourage you to speak to the member of staff with me.

- **What are the possible benefits of taking part?**

The information from this study may lead to a better understanding of the interpersonal process of self-injury and help to improve services for people who self-injure. The interview questions may also help you explore your self-injury, which may result in greater understanding.

- **What if something goes wrong?**

If you are unhappy about any aspect of the study, or your participation in it, please feel free to make a complaint through: Debbie Ridings, Research Institute Administrator, Institute for Health and Social Care Research, The University of Salford, Salford, M5 4WT. Tel- 0161-295-7006

- **Will my taking part be kept confidential?**

All information collected about you during the study will be kept strictly confidential. Confidentiality will be maintained and the recording of the interview will be deleted on completion of the study. Any direct quotations used when writing up the research project will be anonymous. As your team has agreed that you may take part in this study, they will be aware that you may be talking to me, they will not be aware of what you say unless I need to breach confidentially as discussed in "What are the possible disadvantages and risks of taking part?" and I will discuss this with you first.

- **What will happen to the results of the research study?**

The research study is part of a PhD and the results will be contained in this document. Published journal articles will also result from the study, but you will not be identified in any way.

- **Who is organising and funding the research?**

The research study is being undertaken through the university of Salford as part of a PhD and no funding has been sought. Application may be made to the university to cover travel and administration costs.

- **Who has reviewed the study?**

  The study has been reviewed by Salford and Trafford Local NHS Research Ethics committee, the research ethics committee at the University of Salford and Bolton, Salford and Trafford Mental Health NHS trust Research Governance Group.

- **Contact for further information.**

Gillian Rayner, Lecturer in Mental Health Nursing, The University of Salford, Department of Nursing, Peel House, Albert Street, Eccles, Manchester. M30 ONN. Tel – 0161-2952780.
E-mail g.rayner@salford.ac.uk.

Should you decide to participate in this study, you will be asked to sign a consent form.

Appendix 2

(To be on headed paper from Salford University)
"An Interpersonal process of self-injury" – Gillian Rayner
Staff Participant information sheet version 3 – Jan 2006.
Local REC project number:
Staff Participant Information sheet.
Study title – "An Interpersonal process of self-injury"
Researcher – Gillian Rayner.

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 other people if you wish. Please contact me if there is anything that is unclear, or if you would like additional information. Take time to decide whether or not you wish to take part.
Thank-you for reading this.

- **What is the purpose of the study?**

The study aims to explore the interpersonal process that may occur between people who self-injure and their professional helper. Completion is planned for 2007.

- **Why I have I been chosen?**

You have been chosen because the client selected by your team thought you had the closest relationship with them.

- **Do I 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 decide to take part, you are still free to change your mind at any point, without giving a reason.

- **What will happen to me if I agree to take part?**

I ask you or another member of staff to contact me when the client has self-injured. I will contact you to arrange a mutually convenient time to meet. This confidential meeting may occur in a hospital or university setting, depending on where we both find agreeable. You will then be asked a series of questions, which will be noted using a tape recorder. If you have receipts of travel costs to the venue, these can be reimbursed.

- **What are the possible disadvantages and risks of taking part?**

The interview will consist of questions relating to both good and bad experiences, which may be difficult to talk about. However you can talk at your own pace and stop the interview at any time if required. If you discuss issues of professional misconduct, under the rules that govern my professional conduct, I will have to speak to another member of staff. I will discuss this with you first and encourage you to speak to the member of staff with me.

- **What are the possible benefits of taking part?**

The information from this study may lead to a better understanding of the interpersonal process of self-injury and help to improve services for people who self-injure. The interview questions may also help you explore your clients' self-injury, and the effects on yourself as a professional helper.

- **What if something goes wrong?**

If you are unhappy about any aspect of the study, or your participation in it, please feel free to make a complaint through: Debbie Ridings, Research Institute Administrator, Institute for Health and Social Care Research, The University of Salford, Salford, M5 4WT. Tel- 0161-295-7006

- **Will my taking part be kept confidential?**

All information collected about you during the study will be kept strictly confidential, unless I need to breach confidentially as discussed in "What are the possible disadvantages and risks of taking part?" and I will discuss this with you first. Confidentiality will be maintained at all times and the recording of the interview will be deleted on completion of the study. Any direct quotations used when writing up the research project will be anonymous.

- **What will happen to the results of the research study?**

The research study is part of a PhD and the results will be contained in this document. Published journal articles will also result from the study, but you will not be identified in any way.

- **Who is organising and funding the research?**

The research study is being undertaken through the University of Salford as part of a PhD and no funding has been sought. Application may be made to the university to cover travel and administration costs.

- **Who has reviewed the study?**

  The study has been reviewed by Salford and Trafford Local NHS Research Ethics committee, the research ethics committee at the University of Salford and Bolton, Salford and Trafford Mental Health NHS trust Research Governance Group.

- **Contact for further information.**

Gillian Rayner, Lecturer in Mental Health Nursing, The University of Salford, Department of Nursing, Peel House, Albert Street, Eccles, Manchester. M30 ONN. Tel – 0161-2952780.
E-mail g.rayner@salford.ac.uk.

Should you decide to participate in this study, you will be asked to sign the following consent form, with a witness.

Appendix 3

(Form to be on headed paper from Salford University)

Patient Identification Number for this research:

CONSENT FORM – (version 2 Jan 2006)

Title of Project: "An Interpersonal process of self-injury"

Name of Researcher: Gillian Rayner

Please tick box

1. I confirm that I have read and understand the information sheet dated ...Jan 2006 (version 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 or legal rights being affected. ☐

3. I understand that the researcher will have access to my medical notes ☐

4. I agree that the interview can be recorded ☐

5. I agree to take part in the above study. ☐

Name of patient	Signature	Date
Researcher	Signature	Date

1 for patient; -1 for researcher; 1 for notes

Appendix 4

(Form to be on headed paper from Salford University)

Staff Identification Number for this research:

CONSENT FORM (Version 2, Jan 2006)

Title of Project: "An Interpersonal process of self-injury"

Name of Researcher: Gillian Rayner
Please tick box

1. I confirm that I have read and understand the information sheet dated Jan 2006 (version...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 rights being affected. ☐

3. I agree that the interview can be recorded ☐

4. I agree to take part in the above study. ☐

______________________	______________________	______________
Name of staff	Signature	Date

______________________	______________________	______________
Researcher	Signature	Date

1 for staff; 1 for researcher

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