Stories of Self Harm; A critical approach to the existing evidence base and the proposal of alternative perspectives.

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"I never saw a wild thing
Sorry for itself.
A small bird will drop frozen dead from a bough
Without ever having felt sorry for itself." D.H. Lawrence.

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Abstract

The initial aim of the study was to consider the health promoting and survival function of self harm. However, this evolved and became increasingly concerned with the storied lives of people who self harm and in challenging dominant discourses that do not support this endeavour. The issues were considered using aspects of social constructionism and as such embrace the interpretative and provisional nature of knowledge.

The main body of the thesis is divided into three sections, *"Going There,"* *"Being There*" and "*Being Here"* (Birch, 1998). *"Going There"* includes a critical appraisal of the literature prior to discussion of the theoretical underpinnings to the study. In this chapter I endeavoured to present the considerations which underpinned the decision making process with regard to structure and design of the research study. This leads to the next section, "*Being There"* (Birch, 1998).

At this stage in the thesis, the aim to be convincing is pursued with an overview of the practicalities of undertaking the research. Meaning is proposed in the exploration of the stories using elements of psychoanalytic theory and a voice-centred relational method (Mauthner and Doucet 1998). Attention then revolves around the participants, their narratives and reflective points which emerged for me during the study.

"*Being Here"* centres on the ideas which emerged as a result of the research, and where links are made with existing theory. These can be summarised as concerns regarding the participants' relationships with others and the self, in conjunction with a critical appraisal of the existing knowledge base. My own reflexive points are then offered and in the final chapter, implications for practice are considered. These are based on the emerging ideas and illustrate the benefits of using narrative and an eclectic approach to meaning making.

Introduction

The following thesis charts my journey through doctorate study and as the title implies it is a qualitative piece of work which is concerned with individuals' narratives following self harm and attendance at Accident and Emergency (A&E). The initial aim of the study was to consider the health promoting and survival related function that self harm may perform. However, as the ensuing discussion will reveal, the study evolved and became increasingly concerned with ensuring that the storied lives of people who self harm became the central concern through challenging dominant discourses that do not support this endeavour.

The issues are considered using aspects of social constructionism and as such embrace the interpretative and provisional nature of knowledge. This perspective also dictates the need for me to present not as a distant and removed researcher, but as one part in the process and for whom objectivity has not been a quest. Rather, I attempt to be transparent without self indulgence and in doing so, hope to enable the reader to effectively comprehend the journey I have taken.

With this pursuit in mind, the main body of the thesis is divided into three sections, "*Going There*" "*Being There*" and "*Being Here*" after Birch (1998) who describes her experiences in social research as a journey. This resonated with me and my sense of distinct stages within the research, but also their inter-relation, and much as specific elements of a journey stand out, they still remain part of the whole process of travelling from one place to another.

Going There

In keeping with Birch (1998) I use her descriptions of the journey but with my own interpretation. *"Going There"* places me in a particular position prior to entering, defining and gaining access to the "*field of inquiry*" (Birch, 1998 p172). As such the literature is critically reviewed and a brief summary provided prior to discussion of the theoretical underpinnings to the study in Chapter 2.

In this chapter I endeavour to present the considerations which underpinned the decision making process with regard to structure and design of the research study. I also include ideas which were

rejected in an effort to be as open as possible with regard to the research process. This leads to the next section, *"Being There"* (Birch, 1998).

Being There

The main concern of Chapter 3 is to be methodologically, rhetorically, clinically (Miller and Crabtree, 2000) and theoretically convincing and an overview of undertaking the research is presented. Elements of psychoanalytic theory are used to propose meaning in the stories and Mauthner and Doucet's (1998) voice-centred relational method of data analysis assisted in identifying how participants referred to themselves and others in their stories. Using these approaches much is made of the proposed meaning behind the narratives as opposed to their construction and syntax.

This section culminates in consideration of those people who were contacted regarding the study but who were not interviewed and the reasons why before leading onto Chapters 4-7. These chapters concern the participants, their narratives and reflective points which emerged for me as a result of engaging with them.

Being Here

The final section of the thesis represents where the text is created and the practical research world is distanced (Birch, 1998). This centres on the ideas which emerged as a result of the research, as discussed in Chapter 8 and where links are made with wider disciplines and existing theory. My own reflexive points are presented in the penultimate chapter to be interrogated by the reader and the thesis concludes in Chapter 10 where implications for practice are proposed.

All journeys have a start and mine will begin with an exploration of my intellectual autobiography in the hope that it will assist in making my position explicit in relation to the study.

Intellectual autobiography

Mauthner and Doucet (1998) and Stanley and Wise (2002) propose the integration of the researcher's intellectual autobiography within the research process. It is argued that reflexivity of this nature enables comprehension as to how understanding and conclusions are reached and is one facet of so called

feminist approaches to inquiry.

Briefly, such approaches can be regarded as taking a critical perspective in relation to dominant discourses, to have an interest in issues of power and to regard relationships within a wider societal context and specifically within the research process, as inherent to the inquiry. This is explained in more detail within the main body of the thesis but suffice to say at this point, an interest in reflexive approaches drew me to authors such as Mauthner and Doucet (1998) and Stanley and Wise (2002) and the influence of such perspectives can be seen to run throughout this research study.

Based on the proposed explanation above, it may seem curious that I begin with consideration of my intellectual autobiography before I propose any points derived from undertaking the study. However, it seems prudent to offer pertinent aspects of myself at this juncture to reflect how they weave throughout the thesis. Additionally, I do not come to this research study from within a vacuum; I bring my presuppositions and experience with me and wish to be explicit from the onset where I position myself in relation to the study to be discussed.

In her text, Etherington (2006) invites the reader to consider a number of questions in relation to the author and the reader themselves. I will attempt to use these to encapsulate aspects of myself which were inherent in all stages of the research from conception to the final thesis. In doing so, I hope to make my position as transparent as possible with the aim of being as open as is achievable and so enable judgements of the study to be conducted.

In keeping with Etherington's (2006 p11) invitation, I also urge the reader to consider these questions from their own perspective, as they will influence how the ensuing discussion will be engaged with and interpreted.

- How has my personal history led to my interest in this topic?
- What are my presuppositions about knowledge in the field?
- How am I positioned in relation to this knowledge?
- How does my gender/social class/ethnicity/culture influence my positioning in relation to this topic/my informants?

Rather than deal with each question individually, I intend to provide an account of the beginnings of the journey towards this study and in doing so will endeavour to attend to each of the elements presented.

As a Mental Health Nursing Student I was allocated a placement within a Regional Secure Unit (RSU), a decision I was far from happy with due to worries and concerns evoked by the notion of working with mentally disordered offenders. Despite my reticence, this placement proved crucial in moulding my future career because I chose to return as a final year student and also worked as a qualified mental health nurse within RSU provision for almost six years. Following this I was employed in a mental health service based in A&E working specifically with people who had self harmed and it is this issue which is the focus for my doctorate study.

Throughout my career there have been a number of defining experiences, the vast majority of which have been precipitated by clients and perhaps one of the most important took place during my first day as a student placed within the afore mentioned RSU. Amy (to protect confidentiality) was a 20 year old woman with an offending history who was undergoing a period of assessment of her mental state for court reports. She was dressed in tracksuit bottoms and a cap sleeved t-shirt, the entire length of both her arms were covered in scar tissue as a consequence of self harm.

Amy was a similar age to me and in a way there was some resonance between her situation of not knowing what was going to happen at court and my feelings of being in an unknown and frightening environment. More than this though, I distinctly remember trying not to look at her arms but because this was my first encounter with the physical scars of self harm, I found it difficult. I recall trying to process and understand how and why someone would do that to themselves and most importantly what did it mean?

This latter question has continued to stimulate my desire to explore issues associated with self harm further and has defined my work clinically, educationally and my research interests. It is through my doctorate study that I have been able to provide an answer of a sort to the question "*what did it mean?*" and which is presented in this thesis. However, it is crucial to note that this is filtered through my views and perceptions which have been formulated by my clinical and academic experiences and my world view, including who I am in that world. The importance of which was highlighted to me when I attended

an event aimed at exploring the issues of harm minimisation within the clinical area. I recall during and after this event being conscious that the discussion relating to self harm was stifled by those who refused to consider it an issue worth debating. This strength of feeling prompted me to return to a recurring question concerned with why this issue evoked such an emotive response.

It seemed to me that dominant medical discourses espoused during this event were out of kilter with the views and wishes of a growing body of literature written from the perspective of those who self harm. To me this was characterised by scant appreciation of the part that self harm can play in an individual's life and an overwhelming dismissal that harm minimisation could potentially offer anything useful within the clinical arena.

I could appreciate the view that harming the self conflicts with much of the doctrine around what it means to be healthy, particularly when casting my mind back to my encounter with Amy. I could also see that this conflict represented a challenge to the role assumed by clinicians. This led me to wonder whether the responses I had witnessed were prompted by a perceived need to defend one's position and I questioned why, despite appreciating where this concern might originate, I did not feel the same way.

On exploring this question it struck me that I did not wholly ascribe to the view that self harm is intolerable and so should be treated and eradicated. I could see it in less definite terms and whilst many people I had worked with stated a preference not to self harm, they also acknowledged its place and function in their lives and I could appreciate this.

That said, I was part of this dominant medical discourse which is underpinned by issues of treatment and cure. I knew that there were some people who had experienced useful mental health service provision in relation to self harm, but I also knew there was a raft of evidence to the contrary. As an individual I felt able to defend my clinical practice. However, it is inescapable that my practice was couched within a much larger system and was being guided by procedures I knew to be of limited use, this was a clear motivation in aspiring for change.

Change is notoriously difficult to effect but perspectives associated with social constructionism have proven liberating in enabling me to understand pertinent issues from a different viewpoint and to regard change as possible. The ensuing discussion will reveal that I do not endorse such theories in their entirety, but there is something energising about engaging in an issue whilst acknowledging that multiple realities exist and the part that our history and culture play in our comprehension and world view. Explanation of which is encapsulated by the quote below;

"all ways of understanding are historically and culturally relative. Not only are they specific to particular cultures and periods of history, they are seen as products of culture and history, and are dependent upon the particular social and economic arrangements prevailing in that particular culture at that time. The particular forms of knowledge that abound in any culture are therefore artefacts of it, and we should not assume that our ways of understanding are necessarily any better (in terms of being nearer the truth) than any other ways." (Burr, 2005 p4).

Taylor and White (2000) argue that one of the strengths of social constructionism is that it advocates knowledge as situated, local and provisional which enables scrutiny to a greater degree than if something is true, universally applicable and therefore not susceptible to change.

As stated, being part of clinical services which seemed on occasion to make matters worse for people who self harm was an unenviable position and provided me with the motivation to improve the way in which people experienced such provision. On one level I endeavoured to do that with my own clinical practice and more latterly through teaching, which leaves research.

My master's dissertation was concerned with the ethnicity of women who self harmed in secure provision and the nursing management of incidents. This was a quantitative piece of work and to an extent I feel I was seduced into using such methods by espoused notions of what constitutes quality research. Wilkinson (1988) argues that when a definition of what is legitimate is proposed, such as favouring the dominant positivist paradigm, anything outside of this, such as qualitative research becomes easier to dismiss and devalue.

In my doctorate studies, I wanted to distance myself from such notions and became immersed in

considering how I could formulate and answer the questions I felt were unanswered in relation to self harm, whilst remaining true to my values and beliefs. This was further informed by exposure to the existing knowledge base and at the beginning of the study Aaron Antonovsky's salutogenic orientation captured my attention as it offered a different perspective to that which seemed to dominate existing theory and practice.

This theory was derived through exploratory interviews with Holocaust survivors and Antonovsky's observation that horrific experiences could be understood and internalised in a number of different ways. Further, that potential damage may be protected by a strong sense of coherence which is described below and comprised of comprehensibility, manageability and meaningfulness.

"The sense of coherence is a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that 1) the stimuli deriving from one's internal and external environments in the course of living are structured, predictable and explicable; 2) the resources are available to one to meet these demands posed by the stimuli; and 3) these demands are challenges, worthy of investment and engagement." (Antonovsky, 1987 p19).

Antonovsky (1987) states that the salutogenic orientation, in which the sense of coherence (SOC) is embedded, derives from a rejection of the health/ill-health dichotomy in favour of considering one's location to be on a multidimensional health ease/disease continuum. Embracing this concept takes into account the person's story that includes illness, but is not solely concerned with aetiology. As such, instead of asking what has or will cause a person to experience a given disease, Antonovsky urges consideration of the factors which have maintained someone's location on the continuum or will assist movement towards the healthy end. This perspective, in conjunction with my understanding of the existing knowledge base, helped to formulate the key questions of my study which were;

- To explore the health promoting function of self harm
- To investigate what has prevented people who self harm from committing suicide.

At stated above, Antonovsky's theory was initially central to my consideration but as the study developed came to be regarded metaphorically as a door which enabled me to be open to other

perspectives and supported my view that people who self harmed should tell their stories in an effort to illuminate pertinent issues. I was determined about this particularly as the availability of qualitative studies may be limited if seen as methodologically inferior to quantitative approaches, which hierarchies such as the framework proposed in the NSF for Mental Health (DoH, 1999) can potentially reinforce.

I did not attempt a position of objectivity because I felt no need to make a claim in this respect. As Burr (2005) indicates, we all encounter the world from one perspective or another which renders objectivity and value freedom as impossible. As such, acknowledgement that one's perspective is integral to informing the research process is crucial. In this respect, Burr (2005) states that reflexivity makes reference to the way that theory re-constitutes the role of respondents, their relationship to the researcher and the status of their accounts. There is also acknowledgment that when giving an account of an event, it is simultaneously a description of the event and part of the event because of the constitutive nature of talk.

In considering this I became aware that I too would be part of the research process and needed to be mindful of issues associated with such methods. Burr (2005) states that the social construction of one's own account as researcher undermines its claim as the only possible truth, but this should not be used as an illusion of democratisation within the research relationship. From my perspective I have attempted to be transparent in relation to the issues of power but can not wholeheartedly claim to have engaged in a democratic relationship with participants. The transcripts of interviews were not made available, redress was not possible if a point was contended in the writing of the research findings and whilst I offer an explanation as to why I chose not to do this in Chapter 3, it remains a tension for me.

I have attempted to remain true to the participants' stories as I heard them but wish to say categorically that Chapters 4 onwards are my own interpretations, that is they are simply one perspective and as Winnicott (1991 p66) stated *"...I dare say that some of what I said is not quite rightly put. But it is not all wrong..."* and whilst this is not a statement of intent that *"anything goes"* (Rolfe, 2006 p7), it is an open acknowledgement that I have inevitably made interpretations from my own perspective. As such, I hope I have presented the people and their stories through this research as individuals defining and defined by their narratives. They are not *"self harmers"* but people with storied lives consisting of love, loss and concerns and the journey towards accomplishing this aim begins with a critical approach to the existing

knowledge base as discussed in Chapter 1 where I review the available literature.

Chapter 1

A critical review of the literature

Hart (1998) states that a key objective of the literature review is to provide a balanced picture of current leading concepts, theories and data pertaining to the topic under study, further it is where application of a critical attitude should be demonstrated and enables a proposal for the intended research.

It is in the pursuit of these aims that the following review is presented and begins with details of the search strategy. Having completed my master's degree in 1997 I felt confident I had a working knowledge of the literature up to that point and this was reflected in the search strategy for this thesis. The following terms were entered into CINAHL, medline and psychINFO; self harm, self injury, self inflicted, self mutilation, self poisoning, overdose, self burning and cutting. Articles were identified, collected and reviewed; the search was then revisited and updated as necessary during the writing up period and in its entirety covered 1997-2008.

Duplicates were removed prior to displaying the citations and articles written in English with the search term in the title were identified. Articles which focused specifically on learning disabilities and or psychosis were considered too narrow a focus and were excluded from the search. On reviewing the literature, any studies which contained relevant references to my study were also sought. This provided evidence of the vast array of literature pertaining to self harm and the need to provide focus and structure for the purposes of this review.

Government guidelines in the UK provide recommendations for practice based on the best available evidence and one such guideline is the short term management of self harm patients in primary and secondary care (Cooper et al, 2008). It has also been proposed that an additional benefit of this guideline is that it can help identify priority areas for research (NICE, 2004). For these reasons the overview of self harm provided in NICE (2004) will be used as a framework on which to base this literature review in an effort to achieve the objectives proposed above by Hart (1998). For ease of comprehension this chapter is organised into themes and the first to be considered is that of definition.

Say what you mean

The issue of language and self harm is fraught with problems and confusion, there are copious terms to describe self harm which Burrow (1992 p139) referred to as a "*semantic paella*" and which represents a lack of agreed terminology. An example of which is contained in the study conducted by Solano et al (2005) who explored self injury with people who had a diagnosis of an eating disorder. This paper exemplifies both the diversity in terminology and the problems inherent in using one term to describe a host of expression. Illustration of this is through an overview of behaviours associated with self harm as used in the available literature. Reference is made to a number of studies where collectively the term self harm is used to denote actions such as scratching, suicide attempts, cutting, severe nail biting, hair pulling, and substance misuse among others. However, commonality may not underpin these expressions, someone who uses self harm as a survival strategy, such as the person who harms themselves physically to feel better emotionally (Turp, 2003) may have different intentions from a person who has attempted to end their life through suicide. This issue is crucial as any term used is not simply a label, it is loaded with a message regarding intention, motivation and perceived risk.

A further illustration of this is exemplified by Maghsoudi et al (2004, p217) who considered self inflicted burns and women in Tabriz, Iran. These authors defined suicide as *"the result of an act deliberately initiated and performed by a person in the full knowledge or expectation of its fatal outcome."*

Yet a person may both expect and have knowledge that the self inflicted burn could kill them yet survive it and as such it is not suicide. There is a potential discrepancy between the term used and the outcome of the action. Personally I believe a more suitable term would be "*attempted suicide,*" however someone else may argue that this is an act of self harm. The terms may bear some relation to one another in that both are associated with harm directed to the self but the intent, motivation and perceived risk may not be and it is this issue which remains problematic (Allen, 2007).

Similarly Comtois (2002) reviewed interventions to reduce the prevalence of parasuicide which she states is a major risk for completed suicide. In the paper parasuicide is defined as any non fatal self injury including lethal suicide attempts and self mutilation. Allowing the reader insight into the proposed definition used in this paper provides some context, but there is an issue in including what may conceivably be a range of motivations from wanting to survive through to wanting to die within this

description of parasuicide. The ramifications of this are illustrated through consideration that this paper is concerned with interventions and the concern being that as a result of using ill defined terminology, practice and ultimately the care delivered to the individual is adversely affected (Allen, 2007).

One way to avoid such complications is refraining from ascribing labels preferring instead to routinely record the individual's perception of the act. In doing so, those individuals who participate in research define themselves as opposed to having their experiences labelled by the researcher. There is an additional desired outcome with respect to this which is concerned with power, or rather the wish to refrain from reinforcing the existing power dynamic which some writers propose is typical of service provision in relation to people who self harm (Spandler and Warner, 2007 px).

Power Crazy

Having proposed this dynamic, it is imperative to offer further evidence of its existence and at a fundamental level this can be seen with regard to language. There are occasions where words and phrases may be used with inattentive consideration of how they might be interpreted by others. There are also instances where the choice of language can be seen to be more sinister and betray underlying oppressive attitudes.

The exploration in Claes et al's (2005) study concerned with self care versus self harm in a group of people deemed to have eating disorders illustrates this point with regard to language and power. The abstract of this Belgian study begins as follows;

"Eating disordered patients seem to have a love-hate relationship with their bodies. Why do some decorate their bodies by means of tattooing and piercing, while others deliberately injure themselves and make parts of their body unattractive?" (Claes et al, 2005 p11).

The definition of self-injury/self-injurious behaviour is then noted to be *"any socially unaccepted behaviour involving deliberate and direct injury to one's own body surface without suicidal intent."*

The subjectivity in both these statements is notable and the question must be asked as to who decides when something is socially unacceptable and/or unattractive. To their credit Claes et al (2005) do state

that self care and self harm may vary according to one's perception and purpose of the act but then go on to state that for the sake of clarity distinctions between normal and abnormal self care and self harm may be helpful. Such statements reflect issues on a much bigger scale. From the forenames of the authors one presumes they are male and their participants in this study were 101 females diagnosed with an eating disorder. Shaw's (2002) contentions are brought to mind here, specifically where she argues that clinical literature concerned with self injury reproduces the violating and distorting experiences in a patriarchal culture that facilitate the emergence of self injury in women.

This power laden dynamic is not solely confined to clinical settings. Best's (2005) exploration of the educational response to self harm was concerned with a school which is described as an independent church school in a middle class area, not in an area of poverty, deprivation or violence, to which the author states *"was in itself interesting"* (Best, 2005 p276). As the author does not clarify why it is interesting the reader is forced to make their own suppositions. One of which could be that this statement is an example of a highly pejorative comment which reveals the author's inner belief that self harm is not an issue for the middle classes, which taken further could be related to a disbelief that the middle classes could be *"self harmers."*

To consider the issue of power and language further, I referred to Burr (2000) in Allen (2007) to illustrate how language can be expressed in such a way that it conveys people in terms of what they are, rather than what they do. Burr uses the example of *"homosexual"* to make this point stating it is only recently that this term became a noun rather than an adjective. I then proposed the role this plays in dehumanization (Allen, 2007) and such a process can be seen here in Best's (2005) paper. Even if one disagrees with the link proposed between the middle classes and *"self harmers"* the author goes on to repeat terminology used to describe a young woman not solely experiencing depression but as a *"young depressive"* (Best, 2005 p280) as if that is all she is.

The consequences of portraying people as what they do rather than who they are enables dehumanization which in turn reinforces a power dynamic through oppression (Thompson, 1998). Reducing people in this way negates a whole host of other information which, in the pursuit of understanding, seems nonsensical. To resolve this, a narrative approach concerned with how stories can give meaning to people's lives as advocated with specific reference to self harm by McAllister

(2001) could be pursued.

Self Harm; whose problem?

Language is not the only issue of concern in relation to self harm. Attitudes within clinical settings are a well established point of critique which can not only lead to the dehumanization of people, but also reflect on access to assistance from health care provision.

Anderson et al (2003) conducted an analysis of nurses' and doctors' perceptions of young people who engage in suicidal behaviour. The authors state that the values, beliefs and attitudes of health care professionals in relation to young people following an incident of self harm will influence the relationship with the young person. This is noted to be crucial with reference to Talseth et al's (1999) contention that establishing effective communication is essential when caring for what the authors refer to as, suicidal patients.

The findings reported in Anderson et al (2003) included the frustration felt by nurses and doctors, as they were unable to devote the time and resources necessary to enhance relationships with those young people who had engaged in self harm. Further, that without adequate time the worth of interventions was questioned.

There was also a moral issue for the respondents who regarded themselves as preservers of life and which conflicted with suicidal behaviour and again compounded the feelings of frustration. The act of suicidal behaviour was felt by some to separate the professional from the young person as it was not something the nurse or doctor had resorted to themselves. This then led them to consider what they had relied on during times of distress which further distanced them and underpinned the health care professional's belief that young people who engage in suicidal behaviour are unconventional and difficult to engage with. However, the authors also propose that for some health care professionals there was recognition that the young person's life was so vastly different to theirs that this enabled them to sympathise.

In the same year Batsleer et al (2003) documented the responses of 18 health and social care staff and seven South Asian women who had survived attempted suicide/self harm. The staff were said to be from

a broad range of disciplines and worked across voluntary and statutory sectors. They were mixed gender but predominantly white and the focus of the article was to consider the findings derived from the workers interviews, but which also draws on the seven survivor interviews to support the comments made.

Batsleer et al (2003) stress the importance of staff as a major resource and as such, it is critical that they are supported in implementing the policies and procedures of a given service. Within this context these authors acknowledge the ambivalent and mixed feelings that self harm and attempted suicide evoke in some workers. This ambivalence and having to deal with issues of race was said to lead to the development of coping mechanisms in the staff group which do not benefit clients. The authors suggest that one consequence of this may be to regard some clients as undeserving.

This contention is in direct conflict with McAllister's (2003) premise that as so much information pertaining to self harm is available, it would be reasonable to assume that understanding of this issue exists and that clients' needs are addressed by service providers. However, McAllister does not subscribe to this view and in fact suggests that there may be various reasons why health care professionals may not access or apply knowledge to practice. These, she suggests, include lack of awareness, lack of sufficient skill development, a culture that is not challenging, resistance and lack of support for new approaches.

McAllister (2003) further comments that hospitalisation does not decrease the incidence of self harm and makes reference to Johnstone's (1997) arguments that medicalisation of this issue professionalises it and puts the health care provider in the position of expert and the client as the one who needs to develop expertise. Additionally, that it ignores the social reasons for self harm, locates the problem as pathology and in keeping with this medical model approach, the emphasis then tends to be on physical treatments which ignore perspectives derived from the disciplines of psychology and sociology (McAllister, 2003).

McAllister's (2003) criticisms can be exemplified through reference to Claes et al's (2007) paper in which two main questions were examined; whether Self Injurious Behaviour (SIB) which was defined as direct and deliberate damage to one's body tissue without suicidal intent, psychopathological symptoms,

personality disorders and aggression regulation differs in relation to males and females who were receiving psychiatric in-patient treatment. Secondly, whether there were clear differences between those who self injure and those who do not. The paper offers little critique of these characteristics, it is taken for granted that such a relationship exists, and the authors go on to state that *"Hence, one may conclude that the presence of SIB in psychiatric patients is an indicator for the severity of psychopathology."* (Claes et al, 2007 p619). Yet the links between self harm and psychopathology are fiercely debated and using the example of borderline personality disorder, are proposed by some to be fabricated.

Johnstone (1997) states that self injury has been a feature of many cultures for centuries and remains a present day phenomena yet there has been a growing recognition of some forms of self injury as a psychiatric problem. This, she contends, has been largely unhelpful and even damaging. She goes on to claim that the problem lies in the psychiatric model and critiques the issue of diagnosis offering a compelling argument as illustrated below.

"Why does this woman cut herself? Because she has borderline personality disorder. How do you know she has borderline personality disorder? Because she cuts herself." (Johnstone, 1997 p422).

Thereby illustrating that this medicalised approach explains very little and that the limitations of this circular argument are not just confined to a lack of explanation but also prevent more searching questions about the reasons behind one's actions (Johnstone, 1997). In the same paper it is then remarked that the psychiatric model gives no way of understanding why self injury provokes such intense emotions in staff, how to deal with these, what they tell us about the service user and ourselves and whilst these issues are never discussed in ward rounds, an individual's experience of treatment will be impacted upon by staff attitudes and feelings which may include rage, sympathy, guilt, solicitude and the urge to retaliate (Johnstone, 1997).

To refer back to Claes et al (2007), the paper illustrates some of these criticisms in relation to taking a narrow focus which does not embrace the wider complexities as urged by Johnstone (1997). Two Belgian psychiatric hospitals were used to recruit participants to this study and anger regulation was explored. It was found that both males and females scored higher on measures of internalized anger and lower on anger control. The authors' link this with the literature stating it supports the conclusion that

elevated levels of internalized anger are linked to a risk for developing SIB. Yet there is no consideration of environmental factors and the effects that residing in a psychiatric unit may have despite the role of institutions in the creation of self harm having been explored by Matsumoto et al (2005) and Marzano (2007) among others and commented upon by Pembroke (1991).

Marzano (2007) explored self harm among male prisoners and states that not withstanding the issues of vulnerability of people in prisons, the ethos of the establishment plays a role in creating self harm which has been conceptualized as a way of coping with the pains of imprisonment. Shaw (2002) contends similarly that where self injury has been investigated in men, much of the work has focused on institutional contexts where it may be attributed to institutionalisation.

In her analysis of the literature Shaw (2002) draws on work conducted in the 1970s regarding restructuring a closed psychiatric unit into an open unit that was said to decrease self injury by 94%. Shaw also comments that authentic relationships in therapy are required for healing and refers to the evidence base which contends that strict controls are ineffective, may escalate self injury and be more reflective of the clinician's need to allay their own discomfort rather than focusing on the needs of women who self injure (Shaw, 2002).

Clearly attitudinal factors are crucial in relation to self harm as they can have a direct influence on the type of service provided and as a result the individual's experience of it (Anderson et al, 2003., Pembroke, 1991; 1994). Additionally one's attitude may also influence the design and reporting of research findings examples of which include Bohus et al (2000), Claes et al (2007) and Kemperman et al (1997), yet self harm is not always seen in negative terms and condemned.

"Beliefs, attitudes, practices, and images diffuse across latitudes and longitudes and centuries. Our perceptions of self-mutilation as grotesque or beautiful, heroic or cowardly, awesome or pitiful, meaningful or senseless derive in great part from the perceptions of those who have lived before us." (Favazza, 1992 p4).

In this respect it can be argued that differences exist with regard to how self harm is comprehended and as the ensuing discussion will show, issues associated with self harm are inextricably entwined in

cultural and sub-cultural terms. Laloe and Ganesan (2002) noted a high incidence of self burning in Batticaloa, eastern Sri Lanka and sought to examine the epidemiology, outcome and psychosocial aspects of 87 patients admitted following self burning over a period of two years. Although the authors do not make it clear how they can definitively state that those who had died intended to, given that this is fraught with problems such as accidents and lack of knowledge with regard to lethality of methods. This is not the issue they pursue; rather it is that the results from their study are contrary to what might be expected based on the available evidence. This related to the group of people who were admitted with self burning injuries being less distinct when compared with those who had sustained accidental burns and those who used other methods of suicide. As such, the authors contend that those who died were young, that the male to female difference was narrow and of those who attempted suicide by fire, few had a mental illness.

Similarly, Laloe (2004) reviewed patterns of self burning in various parts of the world and found that in western countries self burning is relatively uncommon whilst in some parts of the world it is a major cause of extensive burns and as a consequence, death. It is concluded in this review that the significance and interpretation of self burning as a method of self harm or suicide varies according to the country or part of the world. Acknowledgement of which may lead one to consider the evidence base relating to self harm and suicide as local and situated. This perspective is a fundamental premise on which social constructionism lies and acceptance of which enables knowledge to be interrogated more thoroughly than if it is regarded as a universal truth (Taylor and White, 2000). Given Hart's (1998) contention regarding the application of a critical attitude within the literature review, perspectives which draw on social constructionism can be seen to be pertinent, this concept is explained in more detail in Chapter 2 and pursued throughout the thesis.

Returning to the issue of self harm within sub cultural terms, Matsumoto et al (2005) examined the clinical features and differences between those who self cut and self burn in a Japanese juvenile detention centre where the practice of *Konjo-yaki,* that is to burn the skin with a lit cigarette seemingly to imply that one has "*guts*" (Matsumoto et al, 2005 p63) has been noted as a form of social binding and which the authors wished to explore in comparison to cutting.

The study concludes that within this population burning unless accompanied by cutting, may be less

serious clinically than cutting and that a combination of cutting and burning may indicate underlying "*psychopathology*" (Matsumoto et al, 2005 p 68). As such, the suggestion appears to be that burning is therefore more socially acceptable within this context.

Findings such as those proposed by Laloe (2004), Laloe and Ganesan (2002) and Matsumoto et al (2005) underline contentions that methods of self harm, attempted and completed suicide are a form of information but need to be contextualised within the individual's story if a greater understanding is to be achieved. It also follows that outwardly observed harm can be seen as indicative of internal issues and it makes sense that it is at this level where attention should be focused (Turp, 2003). Yet so often practitioners are subsumed in issues of risk (Seager, 2008) and this is reflected in the literature as the following discussion will illustrate.

If I could see into the future I'd be famous

Clearly the preceding section made reference to self harm and also suicide and this perceived link is pursued here to illuminate the issues further. The title of this section represents the quandary for practitioners when attempting to discern intent and motivation which essentially entails making a judgement based on the here and now to inform a future prediction. This issue was pursued by Cooper et al (2006) who state that it is unrealistic to expect a rule or clinical assessment to predict long term risk. As such, fail safe prediction is not possible as no one can be absolutely prevented from completed suicide (Bell, 2008) because if someone is determined to kill themselves, there is little that can be done to prevent them (Anderson, 2008).

Yet to acknowledge these difficulties through a perspective which embraces the complexity of risk assessment and recognises the problems associated with this challenging task, does not support the agenda surrounding suicide prevention and targets aimed at reducing this rate. The reason being, that this agenda relies on attempting to reduce such assumptions around intent and motivation to manageable, predictable components. This illustrates Thompson's (1998) contention that where an incomplete evidence base exists, reductionism of an issue is likely in an attempt to make the complex more simplistic and manageable. To compound these difficulties evidence suggests that not only do attitudes of staff effect the way a person experiences a service following self harm, but values, beliefs and attitudes also influence how risk is assessed and consequently judged.

Ireland (2000) considered this issue in respect of how intent is identified and comprehended and found that among incarcerated adolescent male offenders, perceived risk of self injury as opposed to actual self injury is the most frequently reported reason for opening a self harm form. This procedure sets in motion the process for observation, referral to the medical officer and a plan to deal with the self harm and is entirely dependent on the perceptions of the staff member as to whether the individual's behaviour is "*serious*" enough to deem an official record being kept (Ireland, 2000 p612).

It may be fair to suggest that this reason for opening a form could indicate a robust system whereby self harm is being prevented by accurate identification of those at risk and the introduction of those measures described. However, it is difficult to confidently conclude in this manner given evidence from a clinical perspective which links the response to self harm with one's perception of it and the desire to avoid blame. This point was pursued by Bell (2000) who refers to the spirit of inquiry becoming subsumed by the need to protect the self from *"inquisition"* when things go wrong. He argues this case in the context of the external world placing impossible demands on staff by insisting acceptance of unreasonable levels of responsibility (Bell, 2000 p36).

There is also the added complexity that as self harm is cited as the best predictor of eventual suicide (Hawton et al, 2004), anxieties may be raised and as the onus is placed on prison staff to accurately assess and effectively deal with risk of this nature within the prison environment, the ability to make reasoned judgments may be impaired by fear of potential reprisal.

In keeping with this perceived link, Clarke et al (2002) remark on work that indicates self harm as being identified in the epidemiology of suicide and as such, is regarded as a predictive factor. However, they also state that the significance of self harm as a predictor of suicide is difficult to determine and in Allen (2007) I echoed this contention. I illustrated this through use of the analogy that just as crossing the road raises one's risk of being involved in a road traffic accident, then engaging in a potentially risky activity such as self harm may result in suicide (Allen, 2007). However, the fact that someone engages in a risky activity which may result in death does not mean that this was the intention. That said, it may have been and additionally people can hold conflicting ideas at the same time. The problem however, is that if the person has died this can not be explored with them and retrospective judgements are made based on the available evidence which excludes the person's account. Hawton et al (2004) also acknowledged

this problem when they stated it is difficult to examine treatments in relation to completed suicide but intervention following non fatal self harm is more amendable to evaluation. The point being, information of any nature can not be explored with the individual if they have died.

Where seemingly untroubled links between self harm and suicide are made without thorough consideration of the complexities those charged with the task to understand intention are assigned an almost impossible undertaking. As indicated by Bell (2000) attempting to manage care which is in the best interests of the individual, yet which supports a duty of care and the purpose of the organisation in which they are employed, is far from easy and the literature is not always helpful due to the use of misnomers and confusing operational definitions.

Roy and Janal (2005) contend that whilst being female, having experienced childhood trauma and having a family history of suicidal behaviour are three well established risk factors for attempting suicide, the interactions between these factors had not previously been studied. It was therefore, proposed to investigate this with 1889 participants. The sample was derived from a population of people who were referred to as *"abstinent substance dependent patients"* (Roy and Janal, 2005 p367) which is justified through reported links between substance misuse and high risk suicidal behaviour (Roy and Janal, 2005).

In this study a suicide attempt was defined as *"a self-destructive act with some intent to end one's life that was not self-mutilatory in nature."* (Roy and Janal, 2005 p368). Yet what constitutes some intent, and why self mutilation was not considered to be indicative of attempted suicide is unclear and reiterates the difficulties associated with definition, terminology and self harm.

In contrast to the exclusion of self mutilation, Klonsky (2007) reviewed empirical research on the function of self injury which was defined as the intentional and direct injuring of one's own body tissue without suicidal intent. In this review 18 empirical studies were included and it is stated that *"Self-injurers may not know why they self-injure or have difficulty verbalizing reasons and offer explanations that are not accurate. Others may fabricate explanations if they are embarrassed by their true reasons."* (Klonsky, 2007 p230). This statement is supportive of the difficulty in ascertaining motive and therefore judging risk. Klonsky (2007) also makes a further observation that methodologies used to explore the functions

of self injury have focused on affective and physiological variables and less on social and interpersonal variables. This is a recurring point of critique for those authors who advocate the need to emphasise interpersonal and intrapersonal processes in relation to self harm, such as Bell (2000), McAndrew and Warne (2005) and Shaw (2002).

In this respect, Shaw (2002) charts the historical progression of the self injury literature and comments that more recently issues of an interpersonal and environmental nature have been deemphasized and incorporated into the context of epidemics where patients are held responsible for the spread of self injury. With few exceptions she contends that the roles that culture, social structures, hospital environments, relationships and clinicians may play in fostering the conditions for self injury are absent from consideration.

Shaw (2002) also comments on the move from psychodynamic approaches to pharmacological and short term interventions. Current models, she contends, focus on symptom removal, cognitive-behavioural techniques, medications and contracts and are characterized by disengagement with women who self injure. These contentions are supported by the work of Spandler and Warner (2007 pxii) specifically in relation to their comments regarding dialectical behaviour therapy (DBT). Which they state is here and now focused so can allow for difficult issues such as past abuse to be avoided and can be punitive if the client self injures as this allows the therapist to cancel the subsequent session in an effort to prevent reinforcement. Spandler and Warner (2007) go on to state that it is not surprising that the model underpinning DBT is frequently disliked by many people who self harm.

However, it is not enough to embrace the roles that culture, social structures, hospital environments, relationships and clinicians may play in relation to self harm as advocated by Shaw (2002) as even when there appears to be recognition of such factors, some authors seemingly still struggle to detach from the dominant medicalised position of the professional.

Zaragami and Khalilian (2002) conducted a prospective descriptive study concerning deliberate self-burning in Mazandaran, Iran. These authors considered demographic correlates and situational and diagnostic precursors with a view to prevention. As such, this study described a process whereby all patients admitted to the sole burns unit in Mazandaran over a three year period and whose burn might

have been the result of a suicide attempt were assessed by a social worker. Three hundred and eighteen patients who had "*clearly and unequivocally made suicide attempts*" (Zaragami and Khalilian 2002 p116) were identified. Inclusion criteria were based on the patient's confession to self burning and/or a reliable witness. Those who denied a suicide attempt but for whom there was suspicion but no corroborating data were excluded.

It seems reasonable to highlight issues in this paper which require more consideration such as, what constitutes a reliable witness and it is interesting that the inclusion criteria states and/or. This suggests that the person may deny a suicide attempt but due to a reliable witness stating otherwise, would have been included in this group. The problems of which are potentially compounded as there is no mention as to whether the social worker had sufficient expertise in such assessment. However, it is interesting to note that none of the cases presented in this study had a past history of self burning nor had a further attempt been made at follow up. The most important stressor cited in the inquest notes was marital problems, although it was unclear how this ascertained. Despite these methodological issues, the findings of this study seemingly conflict with espoused links between past and future behaviour such as Hawton et al (2004).

A similar finding to Zaragami and Khalilian (2002) was reported in Maghsoudi et al (2004). This study sought to consider self inflicted burns and women in Tabriz, Iran. It is similarly notable that none of the 412 women reviewed for the purposes of the study had a past history of self burning, and whilst the majority, 79.6% had died, survivors had not made more attempts at follow up. Whilst this and the previous study may be considered a narrow population, and cultural differences may prevail, it does highlight some of the difficulties associated with risk assessment, management and future prediction. The consequences of which are aptly described as follows;

"*To insist that mental health personnel accept a level of responsibility that is quite unrealistic, seems increasingly to be part of mental health policy. Such policies, based less on thought and more on the wish to project unmanageable anxiety into those faced with an already difficult task, set the scene for a deterioration in the real care of these patients.*" (Bell, 2000 p36).

In a British study conducted by Harriss et al (2005) the value of measuring suicidal intent in the

assessment of people attending hospital following self poisoning or self injury was investigated. The authors contend, in direct contrast to the previous two studies discussed above, that the risk of suicide in a person who has self harmed is higher than the general population and in particular during the first 12 months following the incident. They do however also note that follow up studies of people treated for self harm have produced inconsistent results concerning the relationship between suicidal intent and future suicidal behaviour.

Harriss et al (2005) proposed that as suicidal intent was routinely measured in clinical practice its value should be verified. To achieve this clinical and demographic details of 4415 patients attending A&E from 1993 to 2000 were analysed. In order to provide sufficient follow up time, self harm and suicide were then investigated for 2489 patients from 1993-1997. Suicidal intent was measured using Beck's Suicide Intent Scale (SIS).

Of those who died by suicide (2.9% of males and 1.7% females), 63% of men and 79% of women had high SIS scores at the index episode. The SIS scores of those who had died by suicide and those who had not were then explored in three age groups. With the exception of men in the oldest group as none had died by suicide, the proportion of those with high SIS scores within each age group was greater among those who had ended their lives, although the authors state that due to small numbers, the differences were not significant.

Harriss et al (2005) state that SIS cannot reliably be used to assess risk of repetition of self harm and acknowledge it was not originally designed for this purpose. It might also suggest that risk factors associated with suicide and repetition of self harm are different. The authors further state that accurate prediction of suicide following self harm is restricted by the low rate of suicide and by low specificity of predictive factors. However, they do contend that measurement of suicidal intent is valuable in the evaluation of suicide risk and is most likely to be beneficial when used in conjunction with other known risk factors.

In this pursuit Murray and Wright (2006) discuss the integration of theories to establish a comprehensive assessment of risk in relation to adolescents, emphasising the need to contextualise young peoples' experiences within their family, social world and the broader community. This paper explores the

experiences of three adolescents and it is concluded that a connection with the adolescent is necessary in conjunction with understanding their self harm within the context of their family, their social and school experiences and it is stated that; "*Although the intent of the study was not to generalize the results, caution should be exercised in generalizing from the experiences and perceptions of the three adolescents in the study.*" (Murray and Wright, 2006 p162-163). This comment is interesting in the context of hierarchies of evidence and is pursued in Chapter 2.

Knock and Kessler (2006) considered factors for suicide attempts as opposed to suicidal gestures. They define this latter term as self injury where there is no intent to die but instead intent to give the appearance of a suicide attempt in order to communicate with others. To ascertain intent, respondents were asked if they had ever attempted suicide and if so, were asked which of three statements, presented below, most closely described their attempt, or first and most recent attempt where there was more than one;

"I made a serious attempt to kill myself and it was only luck that I did not succeed"
"I tried to kill myself, but I knew the method was not fool proof"
"My attempt was a cry for help, I did not want to die" (Knock and Kessler, 2006 p617)

A method such as this limits the opportunity to gather information and an alternative method may be to use participants own words to portray their intention. Particularly as an attempt may not have been a wish to die or a cry for help either. Further examples of reports concerned with self harm and suicide which can be critiqued in this manner exist within the available literature and in keeping with the issue of risk, cause and effect, Comtois's (2002) review is illustrative of this.

Within this review a study is cited which found that 3 to 10 percent of suicide completers committed suicide within ten years of the first parasuicide incident. The ability to predict risk over the span of a decade is clearly limited and to use an alternative term, would literally mean being able to see into the future. This is also in keeping with comment by Cooper et al (2006) who state it is unrealistic to expect a rule or clinical assessment to predict long term risk.

To return back to the original point, it also means that 90-97% of people in this study did not commit

suicide in that same ten year period yet this statistic is seldom presented in the literature. This bias in how statistics are presented in relation to self harm and suicide illustrates a pattern whereby findings from the minority disproportionally impact on the generation of knowledge and in this respect the work of others can also be presented.

Owens et al (2002) identified that recent self harm was probably the major predictive factor in eventual suicide and undertook a systematic review in an attempt to quantify the rates of subsequent suicide and non-fatal repetition following self harm. As such a literature search was undertaken, 90 studies were said to fit the inclusion criteria and despite conceding that their review might suggest that suicide following self harm has a substantially lower incidence in the UK than elsewhere (Owens et al, 2002), the authors feel confident enough to state that;

"The strong connection between self-harm and later suicide lies somewhere between 0.5 and 2% after 1 year and above 5% after 9 years" (Owens et al, 2002 p193).

Again the point which was made previously regarding the impact of the minority in relation to knowledge applies here. To completely ignore the converse of this statistic in that according to these figures between 99.5 and 98% of people who had self harmed did not kill themselves after a year and after 9 years approximately 95% had not, seems remiss, yet this pattern is not an isolated occurrence within the literature and in a similar vein to Owens et al (2002), McElroy and Sheppard (1999) also highlighted that those who self harm are an important group in terms of suicide prevention.

These authors contend that people who self poison and engage in self injury place pressure on general hospitals, may experience unhelpful encounters when using services and so proposed to enhance departmental policies and procedures to address these issues.

An action research approach to determine knowledge and attitudes of A&E staff and to identify and enhance policies aimed at self harm was undertaken. It was contended that those who self harm are distinct from those who complete suicide, seemingly concurring with Harriss et al (2005), but that there is an overlap.

McElroy and Sheppard (1999) also cite previous work stating that over half of those who commit suicide are not in contact with psychiatric services and state a need for collaboration amongst a variety of agencies and services. This cited study was 25 years old when McElroy and Sheppard's (1999) paper was published and perhaps those who committed suicide were not in contact with psychiatric services because they were not deemed psychiatrically ill. This is not to deny the elevated risk of suicide among people with mental health problems but instead to highlight that whilst the objective of this project is necessary, the simplistic cause and effect interpretation to issues as complex as self harm and suicide is not necessarily useful.

Hawton et al (1999) explored the role of psychological factors in relation to repetition of deliberate self-harm by adolescents. In this pursuit their previous studies are cited which estimate that 20-30% of those referred to general hospitals will have engaged in self harm previously and between 10-15% will carry out a further act within the following year. It is perhaps also prudent to state conversely then, that the vast majority either will not engage in a further act or do not come to the attention of services.

Justification for this exploration is given on three counts; repeated self harm indicates persistent or recurrent psychosocial problems, it is a strain on clinical services and associated with a considerable risk of suicide. With regard to the latter point, one could argue for use of the term "*sudden death*" as chosen by participants in Cooper (1999) who, as relatives of the bereaved, did not believe their death to be the result of suicide.

Hawton et al (1999) go on to contend that specifying psychological characteristics associated with an increased risk of repetition which might be susceptible to treatment would be valuable. To this end they sought to explore problem solving, impulsivity and self-esteem in those who do and do not repeat self harm, using self poisoning as the issue for consideration and not self injury the reasons for which are not clearly identified.

Hawton et al (1999) found that very few differences could be discerned between the nine adolescents who repeated self harm during the following year and the thirty-six who did not. The authors cite the small sample size as inhibiting the ability to detect other psychological characteristics aside from depression as contributory factors. This finding may also be indicative of self harm as a mutifactorial

issue and not simply related to psychological aspects but which requires issues to be placed in a wider environmental and interpersonal context. This is not something Hawton et al (1999) make comment on but which may reflect Shaw's (2002) contention that with few exceptions the roles that culture, social structures, hospital environments, relationships and clinicians may play in fostering the conditions for self injury are absent from consideration.

That said, Santa Mina et al (2006) take a perspective more aligned to regarding self harm as a multifactorial issue and contend that clarification of intention in self harm may assist clinical assessment and management. The authors make the important point that not all suicidal acts are driven by a wish to die despite intention in suicide and self harm having been conceptualized from the death wish perspective. The paper describes an exploratory analysis of a new measure to assess intent, The Self-Injury Questionnaire based on Robin Connors work and the authors conclude that;

"*It is important to educate nurses regarding the multi-intentional nature of self harm behaviour and the importance for all mental health care clinicians to develop and to conduct multifocused self-harm assessments, regardless of gender, method or an abuse history, and to provide interventions which target the motivations.*" (Santa Mina et al, 2006 p226).

Regarding self harm as a multi-factorial issue, which does not solely emanate internally, reflects the contentions of authors such as Johnstone (1997), Marzano (2007), Matsumoto (2005) and Shaw (2002) and acknowledges the intrapersonal, interpersonal, cultural, environmental and social perspectives associated with self harm and at this juncture it is timely to review the proposed causes of self harm.

Reasons, roots and origins

Over twenty years ago Favazza and Conterio (1988) stated that due to the diversities involved, it is impossible to make a unitary aetiological formulation for people who harm themselves. Yet this is an issue which continues to be pursued as the ensuing discussion will reveal.

Glassman et al (2007) endeavoured to explore the extent to which childhood maltreatment is associated with non suicidal self injury and to test a mediation model of self criticism. These authors contend that whilst a history of childhood maltreatment is consistently related to the development of self injury, this

relationship remains unclear as most studies examine only one type of neglect or abuse. This, the authors further propose, makes comparison between studies difficult. In addition they propose that a lack of explanation exists as to why some people self injure for the purposes of emotion regulation or social communication, rather than engaging in other behaviours that might serve similar functions such as substance misuse, bingeing or purging.

Glassman et al (2007) suggest that if maltreatment as a child has involved excessive criticism, verbal or emotional abuse, this may lead the individual to engage in a direct form of self abuse or self punishment. The authors make the point that self injury is a multi determined behaviour that cannot be explained by one simple pathway and that examination of multiple pathways is necessary to understand what they refer to as "*this dangerous behaviour.*" Glassman et al (2007, p2484).

To explore this, Glassman et al (2007) recruited 94 adolescents aged 12-19 and assessed for the presence of childhood maltreatment, self criticism, perceived criticism, non suicidal self injury and depression. Eighty-six fully completed all measures and so formed the sample group. The results of this study concur with others which have found sexual abuse and physical neglect to be associated with self injury and that the relationship between emotional abuse in childhood and self injury in adolescence is partially explained by the presence of a self critical cognitive style. As such, the authors contend that at times of stress, adolescents who have developed this cognitive style may be more likely to engage in non suicidal self injury for the purposes of self punishment.

Further findings state that emotional abuse during the formative years could result in a tendency to internalise critical thinking towards the self. However, the authors make the point that self injury may produce a self critical style in contrast to the assumption that the presence of this style is a cause of self injury. This is an important point which acknowledges to an extent, that the identification of causes of self harm (injury) is not a simple cause and effect relationship but is embroiled with a host of processes which may not be easily identifiable.

Paivio and McCulloch (2004) in their examination of alexithymia as a mediator between childhood trauma and self-injurious behaviours describe childhood trauma as being linked with deficits in emotional regulation. This, they state, derives from abusive and neglectful environments with intense negative

emotions where feelings and needs are frequently ignored, invalidated or violated.

The authors further contend that this leads to an inability to learn how to express feelings appropriately and limited support for coping and dealing with painful emotional experiences. As such, Paivio and McCulloch (2004) contend that survivors of childhood trauma, without effective capacities to regulate emotion, can experience great disorganisation during periods of stress and amongst other responses, this can precipitate self injurious behaviour. Against the backdrop of this theory, Paivio and McCulloch (2004) sought to test whether alexithymia mediates the relationship between childhood maltreatment and self injurious behaviour.

One hundred female undergraduates were randomly selected from all students enrolled in introductory psychology classes at one university. It is unclear if the population from which the students were drawn was entirely female or whether this was a purposeful strategy in sampling. The sample group were assessed for childhood trauma, alexithymia, self injury using various measures and demographic information was also collected.

Forty-one percent of the random sample reported engaging in at least one method of self injury whilst severity of all types of maltreatment and higher levels of alexithymia predicted a greater extent of self injury in the group. Results were also reported to support the hypothesis that difficulties attending to, identifying and expressing feelings contributed to the association between childhood maltreatment (excluding sexual abuse) and superficial self injury.

The authors further state that alexithymia (to the extent it would signify a clinical level), was higher in this sample group when compared with other university student sample groups. They explain this partly as being a consequence of the group being comparatively young and cite reported evidence which proposes this relationship between age and alexithymia. They do however, concede that this is difficult to interpret and a larger sample group is required. That said, the authors feel confident enough to conclude that;

"For most participants in the study, reported engagement in SIB was infrequent and likely at subclinical levels of severity. Nonetheless, the high rate of SIB found in this sample, overall, suggests that young

undergraduate women are a vulnerable group." (Paivio and McCulloch, 2004 p351).

This statement carries much gravity yet may lack justification given the number of limitations to the study noted by the authors and the narrow sample population. As such, it seems ill advised to generalise the findings of this study seemingly to the entire female undergraduate population. Particularly as despite the array of studies which link childhood maltreatment and later self harm, Alder and Alder (2007) found that most of their participants had an unremarkable childhood and comment on one respondent's statement that having had no recollection of abuse and experiencing a happy childhood, she could not say why self harm had been a feature in her life for the last twelve years.

It seems reasonable to suggest that the reasons underpinning self harm appear to be multi-factorial and individual yet this further compounds the challenge to those pursuing treatment strategies and as such may not be a welcome admission.

Intervention- to kill or cure

Having offered a critique of the evidence pertaining to the causes of self harm, attention now turns to that which is occupied with clinical interventions, one example of which is reported by Bateman and Fonagy (2001). This piece of work documents an evaluation of treatment for people diagnosed with borderline personality disorder, of which self harm is one diagnostic criterion according to DSM-IV-TR (2000). The study was an 18 month follow up of people who had been assigned either psychoanalytically orientated partial hospitalisation or treatment as usual.

The study draws conclusions from a comparison of these two treatment groups and utilises a randomised controlled design, although as stated the groups were small with 44 participants divided between the two. The authors determine that psychoanalytically orientated partial hospitalisation as a treatment for borderline personality disorder had a better outcome than treatment as usual, which was referred to as standard psychiatric treatment.

However, there are some issues to consider in relation to this as reported in Allen (2007). Use of the term standard psychiatric treatment gives very little indication of what it actually entails as standard psychiatric treatment may be subject to variation within services. There is also a need to question the

outcome measures used in this study which attempts to illustrate progress through the use of hospitalisation, incidents of self harm and attempts at suicide. Additionally these terms are not defined and it is therefore difficult to discern the differences perceived by the authors between "*serious suicidal gesture*" and "*attempted suicide*" (Bateman and Fonagy, 2001 p38).

Information was not provided with regard to admission criteria and whether these were applied in a uniform manner for all participants and secondly using self harm as an outcome measure negates the complexities associated with it. For instance, someone who has sought therapy may experience an increased frequency and/or severity of self harm in the short term due to the exploration of difficult material. However, this does not mean that undergoing therapy is not a positive step and therefore a favourable outcome.

There is also the issue of how the associated feelings of self harm manifest themselves. For instance someone who cuts may be prevented from doing so in hospital and this could be regarded as an effective strategy but not if the thoughts and feelings of the individual are explored and reported to be a loss of control and disempowerment. Additionally self harm may manifest in other ways for example the individual may not cut but stop eating instead.

In a similar manner to Bateman and Fonagy (2001), Clarke et al (2002) also utilised admission rates as an outcome measure to determine whether there were any differences between routine care and a nurse led case management approach using a randomised controlled trial. This entailed routine management plus a psychosocial assessment, negotiated care plan and open access to the case manager, who was the researcher with a background in Mental Health Nursing, via mobile telephone. As compared with routine care only, which involved triage through A&E, medical and psychiatric assessment and treatment as required. If admitted because of attendance to A&E, routine treatment usually involved a request for psychiatric assessment. The conclusion from the study was that there was no significant difference identified in the overall readmission rate which was measured 12 months from the index episode of self harm.

However, it should be noted that information relating to the instances of self harm was only collected from Monday to Friday and so will not provide a representative sample. Additionally people who

presented having overdosed which resulted from recreational and problematic alcohol and/or drug use were excluded from the study which may be questionable based on some available evidence which suggests that "*substance dependent patients are a group at high risk of suicidal behaviour.*" (Roy and Janal, 2005 p368).

The intervention group were offered a case management approach and were able to contact their case manager during office hours only and at other times by agreement. This may be contrasted by the finding of Hawton et al (2007) in their multicentre study of self harm which found that the most common time of presentation was between 10pm-2am. Further critique may be offered as the paper does not document in detail what contact by agreement means and so it is unclear if a crisis needed to be pre-planned in order to secure this assistance. Or if contact was agreed with the participant at the beginning of the intervention it would perhaps have been more useful to provide a set time for all in order to reduce variation in the service.

The ramifications associated with making conclusions such as that proposed by Clarke et al (2002) is that despite their findings being based on a flawed methodology, it may contribute to a rationale for denying the development of services by reinforcing the perception that no discernable difference was found when compared to routine care of which Pembroke's experiences are a sobering reminder that this has not always achieved its aim.

"*Psychiatric hospitalisation only compounded my need to harm myself, and the response from staff was frequently angry and hostile...One doctor would stitch wounds which extended to the bone of my arm with just a skin suture, not bothering to repair the underlying layers. As the verbal humiliation and hostility increased with each visit to A&E, I became increasingly reluctant to attend for fear of the response I would get.*" (Pembroke, 2007 p163).

The issue of satisfaction with service delivery and provision was explored by Warm et al (2002) who evaluated levels of service satisfaction received by people who self harm. The study identified respondents through the internet and reiterates findings previously proposed in relation to a general dissatisfaction. More specifically it was found that medical personnel were rated most poorly, whilst self harm specialists were deemed to be the most satisfactory.

In keeping with the theme of specific and useful strategies, Corcoran et al (2007) investigated the role of self injury support groups for women using a grounded theory approach and overall conclude that such support groups are valued by the women who use them. A further benefit derived from this study was the formulation of a conceptual model, which may provide a provisional framework on which to investigate further with its potential benefit relating to the fact that it was grounded in participants' experiences. Whilst this may be susceptible to the criticism that it is subjective and not amendable to generalisation to other populations, it may answer some of the criticisms of other intervention based approaches such as that described above by Pembroke (2007) and in relation to DBT (Spandler and Warner, 2007) although others point to the growing evidence of the possible benefits of this approach (Lilley et al, 2008).

Huband and Tantum (2004) also reported findings derived from the experiences of those who self harm by interviewing ten women about their experiences of cutting and the interventions which had helped. They used a grounded theory approach and concluded that a long term relationship with a key worker where encouragement is given to express feelings was regarded as most helpful with relaxation techniques being implicated in making self injury worse. In addition the positive impact of interventions was reduced when delivered by someone who was perceived as under concerned, overprotective or incompetent.

It is interesting that in this study, which uses a semi structured interview approach, the authors go into great detail as to the length of the visual analogue scale on which women rated their opinion of intervention. It is possible that reference to the use of a Likert scale would have been sufficient and whilst the reasons for this level of detail are unknown, perhaps it relates to a perceived need to engender a sense of objectivity.

That said, Huband and Tantum (2004) make an interesting proposal that the pathways to cutting may be distinct and describe these as a "*spring*" which involves feeling wound up, experiencing an intense emotional state over time which becomes intolerable and a "*switch*" which was associated with a sudden and overwhelming desire to cut. This latter pathway was the most frequently reported by the women in this study.

These points of interest are slightly overshadowed when it comes to the authors stating that the investigation focused on recollections of past events but did not seek any evidence. The assumption being that the women themselves were not good enough in this respect and which brings into question the nature of what is and what is not evidence. Further, that the sample may be considered naturalistic and non random as people volunteered. It would however be very difficult to explore this kind of information with people who were randomly selected from the population but had no experiences of cutting.

Hawton et al (2004) undertook a Cochrane review to identify and synthesise findings from all randomised controlled trials that examined psychosocial and pharmacological treatment for deliberate self harm. The outcome measure used to determine efficacy of treatments was the rate of repeated suicidal behaviour and so previous comments pertaining to the limited meaning of this are pertinent here. Particularly as a decrease in self harm may be the person's long term objective but short sighted views may occlude the effectiveness of particular interventions which are not seen to directly relate to such a reduction but which may be part of the process in supporting this long term aim.

Hawton et al (2004) reviewed 23 trials, which were then classified into 11 categories. The results indicated that both problem solving as compared with standard aftercare, and the provision of an emergency contact card in addition to standard aftercare compared with standard aftercare alone, tended to lead to reduced repetition of self harm. The reviewers do however conclude that there still remains considerable uncertainty as to which forms of psychosocial and physical treatments are most effective. This, they state, is due to insufficient numbers of people in trials and it is acknowledged that in nearly all the trials people were recruited following general hospital attendance and so the results may relate only to those people who self harm and use this service.

Studies which use research methods that do not aspire to generalisation include the case study approach of which Bateman and Holmes (2005) contend is being increasingly used within the literature. With this in mind, Jones et al (1998) utilised a single case study approach in relation to a client who was residing in a RSU. This study investigated therapeutic medication levels in conjunction with incidents of self harm although, this was not the sole aim of the study and the desire to demonstrate the application of the "*scientist-practitioner model*" in clinical practice is also seen as having precedence.

Within this context the use of the case study approach appears a curious method of choice. However, the opening sentence of the abstract states that the paper uses a case study to illustrate an application of the scientist-practitioner model to clinical practice. As such it may be that the primary purpose is to demonstrate this application as opposed to present the findings from the intervention. It is interesting that this study was undertaken by two psychologists and a nurse given its medical model orientation. It may be reasonable to consider whether it was the pursuit of a scientific approach that drove the design and structure of this study above other considerations. This is particularly poignant when considering the study's limitations which means that the conclusions must be considered with trepidation as the complexities associated with self harm are somewhat neglected in this paper.

The study solely focuses on medication and as such does not take into account the nature of day-to-day experiences including interpersonal, intrapersonal processes and environmental factors which, as noted previously will feasibly have a significant bearing on the individual's expression of self harm. Additionally this is a single case study, which in itself is not an issue and acknowledgement of the limitations in the study is made, but it is the conclusion in this paper which requires consideration. The authors feel confident to state that based on this piece of work, there is clear evidence that as the dose of the antipsychotic medication Risperidone increased, the incidence of self harm decreased. Given the points highlighted above, this conclusion appears overstated and arguably as an intervention may prove to be more detrimental than helpful to some people.

McAllister (2003) states that self harm may be related to psychological, social and cultural disturbances and treatments which focus on correcting it, may be misdirected or incomplete. Further, that meaning should not be assumed but should be explored with the individual through listening to what they say. McAllister goes on to suggest that thinking about self harm as a form of self-soothing may facilitate a shift in attitude of both the individual and health care professional and as such by conceptualising self harm as a survival strategy, helplessness and pessimism may be replaced by hope and recovery.

This contention may be illustrated through reference to an earlier paper where McAllister (2001) used a post-modern narrative inquiry to explore the issues around self harm. The author contends that stories can give meaning to peoples' lives and wider cultural practices. However, she also points out the ineffectual care delivered to clients in the form of a uniform and inflexible nursing response and the

resulting "*deleterious*" consequences this can have on nurses and nursing (McAllister, 2001 p391). In response to this McAllister (2001) suggests that narrative inquiry may open up issues previously overlooked and as such offer an alternative approach to a difficult situation. She exemplifies this using the supervision of a nurse, Fran who had been involved with a fourteen-year-old female client. Using a post modern narrative inquiry approach, the tradition of clients as passive recipients of care and nurses as active solution finders is said to be challenged. As such, McAllister (2001) urges this approach as one to enrich understanding, improve the therapeutic relationship and ultimately outcome for both the client and nurse.

In a further attempt to encourage a positive and useful response to self harm by the clinician, McAllister and Estefan (2002) describe concepts used in teaching therapeutic responses. They reinforce the need to respond therapeutically stating that clients may be abandoned by health carers who lack skills at the point when assistance is required most. Further, carers may compensate for feeling a loss of control by becoming excessively controlling with the use of sedation, restraint, involuntary detainment and observation. Additionally, that the belief may be conveyed to the client that there is no expertise to help them and as such it is unsurprising that self harm is repeated.

McAllister's approach to exploring the issues associated with self harm takes a more inclusive and broad perspective than many other approaches discussed in this section of the literature review. In this respect self harm is considered as one part of the person's story which connects to other aspects of the person's narrative. However, this approach is the exception as opposed to the rule and as the remaining section of this review will reveal, there is a pattern observed in the literature which focuses on self harm as an isolated phenomenon in its own right as opposed to indicative or representative of something else.

Spandler and Warner (2007, pxiii) make a similar observation stating that research concerning self harm tends to prioritise outcomes related to symptoms such as lessening or stopping self harm, whilst survivors focus on improvements in other area of their lives. This begs the question, who is the research for and Horrocks et al's (2003) paper can be seen to illustrate the disparity between the identified needs of people who use services which, according to Spandler and Warner (2007 pxiii) can be sidelined in favour of evidence based practice which prioritises interventions which are amenable to formal measurement (Spandler and Warner, 2007 pxii).

Horrocks et al (2003) suggest that there is a lack of research into the epidemiology of self injury, hospital care and outcome in comparison with self poisoning and undertook to address this dearth in the literature by collecting data over a period of 18 months within general hospitals situated in the North of England. Yet if this is considered from the perspective of someone who uses services one could be forgiven for considering what difference the findings from this study would make to their experiences of care and to wonder whether this is illustrative of Spandler and Warner's (2007) contentions regarding measurement as presented above.

That said, such a proposal could be considered as hyper critical and Horrocks et al (2003) suggest their study will allow inclusion of the broad range of self harm in order to determine patterns, clinical characteristics and hospital responses. With respect to this, data was gathered from A&E records of people aged 12 and over and self poisoning was defined where a substance had been ingested in order to cause self harm. Self injury was denoted as any episode of self harm that did not involve self poisoning. Intent without physical injury was also included, for example when someone had been rescued from jumping off a bridge or retrieved from a busy road. Accidental harm from recreational drugs or alcohol was excluded but where a deliberate overdose of recreational drugs had been taken this was classed as self harm.

Where both self injury and self poisoning had occurred, which was reported in 3.7% of the total, these were excluded from analyses. Of the remaining 4877 attendances, 18.1% were deemed to result from self injury, of which almost three-quarters were due to laceration and 81.9% of attendances explained by self poisoning.

It is interesting to note that those people who injured themselves were more likely to be in contact with mental health services at the time of injury, more likely to have a history of self harm and having undergone a psychosocial assessment were more likely to be admitted to a psychiatric ward then those who attended as a result of self poisoning.

It is also of interest that the authors cite a high proportion of men in this group as compared to the commonly perceived predominance of women. It may be conjecture but there is a possibility that this reversal of the commonly held perception may be explained by those in the role of assessor considering

these men more *"disturbed"* for the mere fact that their presentation was perceived to be unusual and hence help explain these in-patient statistics.

Those who injured themselves were less likely to undergo psychosocial assessment than those who had self poisoned. The authors suggest that this may be a result of the proposed belief that self cutting is more about coping than acting on suicidal feelings and thereby explain the lower proportion of psychosocial assessment and specialist follow up for those who had self injured. This, the authors suggest, reinforces the need to ensure parity of service provision for those who self injure and self poison and it may also be reasonable to add, illustrates the role that perception plays with regard to access to service provision.

As such there are important messages gleaned from this piece of work which may impact on the experiences of people who use services, however the pursuit of measureable outcomes does not always achieve this aim.

Comtois (2002) reviewed interventions to reduce the prevalence of parasuicide and previous comment highlighted the limitations with the operational definition used in this study. Further comment revolves around the purpose of this paper in which Comtois (2002) advocated the evaluation of local programs and the dissemination of effective practice stating;

"Programs that local stakeholders such as clinicians, advocates, and administrators believe to be effective should be evaluated and compared with treatment as usual." (Comtois, 2002 p1142).

Notable by their absence, this suggestion excludes those people for whom such interventions are focused. Such remiss in the literature reflects and compounds the inherent problem with interventions which undermine and devalue the experiences and opinions of the person using services. There are other examples of this observed pattern reported in the literature which centres on the infliction of pain as a legitimate tool for researching self harm.

Kemperman et al (1997) assessed "*self- injurious patients with borderline personality disorder*" (BPD) using signal detection theory to determine whether there were any reported differences in pain

expressed within this female sample group. Those who reported no pain during self injury were found to discriminate more poorly between noxious thermal stimuli than those who did report pain during self injury and those without a history of self injury.

The authors go on to say that the "*analgesic* subgroup could represent a distinct subset of *self- injurious patients with BPD who experienced particularly severe or early trauma.* (Kemperman et al, 1997 p181). Surely the next question should be, so what can be done if this is the case? But the authors do not go on to consider this and overwhelmingly the reader is left with this unanswered question.

Similarly Bohus et al (2000) explored pain perception during self-reported distress and calmness in patients with "*borderline personality disorder and self-mutilating behaviour*" using The Cold Pressor Test and the Tourniquet Pain Test. These were reported to have been administered to 12 female patients with a diagnosis of borderline personality disorder who reported analgesia during self mutilation and 19 age-matched, so called healthy female control subjects. It was found that even during reported calmness those with a diagnosis of borderline personality disorder showed a significantly reduced perception of pain, an observation which was also reported during periods of distress.

However, the findings are less noteworthy than the overall assumptions which underlie the study. The authors begin by stating that self mutilation occurs in 70-80% of patients, who meet DSM-IV criteria for borderline personality disorder, and in keeping with Johnstone (1997) contentions, this is not an explanation, it merely reflects one of the criteria for this diagnosis.

There is also concern related to the methods employed in this research. On administering the Tourniquet Pain Test the authors comment that the sight of the arm turning blue is sometimes more distressing to the individual than the pain she is feeling and which necessitates it being covered with a towel. The overwhelming consideration here is the ethics of such a study not least because their findings seem to have little clinical worth and do nothing to justify a study of this nature.

It is reported in the paper that there was a difference in pain perception between the two specified groups but this has little bearing on advancing the pursuit for enhanced understanding and care for people who self harm and merely reiterates the points made by Shaw (2002). Additionally there is a

more concerning possibility associated with this study and that is its potential use to justify pernicious acts, such as sutures without analgesia. As such the inclusion in this review of studies such as Kemperman et al (1997) and Bohus et al (2000) is solely to highlight approaches which seem to have very little meaning to those who use services following self harm or credence in the pursuit of enhanced practice.

Summary

It is the endeavour of enhancing practice and service provision for people who self harm that motivated me to engage in this doctorate study and I hope that through this chapter I have made my position in relation to the evidence base transparent. What follows is an overview of my main contentions as derived from this literature review.

I have offered appraisal of the mixed messages and their consequences regarding definition, terminology and misnomer regarding self harm and suicide. In the preceding discussion I suggested that routine inclusion of individual's perceptions regarding their self harm may assist in this respect and in Chapter 3 I discuss my use of this method in conjunction with the unintended consequences which followed.

Much is made in this review of the literature with regard to power and that related issues should be made explicit. I have also noted their neglect by some authors and to address this in my own work, power is a theme which runs throughout the thesis from design of the study through to the analysis, emerging themes and which culminates in the final chapters concerned with points of reflexivity and the implications for practice. That said, the issue of power is not fully resolved in this study, despite embracing the notion of making such issues explicit and is explained in more detail in the chapters which follow.

I have also suggested that power underlies the issues of self harm on a number of different levels and is often demonstrated through the way a service is experienced by people who self harm. In this context the work of David Bell, Lucy Johnstone, Margaret McAllister, Louise Roxanne Pembroke and Sarah Shaw is integral to this argument. It is also exemplified in the way in which research studies are conceptualised and where I suggest that the experiences of people who self harm are undermined and

sidelined. In this way the literature reveals a tension regarding expertise and who owns it which prompts one to consider who is the expert, the person who can design and report on a piece of research or the person with experiences of the issues to be explored.

This leads to one of the macro themes which emerges throughout the literature review and is associated with what I refer to as "*pseudo science*." There is a significant body of literature which attempts to use language and design which is acceptable to the scientific community yet which does not seem to advance the pursuit for a better experience of those who self harm and use services. In some cases this results in skewed conclusions such as those derived from statistics associated with self harm and risk of suicide. This is aptly summarised by the contentions of Spandler and Warner (2007 pxii) who state that results are dependent on the questions asked and the outcomes desired and that these may differ considerably between service users and providers. Further, that evidence based practice prioritises interventions that have goals which are amenable to formal measurement.

This issue of credibility and integrity is pursued throughout the thesis but is afforded particular attention when I consider the theoretical underpinnings to the study in Chapter 2 and in the pursuit to be convincing (Chapter 3) which leads to a further related macro theme. This may be summarised as my perceived need to move away from the dominant medical and (pseudo) scientific discourses which underpin the existing evidence base and on reviewing and critiquing the literature, it seemed necessary to consider the issues from an alternative perspective.

To begin with Antonovsky's (1987) theory of salutogeneisis enabled me to think differently through reframing the points I was interested in and facilitating my consideration of them in a different way. This informed the construction of the research questions as discussed in the introduction to this study. It also represented the beginning of a process from which I moved from a "*taken for granted*" position to one in which I question the foundations of my own presuppositions. In this context social constructionism with its claims to situated and provisional knowledge became a point to be pursued.

Chapter 2

Theoretical underpinnings

Although the following discussion is written as a distinct chapter, it is not the intention to present it as separate from that which precedes or follows it as these are inextricably linked and both inform and have informed the design, findings and discussion of the study. However, clarity may be enabled by presenting the journey I have taken as a linear process and the format of the thesis represents this aim. The following three beliefs informed the study and were derived from experiences informing my intellectual autobiography and knowledge of the literature prior to embarking on doctorate study.

1. People who self harm have often received a poor service from health care provision (Pembroke, 1994).
2. Service provision has often responded to perceived risk rather than the individual's expressed needs (Bell, 2000).
3. There are occasions where the response of health care professionals has been precipitated by their own beliefs around what it means to be healthy (Anderson et al, 2003).

As stated in the introduction Antonovsky (1987) proposed that pathological approaches which seek to identify and treat the cause of disease are limited and instead stressed the need to ask what promotes well being. This perspective resonated with me and I was influenced by a paper delivered to the European Congress on Mental Health in European Families by Antonovsky in 1991 where he asked, "*Given the world as it is...How anyone can not commit suicide?*" As such, it seemed that exploration of the possible link between self harm and eventual suicide needed to be inverted to capture crucial insights. This would enable a more fertile approach by asking those who self harm what keeps them alive rather than concentrating on retrospective accounts of people who have died through suicide. A desire to pursue this focus in conjunction with the beliefs stated above informed the study and led to the conceptualisation of the initial aims as follows;

- To explore the health promoting function of self harm.
- To investigate what has prevented people who self harm from committing suicide.

The methods employed to fulfil the above aims are discussed in Chapter 3 and how these aims evolved is considered from Chapter 4 onwards. However, to illustrate the foundations on which these rest this chapter will discuss the theoretical perspectives which underpin the study. At a superficial level such perspectives may appear to conflict but it will be argued that due to the complexities associated with self harm, such an eclectic approach has enabled a more cogent consideration of the pertinent issues.

Crotty (2003) states that research terminology can be used in a number of diverse ways and that this is confusing. In an attempt to overcome this Crotty (2003) does not offer a definitive meaning of such terminology but rather a framework to assist in understanding which consists of four elements;

1. What techniques or procedures will be used to gather information and analyse data, that being the *method.*
2. What strategy or plan lies behind the method and links the choice and use of the method to the desired outcome, *methodology.*
3. The *theoretical perspective* which informs the methodology and provides a context for the process.
4. The theory of knowledge, or e*pistemology* which is embedded in the theoretical perspective and as such also in the methodology.

The benefit I derived from consideration of Crotty's (2003) work in this respect was primarily during the initial stages of the study where I tried to encapsulate the work in terms that I could relate to and effectively convey to others. Crotty's (2003) framework assisted in this pursuit as it enabled a structure to be imposed. This in turn provided containment for the information I was gathering and attempting to understand and in following the linear process suggested above, I was also trying to provide clarity for the reader.

As such, information pertaining to each element is seen to inform that which follows, however, on reflection my personal experience was more akin to a cyclical process where the method both informed and was informed by issues associated with epistemology, theoretical perspectives and methodology as I could not dismiss my existing knowledge and experiences which were felt and known.

Therefore, my desire not to reduce self harm to a seemingly disconnected entity from those who express it or conversely as the primary feature of their being, but rather to see it as one part of the person, clearly intruded on my perceptions regarding epistemology, theoretical perspectives, methodology and methods. This in turn, impacted on my beliefs concerning self harm. In trying to be attentive to all these influences some parts of the study design emerged far more naturally than others. Thus the use of a narrative approach, as discussed in Chapter 3 was an uncomplicated decision for me to make. It was based on my criticisms of the existing knowledge base and my epistemological perspective, but what was more complex was considering how this was embedded within the wider discipline of research study.

Crotty's (2003) framework as described above was useful in this respect as it enabled me to structure my consideration of the issues. This is reflected in the following discussion in an attempt to further elucidate the process and provide underpinning theoretical considerations to the study. Crotty (2003) also suggests that consideration of the four elements mentioned previously can assist with the soundness of the study and therefore make the outcome more convincing. I chose to understand this in terms which included participants in the project, other interested parties and in respect of my own development and confidence in the conception of the study. As such, the framework facilitated my consideration and understanding of pertinent issues as follows.

A question of epistemology

As an epistemology Crotty (2003) states that objectivism is the view that things exist as meaningful entities independently of consciousness and experience and that this approach aims to attain an objective truth. With regard to the piece of research I have undertaken I can say that I have attempted to establish truth of a kind which relates to the individual and their personal experiences but refrain from presenting these findings as objective, value free entities.

As such, objectivism as an epistemology never featured in my pursuit and in keeping with Crotty's (2003) contention regarding the soundness of research, I feel compelled to explore this more thoroughly. For ease of illustration, positivism as a theoretical perspective which employs quantitative methods will be briefly contrasted with qualitative methods.

There has long since been a debate about the relative attributes of qualitative and quantitative approaches when applied to the research process. It could be suggested that adherence to one over the other reveals one's inner perspective and philosophy in making sense of the world. Yet these approaches can also be seen as recipes which when put together lead to an outcome and as in cooking, it is important to consider the end result before buying the ingredients. As such, I relied on my belief that it is the nature of the inquiry which should dictate the method(ology), not the comfort zone of the researcher, their preference of one approach over another or that which is likely to gain most kudos.

Bryman (2004) discusses the traditional distinctions between qualitative and quantitative methodologies but goes on to cite a number of studies for which these issues are more blurred and where a seemingly qualitative question employed quantitative characteristics. Thereby illustrating how such methods may be used less traditionally. However, others would disagree with this perspective such as Denzin and Lincoln (2000) who stress the difference between these approaches stylistically, epistemologically and through different forms of representation. Regardless of which view one concurs with, it is crucial that the chosen approach is defensible in keeping with the aim and objectives of the study.

In this respect Johnson (1999) offers an argument against the use of inappropriate methods when he critiques the improper application of an objective approach to what is essentially a qualitative study. He further states that attempting to apply elements associated with the physical sciences to interpersonal and intrapersonal processes is inadequate in attempting to make sense of such complexities. Further, that qualitative research can be rigorous, subjective and refrain from pseudoscience. This contention may betray more than just the sentiment by reflecting a perceived need by those who use qualitative approaches to legitimise their use and present an alternative perspective to hierarchies of evidence such as the example in The National Service Framework for Mental Health (DOH, 1999) which support the Randomised Controlled Trial (RCT) as the gold standard (Rolfe, 2006).

Yet it is apparent that the *"gold standard"* is susceptible to critique and Hollway (2001) contends that the RCT is not derived from a specific object or event as it is dependent on polling then averaging numericised data and that the principle associated with this, that shared characteristics determines behaviour, has been overextended. Further, it is suggested that the dominance of quantitative methods has led to the exclusion of questions which cannot easily be translated into this format (Hollway, 2001)

which may be interpreted as a gap in the evidence base.

In this respect it is also of interest to note the associated critique Taylor and White (2000) offer in relation to evidence based practice (EBP). These authors suggest the main strength of EBP to be its appeal to rationality, further stating that the notion behind it assumes too much in terms of what is meant by evidence and practice and that the status of evidence should also be questioned. The key problem Taylor and White (2000) suggest, is that EBP assumes that a detached process is possible and necessary for the production of knowledge.

Yet in contrast, some would argue that knowledge and science are made not discovered, thereby flouting the notion that such detachment is a prerequisite. Gilbert and Mulkay (1984) conducted a study which focused on aspects of biochemical research. They found that in this positivist domain different accounts were being given in relation to what was happening by different interviewees. Additionally, all of these accounts appeared plausible and convincing. Thereby illustrating the inherent problems associated with the pursuit of an objective *"truth."*

That said, Taylor and White (2000) do propose that EBP is useful and in some cases may be the only type of evidence required to make a decision. However, this tends to relate to straightforward situations and under more messy and complex circumstances this can only go so far to resolve the pertinent issues. As such, further consideration is needed and it is here that Taylor and White (2000) argue the case for reflexivity which will be discussed in more detail later.

In keeping with Taylor and White's (2000) contention, the aim here is not to replicate the arguments concerned with legitimising one approach over another per se. I can appreciate that there are questions which lend themselves to quantitative approaches, however, I do not believe that this is a panacea to inquiry and as illustrated in the literature review, such an approach can not completely answer those messy and complex questions (Taylor and White, 2000) which are akin to inquiry regarding self harm such as risk and meaning. Therefore, for me the most legitimate way of deciding which approach to take was dictated by my hopes for the study. These were to put people who self harm as the primary consideration, it was acknowledgement that their stories could have a future impact on how others experience health services and in conjunction with Cresswell's (1998) contentions, this led me to pursue

qualitative approaches.

Cresswell (1998) lists a number of reasons against which to judge the applicability of using a qualitative approach. These include that a qualitative research question often starts with "*how*" or "*what*" in contrast to quantitative studies which ask "*why*" and look for the comparison of groups. Qualitative research is concerned with something that requires exploration and in addition Cresswell (1998) states that if a detailed view of the subject matter is required and if individuals are to be studied in their natural setting, then the use of a qualitative approach should prevail.

Cresswell (1998) further contends that this approach lends itself to writing in a literary style using the pronoun "*I*" or engaging in storytelling. It requires having sufficient time and resources to spend on data collection and analysis. Additionally, this approach is applicable if the audience is receptive to qualitative research and lastly because a qualitative approach emphasises the researcher's role as an active learner who can tell the story from the participant's view rather than as "*expert*" who passes judgement.

Whilst I found some of Cresswell's (1998) reasons to be dubious considerations on which to base such a decision, namely the target audience and having sufficient time and resources, others were applicable to the study I have undertaken. Having convinced myself that qualitative methods were key and thereby excluding notions of objectivity and the positivist stance, issues of epistemology needed revisiting.

Social constructionism

In his definition of constructionism, Crotty (2003 p42) states that this is *"the view that all knowledge and therefore meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social construct."*

As demonstrated in the critique of the literature, opinions differ as to the meaning of self harm and are both susceptible to interpretation and are historically and culturally bound. As such, Crotty's definition of constructionism appeared applicable and required further pursuit in exploring its relevance to this study.

Taylor and White (2000) argue that the objective position of regarding the world as separate from the

knower and that there is a reality which is independent of the researcher, has dominated science and professional practice in modern western societies. More recently this position has been challenged by critical and self reflective discourses including feminism and critical theory. These have matured into an intellectual movement often referred to as social constructionism (Taylor and White, 2000).

Taylor and White (2000) propose that by embracing social constructionism one does not attempt to deny that a real world exists, as this would clearly be folly, but merely decline to be concerned with the nature or essence of things (referred to as ontology). In this respect, the preferred focus is how we come to know about the world (epistemology) and Gergen's contention that social constructionism is ontologically mute is apt and succinctly articulated as follows;

"*Whatever is, simply is. However, the moment we begin to articulate what there is - what is truly or objectively the case - we enter a world of discourse - and thus a tradition, a way of life, and a set of value preferences.*" (Gergen, 2000 p222).

This immediately resonated with me, particularly when I considered that the individual's perspective is a major influence in the way she or he regards self harm and as such it may be thought of as an abhorrent act of mutilation, a survival strategy or an important initiation rite of passage enabling the transition from adolescence to adulthood. Thus an understanding of what self harm is only exists in conjunction with a multitude of realities which are not independent from the individual, but rather, are open to interpretation and are historically and culturally bound. This point is articulated by Burr's (2005) definition and which also contains an important message concerning whose perception takes precedence.

"all ways of understanding are historically and culturally relative. Not only are they specific to particular cultures and periods of history, they are seen as products of culture and history, and are dependent upon the particular social and economic arrangements prevailing in that particular culture at that time. The particular forms of knowledge that abound in any culture are therefore artefacts of it, and we should not assume that our ways of understanding are necessarily any better, in terms of being nearer the truth, than any other ways." (Burr, 2005 p4).

Taylor and White (2000) go on to argue that one of the strengths of social constructionism is that this

approach advocates that knowledge is situated, local and provisional and this enables it to be scrutinised to a greater degree than if something is true, universally applicable and therefore not susceptible to change.

This idea was persuasive in the sense that it was clear from the literature review and my personal observations of clinical practice, that the prevailing response to people who self harm within health services is based on the dominant medical model of rationality yet this approach has contributed to poor experiences of service provision (Pembroke, 1994), a tendency to focus on risk (Bell, 2000) and practice which is influenced by clinicians perceptions of what constitutes health (Anderson et al, 2003). As such, notions of social constructionism which embrace the view that what informs our knowledge base is not fixed engendered my sense of hope that practice and the evidence base on which its rests, is open to scrutiny and that reasoned well argued proposals could result in dominant ideas being susceptible to change.

Yet there is a disadvantage in embracing this stance, Taylor and White (2000) suggest that once objective truth is disregarded and social constructionism embraced, we are plunged into the abyss of relativism and if a number of competing accounts prevail with no objective criteria to establish their validity, a meaningful distinction between them is problematic to make.

Given this argument one might determine that one approach to self harm can not be seen to prevail over another. This quandary was also pursued by Kenwood (1999) when she asked what *"teeth"* social constructionists have if they maintain that all points of view are equally as valid, and further, if all points are equally valid what was there to criticise in the first place?

Yet, and as Kenwood (1999) contends, in an interdependent world what people say and do has real consequences, thereby illustrating the need for adjudication and as the literature review in this thesis has illustrated, such debate is not merely academic. There is an ethical argument pertaining to how people who use services following self harm are responded to and where this is detrimental rather than beneficial, it reinforces the need to question current EBP.

As such, it seemed that social constructionism could offer me an approach from a critical and self

reflective stance yet I recognised the limitations of my knowledge base in this respect and my need to gain a more cogent understanding. With that consideration at the fore, what follows are my interpretations from reading and reflecting on social constructionism and its place in my study.

Social constructionism is multidisciplinary, drawing its influences from a variety of sources, including philosophy, sociology and linguistics (Burr, 2005). The attraction of such an approach in this study relates to this eclecticism for a number of reasons. The limitations associated with the prevailing and dominant approaches to studying self harm from a medicalised position as underpinned by notions of rationality and objectivism dictated a need to consider the issues in a different way. The stories of those people I interviewed were unique and personal and to make links between these and the existing knowledge base, it became apparent that an eclectic approach could assist in achieving this. Finally, in keeping with the aim of the study, I was concerned with suggesting possible meaning within the stories, not in the context of a universal truth, but rather as one interpretation from my perspective and social constructionism supported this pursuit.

Burr (2005) goes on to say that there is no one feature which identifies a social constructionist position but that it may loosely be thought of as having one or more of the following key assumptions as derived from Gergen (1985). The first of these is a critical stance to taken for granted knowledge (Gergen, 1985), which includes ourselves and the desire to challenge the view of what Burr (2005) refers to as "*conventional knowledge*" this being based on an objective, unbiased observation of the world. This notion seems to relate to positivism and empiricism in traditional science and advocates that the nature of the world can be revealed by observation and what exists, is what we perceive to exist. In keeping with a critical stance, Hall's (1997) contention that by considering the constructedness of social reality, we accept the constructedness of all claims which includes our own can be referred to in the context. This contention has proven to be a source of comfort for me at different junctures of this study but has also provoked anxiety and is discussed more thoroughly in Chapter 9.

Gergen (1985) advocates historical and cultural specificity, mention of which has already been made in Burr's (2005) definition but which is also reiterated by Gergen's argument that changes in how we make sense of something do not reflect alterations in the entity of concern but instead seem related to historically contingent factors. To exemplify this Gergen refers to the notion of childhood as a specialised

phase of development which has historical specificity. As such, the idea that understanding an entity of concern is historically and culturally contingent also means that it is susceptible to change.

This then leads to Gergen's (1985) next key assumption that knowledge is sustained by social processes with the argument that what we regard as truth may be thought of as our current accepted ways of the world, which are understood and conveyed through social processes and interactions, as opposed to a product of objective observation.

The final assumption according to Gergen (1985) is that descriptions or constructions of the world sustain some patterns of social action and exclude others. He explains this further stating that to alter description and explanation is to threaten certain actions and invite others. In returning to the example of childhood, this contention may be illustrated with the changes associated with child labour. These four broad tenets bear relation to the underpinnings of this study but Burr (2005) goes on to consider the issue of anti essentialism and it is here that our paths can be seen to diverge.

That realism can be questioned is acceptable to me and that knowledge may not be a direct perception of reality is also a view to which I can subscribe, particularly when I consider the importance of societal influences which have constructed my world. However, Burr (2005) contends that as the social world, including ourselves, is the product of social processes, it follows that there can not be any given determined nature to the world or people. That is, there are no essences that make people what they are and she makes specific reference to psychoanalysis to illustrate her point. It is argued that psychoanalytic theory supposes a pre-given content and is therefore contradictory to the social constructionist stance that a given, determined nature of people does not exist.

It is further contended that this is not a way of taking the nurture side of the nurture-nature argument; rather it is a rejection of this. Social constructionism, as it is presented by Burr (2005), rebuffs the idea that a person has a discoverable nature either from a biological or environmental position. Further that essentialism may trap people into personalities and identities which are limiting and at times pathologised.

To advance this argument, Burr (2005) presents the view that personality is seen to be more or less

unified and stable and whilst we may change from childhood to adulthood, we view our personality as mostly unchanging. Feelings and emotions are seen as private internal experiences which are linked to the type of person one is and things, particularly human beings, have their own essence or nature which explains how they behave and what can be done with them.

However, it is argued by Burr (2005) that there is no objective evidence for the existence of personality and further that personality becomes responsible for behaviour. She illustrates this argument in terms of witnessing one person physically attack another. In the absence of mitigating circumstances, we would probably infer that the attacker was aggressive and this is a description of their personality. If we were asked to try to explain this behaviour, we might reply that this is what aggressive people do. This relates back to the point that essentialism may trap people into personalities which are pathologised.

This argument resonates with that discussed in the literature review regarding Lucy Johnstone's critique of borderline personality disorder and self harm and is a compelling example of what Burr (2005) argues against. As is her point that whatever personal qualities we may display, these are functions of the cultural, historical and relational circumstances in which we are located.

Layder (2007) also exemplifies Burr's contentions in this respect through discussion of essentialist and ahistorical attempts to explain social phenomena as emanating internally, and again gives the example of personality characteristics or instincts. This psychological perspective is also said to reject sociological explanations with regard to the deterministic influence of social structures, instead focusing on the dynamics of social interaction and social practices as the appropriate focus of inquiry.

However, in contrast to Burr, Layder (2007) refers to this stance as extreme and summarises this as focusing on language and discourse whilst regarding the concepts of personhood and subjectivity as hollow and empty. He progresses his argument with the proposal that the interior mental processes of real individuals and their self-identities, as opposed to hollow puppets, dynamically collide and interact with social forces to produce and reproduce the forms of social reality. This leads Layder (2007) to question who or what is doing this interaction if personhood is rejected. Further arguing that human beings differ in terms of capacities, skills and powers and that these underpin the uniqueness of individuals physiologically and socially.

This argument contrasts with Burr's (2005) proposals in respect of personhood who contends that those aspects we take to mean being a person, such as personality, being motivated by drives and the experience of emotion, are not part of an essential human nature, but rather are available to us through language which structures our experience. She goes on to refer to psychoanalytic theory and the idea that identifiable emotions, which may be seen as innate in all human beings, are simply labels. Further, words such as anger, hatred and envy pre-date any one person's entry into the world and when learning to talk we have no choice but to understand ourselves in terms of these concepts.

However, Butt (1999) can be referred to with his contention that whilst the constructionist position may be regarded as an important advance on that of realism, as it focuses on what is going on between people as opposed to within them. It fails to do justice to the experience of emotion and although we are born into a linguistic community that predates us, language evolved from speech and speech is an expression.

For these reasons, anti essentialism as an aspect of social constructionism was difficult for me to wholeheartedly embrace and it would seem I am not alone in feeling ill at ease in this respect. Cromby and Standen (1999) state that social constructionism needs to explicitly adopt a conception of the self in order to progress in a theoretically coherent manner. As such, they argue that social constructionism needs to acknowledge that personal-social history and embodiment are influences upon what we do and say.

In keeping with these proposals, Burr (2005) does make some concessions and acknowledges that views derived from this perspective of anti-essentialism leave our experience of personhood and subjectivity as unexplained as it does not answer questions such as why some people show emotion more readily than others, why some become mentally ill and what happens when we fall in love.

This concession was also alluded to in an earlier published piece of work where Burr (1999) explains her position as being in agreement with the main tenets of social constructionism whist acknowledging its areas of weakness. In this context Burr makes reference to the status of personal experience and the role of embodiment in producing that experience. This argument is deepened with the proposal that important aspects of human experience are "*extra–discursive*" as they are primarily constructed and

expressed in embodiment rather than through language. Burr's (1999) examples centre on art, dance and music in this context. However, if embodiment is taken to mean a tangible or visible expression, then at a fundamental level this can be seen to apply to self harm which may be regarded as the physical manifestation of an inner state (Turp, 2003).

As stated previously, Burr uses psychoanalytic theory to exemplify her arguments regarding essentialism. Yet in this study I have used social constructionism which enabled my liberation from dominant medical discourses related to considerations of self harm and as the proceeding chapters will reveal, aspects of psychoanalytic theory to propose meaning through the stories I was told.

Yet these two seemingly divergent perspectives are not necessarily mutually exclusive as judging by the proliferation of books, articles and practitioners it is the area of psychotherapy where social constructionists appear to have had greatest influence (Kenwood, 1999). In considering the issue of divergent approaches, this may relate to Michael's (1999) reference to "*honourable fudges*" whereby some versions of social constructionism have tacit reliance upon a version of the *"real"*. He goes on to suggest that one reason these are honourable is because they serve to inform the reader of the sorts of background knowledge required to understand what is going in the rest of the text. As such, he argues that this *"honourable fudge"* can just as legitimately be referred to as epistemological eclecticism. This notion of epistemological eclecticism supported my contentions regarding self harm, that there is not one simple and uncomplicated way of making sense of the issues. Rather there are a multitude of realities steeped in historical and cultural considerations which can be related to existing theory in a number of ways and my attempt to understand derives from my world view and intellectual autobiography.

Having considered epistemological issues and in keeping with Crotty's (2003) framework, attention will now turn to those theoretical perspectives which have informed the design of the study and which provide further context for the process.

Theoretical perspectives

Interpretivism

Crotty (2003) describes interpretivism as the search for culturally derived and historically situated interpretations of the social world. At least three subdivisions are said to exist and are, symbolic

interactionism, phenomenology and hermeneutics. What follows is a brief consideration of each and by discussing those theoretical perspectives which I rejected in contrast with those I used, I hope to illustrate why I chose to do what I did, thereby strengthening my rationale for my chosen approach whilst remaining open and transparent within the process.

Burr (2005) states that fundamental to the perspective of symbolic interactionism is the view that people construct their own and others identities through everyday social interactions. At the heart of symbolic interactionism lies ethnography, derived from anthropological approaches and influenced by sociology. As an approach, it is concerned with assuming the place of the "*other*" through immersing oneself in the culture or experiences of that "*other.*"

Reinharz (1992 p46) states that *"Contemporary ethnography or fieldwork is multimethod research. It usually includes observation, participation, archival analysis and interviewing."* Initially this definition offered by Reinharz (1992) may be seen to have a degree of resonance with the study I have undertaken. However, fundamentally this project does not lend itself to an ethnographic approach as it is defined here. There is no "*culture*" to immerse myself in and I wanted to distance myself from anything which may suggest that people who self harm are a homogenous group, which in accordance with Crotty's (2003) sub division, leads to consideration of phenomenology.

On reviewing the nurse led research literature one could assume that my study is in keeping with a phenomenological approach, the reason being that it could be seen to be an exploration of the everyday experience of those who self harm. Yet Crotty (1996) goes to great lengths to illustrate the difference between "*mainstream*" phenomenologists and nursing phenomenologists; contending that nursing phenomenolgists are concerned with human subjects not simply issues, whilst mainstream phenomenologists are engaged in the phenomenon rather than a particular individual or group, hence the call to return "*to the things themselves*" (Crotty, 1996 p51). It is further proposed that involvement with a particular group of people is with a view to gaining a greater understanding of the phenomenon rather than the individual's experience of it, which leads to consideration of the issue of "*bracketing*" as a key concept in relation to phenomenology. This assumes that preconceptions and presuppositions can be suspended in the quest to determine "*the things themselves*" and could be seen as the antithesis to my study given the perspectives presented in my intellectual autobiography. My contention that I cannot

help but have and own my beliefs in relation to self harm and my desire to integrate my own world view into the study in the interest of transparency, can be seen to be alien in relation to a phenomenological approach as it is understood here.

Connected to phenomenology, hermeneutics is said to be concerned with interpretation as opposed to the description of a phenomenon. Nielsen (1990) states that the interpretive or hermeneutic tradition is a theory and method of interpreting meaningful human action. Further, to understand any human social behaviour, advocates of this approach stress the need to know the meaning attached to it by the participants themselves. That said Nielsen goes on to state that the subjective objective distinction is adhered to within this tradition and although true objectivity is impossible, social sciences should remain value free.

The previous comments made in relation to bracketing also apply here and there would have been an element of dishonesty and for me impossibility, had I attempted to assume a value free position. I was, and I am not, value free nor would I have wished to be as my interest lay in the people and their stories as opposed to the phenomenological call to get *"back to the things themselves."* To me, this risks diminishing the person and all they are in favour of focusing merely on self harm and is a pattern in the current evidence base that I did not want to replicate in my research.

Critical theory

In this approach "*critical forms of research call current ideology into question, and initiate action, in the cause of social injustice. In the type of inquiry spawned by the critical spirit, researchers find themselves interrogating commonly held values and assumptions, challenging conventional social structures, and engaging in social action."* (Crotty, 2003 p157).

This quote struck me as something I could relate to and I wanted to know more. However, I did acknowledge a need to be mindful of my natural tendency to believe that all useful research is ultimately concerned with effecting change for the better and as such to be seduced by the notion of critical theory. Yet I was not dissuaded particularly when considering Davison's (2004) contention that the analysis of personal narratives can assist in critique of domination and oppression and subsequently lead to social change.

Crotty's (2003) description of critical theory encapsulated what I hoped to achieve through my doctorate study yet rather than be motivated by it, I found myself with reservations. These centred on claiming to be in pursuit of what could be considered a grand occupation and this was a concern. I worried about my ability to do justice to the people and their stories and this has been a recurring anxiety throughout the study.

However, Nielsen (1990) argues that criticism from a critical theory perspective does not merely rest on a negative judgement; it refers to the positive act of detecting and exposing forms or beliefs which restrict freedom. Theory is critical because it departs from and questions the dominant ideology which is usually in the context of capitalistic, political and economic organisation. Nielsen further stated that proponents of critical theory argue there is no such thing as an objectively neutral or disinterested perspective, knowledge is socially constructed and I felt I was back on familiar territory.

Additionally, to dismiss critical theory for fear of being seen as an interloper would be dismissive of the potential benefits this perspective may bring and I began to feel more at ease particularly when I entered even more familiar territory, that of gender and specifically of being female.

So called feminist approaches to research

My preconceptions and presuppositions regarding self harm have been couched in gender terms, both as a woman working with people who self harm and the existing evidence base which often relies on women as participants within the research process. This is evident on recalling the literature review which includes studies which specifically explored self harm with women as conducted by Batsleer et al (2003), Bohus et al (2000), Corcoran et al (2007), Huband and Tantum (2004), Kemperman et al (1997), Maghsoudi et al (2004), Paivio and McCulloch (2004) and Shaw (2002).

Given this and previous discussion regarding social constructionism and critical theory, the fact that Holloway and Wheeler (2003) proposed a major element of feminist research to be associated with critical theory, it is perhaps not surprising that feminist approaches within the research process resonated with me. This was reinforced further by the attention afforded to the power dynamic which pervades issues of self harm and is an inherent consideration within feminist research. Additionally, acknowledgement that affective components associated with the research, which some would seek to

minimise and detach from, are laid open to scrutiny within so-called feminist perspectives of research, led me to explore this perspective further.

Stanley and Wise (2002) suggest that three themes are central to feminism; that women are oppressed, that the personal is political, in that oppression is a shared set of experiences among women and the nature of this experience is shared and understood in terms of the personal. Lastly that feminist consciousness exists which is related to the new understandings that women gain through consciousness raising activities. The authors state that general acceptance of these three themes exists but it is how they are understood, conceptualised and theorised in relation to the oppression of women and the consequent action required for liberation which differs.

I felt it was important to consider these central themes of feminism albeit through the filters associated with my study and will try to recreate these considerations here. The first issue, that women are oppressed can be seen at a fundamental level in the literature and takes the form of links with trauma and abuse, but there is also the juxtaposition that some of the research which focuses solely on women as discussed in the literature review can be seen to be oppressive. This may be through the language used, the undermining of experiences, the over generalisation of findings, or the methods employed within the study.

As stated above, available evidence contends that self harm largely remains a female expression of distress and much is written in this respect. This renders it difficult to separate notions of self harm from gender and in particular women. However, a healthy degree of cynicism may be prudent in this respect as given the problems associated with language, terminology, meaning and definition, the issue may be skewed.

Perhaps a more useful consideration relates to issues of power and control which are implicated in self harm regardless of gender and which relate to oppression. Additionally, some people who self harm have described the inability to put into words their emotional pain and in this manner may use the body as a canvas for expression (Green, 2007) and the inability to be heard, for whatever reason, is akin to oppression.

These issues also relate to the personal being the political. Stanley and Wise (2002) contend that power can be examined through personal life such as in the form of oppression and that the political must be examined in this way, such as inequitable treatment at home, work, or within society in general and takes in notions that the *"system"* is experienced in every day life. The authors progress this point by stating that such systems and social structures can best be understood through exploration of relationships and experiences within everyday life (Stanley and Wise, 2002). An example of which is using the narratives of people who self harm in an attempt to gain a better understanding of the important issues for that individual.

Despite Reinharz (1992) stating that the use of the semi-structured interview is the principal means by which feminists achieve respondent participation and the construction of data regarding their lives, there is not a distinct feminist method in research (Stanley and Wise, 2002). These authors propose that this has been an assumption expounded by critics who have interpreted their discussion of methodology in this way. However, Stanley and Wise (2002) propose that a more accurate view is to see this as an intervention at an epistemological level concerned with remaking what is seen as knowledge in feminist terms. As such, they state that the important questions are in specifying what knowledge is, how it is recognised, who are the knowers and by what means someone becomes one; it is also concerned with the means by which competing knowledge claims are adjudicated and rejected or accepted. The authors take these arguments further by stating there are a number of areas where the precepts from feminist epistemology need to be integrated in the research process. These are related to the researcher and researched relationships, to the use of emotion as an aspect of the research process which can be analysed; through a critical approach to objectivity and subjectivity as dichotomies, in providing the researchers intellectual autobiography so the processes through which understanding and conclusions are reached are transparent. That different realities or versions are held, and that issues of authority and power are integral to the research and are represented in the written manifestation of it (Stanley and Wise, 2002).

To me these were crucial aspects of the study and are in keeping with Hall's (1997) contention that by considering the constructedness of social reality, we accept the constructedness of all claims which includes our own. A reflexive approach was embraced within the study and clarification of how this was interpreted and used now follows.

Whilst it seems that a general consensus exists as to what reflexivity entails there is no agreed definition or recipe for its application in practice and essentially nor should there be. If reflexivity is anything, it is concerned with the individual and the unique dynamic that one brings to research. Stanley and Wise (2002) reinforce this saying that the presence of the researcher can not be avoided and therefore research must be devised to use this presence rather than deny its existence. The quote below provided me with a useful way to conceptualise what a reflexive approach could afford my research;

"Reflexivity means reflecting upon and understanding our own personal, political and intellectual autobiographies as researchers and making explicit where we are located in relation to our research respondents. Reflexivity also means acknowledging the critical role we play in creating, interpreting and theorizing research data." (Mauthner and Doucet, 1998 p121).

The importance of this is the transparency it affords the research study, particularly one in which a value free approach has clearly been discarded as impossible. Reflexivity enables the research process to be interrogated in such a way that presuppositions and preconceptions are noted and may be judged and appraised in relation to the research. As such, it is imperative to note that merely because a positivist objective approach is not applied, the findings of the study can be subject to critical appraisal and in doing so the integrity of the work judged.

Finlay (2003) reflects these points when suggesting the potential benefits to using reflexivity and contends that such an approach is multifactorial, it enables the examination of the impact of the position, presence and perspective of the researcher. That it is conducive to the promotion of rich insights into the findings resulting from an examination of personal responses and interpersonal dynamics. A reflexive approach makes unconscious motivations and bias in the researcher's approach transparent, it empowers others by opening up a more radical consciousness, enables evaluation of the research process, method and outcomes, and finally, it enables public scrutiny of the integrity of the research through offering a methodological log of research decisions.

As such, I could foresee clear benefits from taking this approach to the research and despite being able to appreciate the fluidity of reflexivity as a concept and acknowledging that this was one of its strengths, it was also anxiety provoking, I wanted a clear framework to follow to allay this. To an extent Wilkinson

(1988) provided this with her proposal of three interrelated aspects of reflexivity, the personal, functional and disciplinary.

The first two of which Wilkinson (1988) stated, raise issues relating to the identity of the researcher and the form of the research. As such the individual, woman, feminist, topic chosen and methods employed are open to critique through self examination of the practice and process of research to reveal its assumptions. Whilst at the disciplinary level, this entails an analysis of the nature and influence of the field of inquiry.

In terms of considering my part in the research process, Wilkinson's (1988) framework appealed to me as it seemed to represent a naturalistic way to consider the important issues. As such, I intended to address the personal element through my own reflective accounts following interviews and treat this as a resource in the same way as the information gleaned from participants. The functional component would make transparent the role I played in the research process and would be considered by making comment on the dynamics between myself and the respondents. In this way I intended to be attentive to the issues of transference and counter transference. Finally, as advocated by Wilkinson (1988) the disciplinary aspect of reflexivity would entail my consideration of the function and place of the study within the wider arena of existing theory and methodology used within research.

In retrospect it became apparent that such a framework was not necessary, almost as if the design of the study lent itself to consideration of these issues seemingly with very little effort from me. Ideas emerged readily and it seemed that being with the participants and considering their narratives during and after the interviews provided fertile ground. That said, I was also conscious of the need to balance this to ensure it added to the process as opposed to being a self indulgent exercise and in this respect I was mindful of Birch (1998 p175) who states;

"The recognition of my research story alongside others is a central addition to sociological understanding. Following this approach I hoped to use auto/biography not as a narcissistic exploration of myself but as a vital sociological tool necessary to understand the social within each individual and how social research is a social construction."

It seems serendipitous to arrive back to social constructionism as despite this report being a linear progression through the research process this reflects the cyclical reality of the endeavour. Additionally I am conscious that the introduction of retrospective comments as above, spans the notions of "G*oing There*" and "*Being There*" and so links to the next section and considerations of the practicalities of doing the research through "*Being There.*"

Chapter 3

The pursuit to be convincing

As stated at the end of Chapter 2, the practicalities of doing the research and "*Being There*" now become the focus. In this respect Crotty's (2003) framework remains relevant as the techniques used to gather information and analyse data (the method) and the strategy which lies behind the method to attain the desired outcome, in the form of methodological considerations, will be discussed presently. However, there would not have been a study had the ethical issues associated with it not been highlighted and interrogated, which is why I wish to discuss them at the beginning of this chapter.

Permission, protection, and power.

In order to undertake the project ethical approval needed to be sought and permission granted by the Central Office for Research Ethics Committees (COREC), the trust site and university ethics committee on the basis that I was able to illustrate the study had the potential to contribute to the existing body of knowledge. Crucially, agreement also took account of whether I could maintain the protection of research participants and their best interests within acceptable limits. Gaining support to conduct the study was exciting and a relief because now I could begin, but was also tinged with a sense of trepidation. This took the form of concern as to whether I had considered and planned for all foreseeable events and that I did not waste the opportunity to undertake a study I believed could prove beneficial to people who self harm. To a large extent this was alleviated by the fact that these concerns were under my control but what was not under my control, was the existence of a power dynamic as an integral aspect of the researcher/researched relationship.

The Declaration of Helsinki states that some research populations require protection. These include people who can not give or refuse consent, those who may be giving consent under duress, those who will not benefit from the research and those for whom the research is combined with treatment (Tee and Lathlean, 2004).

This study did not purposefully target people who would meet these criteria, however, the need to ensure the research process was equitable and transparent and that the Research Governance Framework for Health and Social Care (DoH, 2001a) was adhered to, remained paramount. In doing so

the dignity, rights, safety and well being of those who participated was always the overriding consideration and the study was designed to balance this need with the desire to hear their stories. I felt that to avoid what may be considered difficult and contentious areas would be a lost opportunity and I had envisaged a difficult task in convincing ethics committees that talking to people about their self harm would do more good than harm.

As highlighted previously, there is debate as to whether self harm constitutes a mental health problem but in applying for ethical approval I considered the implications from the position that people who self harm have used mental health services. The purpose in taking this stance was to show I had considered potential issues which may have arisen as a result of having contact with mental health services and to pre-empt any concerns regarding this. Although whether a mental health problem affects one's judgement to participate or not in research is debatable. Stanley et al (1981) challenge the notion that people with mental health problems are less able to engage in the consent process than those who are not deemed to have a mental health problem. The authors found no difference in the decision to participate in studies of high or low risk between hospitalised psychiatric patients and hospitalised non-psychiatric patients. As such, attempts to engage people who had used services in research were supported by this study. The importance of this is highlighted when considering that neglecting to elicit the opinions of people who self harm has led to the delivery of inappropriate and at worst harmful service provision. This is illustrated by the work of Pembroke (2007) who states that using psychiatric in-patient provision simply compounded her need to harm herself.

As such, I considered the views of people who have experiences of services as crucial and did not feel overly paternalistic concerns were justification for not pursuing this, especially as this may be the most powerful of change agents as illustrated by the service user movement, of which Louise Roxanne Pembroke is a key proponent.

Any concerns I or others may have had regarding people being cajoled into unwise self disclosure, or that the study was likely to include aspects of stories which would potentially be difficult to talk about, were dispelled by Hutchinson et al (1994) who stated that people who could not endure talking about a topic would not do so.

As it was, the COREC, the trust site and university ethics committee approved the study without undue concern and an overview of the relevant ethical considerations and their management is included in appendix (i).

Having gained approval, I was able to begin the study which was concerned with individuals who attended A&E as a result of self harm but who were not admitted to in-patient provision. Once deemed medically fit, the process entailed a letter of invitation and Participant Information Sheet (PIS) (appendix ii). This sought consent that I could contact the potential participant to discuss the study and then, if agreed, to arrange the interview. This aspect of the research design was concerned with an effort to include an element of self selection in the study. By doing so McAllister's (2003) critique that assumptions are made with regard to the meaning of self harm would be avoided and the individual's account of their action heard.

To explain this in more detail, someone might decline to participate for a host of reasons and one may be that the incident is viewed as self harm by clinical staff who then provide the person with information relating to the study. However, the individual may not perceive their actions to be self harm and therefore exclude themselves.

Conversely, I did not anticipate clinical staff giving the information to those whose attendance at A&E was due to other reasons nor did I envisage such people agreeing to participate. As such, I hoped those who consented did so because they believed their attendance at A&E to have been as a result of self harm and so this would give a clearer idea of who identified themselves in this way as opposed to such judgements being made by others.

This process would clearly exclude those people who had self harmed but who clinical staff had not considered in this way but there was no way of addressing this other than to leave the letter of invitation and PIS in communal areas. I did not believe this to be a feasible option because it could have impacted on the inclusion criteria regarding being medically fit and not requiring in-patient care. It would also minimise any opportunities for discussion before I made contact which may have inadvertently influenced the decision to participate. There is also the consideration that if the person had chosen not to disclose self harm to A&E staff, their desire to participate in a research study of this nature may have

been minimal.

Informed consent was ascertained in writing (the consent form is included in appendix iii) and confidential interviews were conducted at a mutually convenient time in a room within The University of Salford. On termination of the interview the participant was asked to refer to the plan put in place during their visit to A&E should assistance or support be necessary. Financial arrangements were not part of this study aside from reimbursement for travel costs although in reality all participants declined this offer.

I had envisaged consulting the mental health service notes as an additional source of information and did this following the first interview. However, I then refrained from doing this preferring instead to focus on our meeting. Discussion regarding this decision is pursued in Chapter 9 but suffice to say the opinions and judgments of others became inconsequential as the study progressed. Acknowledgment of the power dynamic as an integral aspect of the researcher/researched relationship, but which is also inherent within research design led me to regard consideration of the ethical issues associated with the study and their and management as minimum expectations. It became apparent that there was more to be considered in relation to how I represented the participants' stories and by definition them in the research. This was effectively summarised for me by the following quote and which I have remained mindful of.

"*We are in the privileged position of naming and representing other people's realities. Thus, in turning private issues into public concerns, and in giving our respondents a voice in public arenas, we have to ask ourselves whether we are in fact appropriating their voices and experiences, and further disempowering them by taking away their voice, agency and ownership.*" (Mauthner and Doucet, 1998 p139).

As such, it was placing the participant at the centre of the study which became my overarching aim.

Interview, narrative and story telling

It is the telling of our stories that help validate our experiences and enable others to try to make sense of us, the essence of which is referred to as follows;

"*Human beings are storytellers by nature. In many guises, as folktale, legend, myth, epic, history, motion picture and television program, the story appears in every known human culture. The story is a natural package for organizing many different kinds of information. Storytelling appears to be a fundamental way of expressing ourselves and our world to others.*" (McAdams, 1993 p27).

In keeping with the aims of the study, the epistemological and theoretical perspectives as underpinning principles, I envisaged that this fundamental means of expression would enable the telling and hearing of stories in as natural way as possible given the confines of the researched/researcher relationship. In doing so I hoped that experiences would be validated and sense made of the narrative.

A number of formats can be used to achieve this including the use of various media such as visual representations but this may alienate some, including myself as I do not posses the skills to interpret such representations sufficiently. Focus groups are commonly reported in research and this was a consideration although was ultimately discounted for a number of reasons.

Owen (2001) contends that the use of focus groups to elicit the views of health care consumers has gained precedence in recent years. In explanation of this growing popularity, Owen (2001) argues that focus groups can aid the establishment of a safe environment, that the researcher does not impose their perspectives on participants, that this is a more respectful, friendly and less condescending approach and, as Owens's (2001) work concerned only women, fits with the notion that traditionally women have a well-established tradition of sharing information. It was also noted that this method enables the inclusion of those who do not read or write and those who would otherwise believe they have nothing to contribute.

However, with the exception of literacy, the other reasons given for the use of focus groups were largely under my control and providing I was mindful of interpersonal and intrapersonal processes, I thought I would be able to take account of these issues. Additionally as self harm is primarily a private act I questioned whether such a format would prove enabling and suspected it might have the opposite and less desired effect of suppressing expression. This view was influenced by a colleague's attempt to establish a group for people who self harmed but which revealed no willing participants despite attention to issues of travel and such like having been accounted for.

It was remarked in Owen's (2001) study that there was little evidence of the exchanging of views and anecdotes among the focus group participants and that in most instances the researcher asked questions of each woman in turn. This confirmed my view and despite appreciating that it may be the most conducive strategy in terms of time, this was not enough to persuade me.

Therefore, one to one interviews were conducted as a way to elicit participants' stories as this seemed like the most natural way for the story to be told and the most effective way to hear what was being said. This reflects Hall's contention that "*writing and reading narrative, hearing and telling stories is the way we communicate with others.*" (Hall, 1997 p5) and Fontana and Frey (1998 p47) who state "*interviewing is one of the most common and most powerful ways we use to try to understand our fellow human beings.*"

Aside from interviewing being considered as a natural medium through which to express ourselves, Sque (2000) comments that it allows the participant flexibility in giving their own account. Further, that the researcher is able to ask questions appropriate to participants' knowledge. However, Sque (2000) also suggests that within this method rigour is questionable and that issues of objectivity are even more problematic when the researcher is face to face with the participant.

Issues regarding perceived objectivity have been explored earlier in the thesis and it is not the intention to replicate the discussion here. That said I feel it important to highlight that within mental health the subjective experience of the person is an integral part of the process towards understanding. It is how diagnoses are made, how needs are identified, is one way of determining progress and as such it is relied upon.

Etherington (2001) can be referred to in the context of providing further critique of Sque's (2000) comment by indicating the importance of recognising the notion of multiple selves when telling stories. This view would posit that in a different time and place and with a different audience, the story would be told differently. Additionally, that none of us hears a story exactly as it is told, we fill in gaps and construct the story as we think the narrator tells it. The author takes this argument further in a later publication where she suggests that;

"*Each story is told for a purpose, and how it is told, and how it is heard, will depend on the listener as much as the narrator. How you, as reader, make sense of the stories will depend on what you bring to the reading from your own life and experiences.*" (Etherington, 2006 p78).

Clearly for the reader of my study, there is an additional layer to this process as a result of my attempt to recreate the stories I heard. Rather than attempt to minimise the risk of being accused of subjectivity, my desire to be open and transparent leads me to acknowledge this as an artefact of the study I have undertaken and to offer justification for this position throughout the thesis. As such, the time I spent with the people who told me their stories was characterised by what they and I brought to the situation on that day and was influenced by our presuppositions, preconceptions and previous experiences of being in similar situations.

Collecting a clutch of stories

I used the skills I had developed having worked with people following incidents of self harm during the semi-structured interview and in keeping with a narrative style the schedule was used as an aide memoir rather than strictly followed.

However, this had not been my original intention. For the purposes of ethical approval the interview schedule was detailed to illustrate all questions to be asked (appendix iv). The order of questions was purposefully chosen with a view to asking the more personal questions midway through the interview with the less emotive issues at the beginning and potentially ending on a positive note. The central concepts of the sense of coherence (Antonovsky, 1987) comprehensibility, manageability and meaningfulness were threads running through the interview schedule and provided a loose framework in this respect.

At this juncture it is prudent to state that Antonovsky's scale has been subject to scrutiny, for instance Eriksson and Lindstrom (2005) provided a systematic review of empirical studies concerning 458 scientific publications and 13 doctoral theses from 1992-2003. They concluded that the scale appears to be reliable, valid and cross culturally applicable. However, it is not without critique and these authors also noted that the sense of coherence, whilst relatively stable was not as stable as Antonovsky first assumed. The structure is unclear as it appears to be multidimensional rather than uni-dimensional and

it is proposed that standardisation of tools is required as is development of associated qualitative methods.

Antonovsky's theory had assisted in conceptualising the initial aims and in providing a loose framework for the semi-structured interview of which I envisaged asking the questions as they were ordered on the schedule and not detracting from it. I thought that on occasion further points to consider following an interview in preparation for the next would be added and this did come to fruition. However, in the first interview it became apparent that the semi-structured schedule would largely not be required. I began by asking what had happened and for the majority of the interview this seemed to be the only question required aside from points of clarification. It seemed the stories needed an audience and to be told without reliance on the schedule.

Had Antonovsky's theory been a more dominant feature of the study it would have been necessary to offer a comprehensive review and critique in relation to its use but as it is, the lack of reliance on the semi-structured interview schedule was more notable and is pursued in the next chapter.

Making links and making sense

I met with the participants once and chose to transcribe the interviews myself. Etherington (2006) talks of the advantages of this as it enables the researcher to pick up on a host of information, to hear more of what might have been missed in the moment and to check that ethical considerations have been attended to. That said, the author concedes that she has also used a professional transcriber and states that free from the task, she was able to pick up more nuances, hesitations, pauses, emphasis and other important additions. I found that transcribing facilitated my familiarity with the narrative which proved useful when deriving meaning from the participants' stories and in this manner Birch's comments resonated.

"While I was transcribing I was often transported back to the setting in which the interview occurred. ...Through the act of transcribing I had relived the act of telling. The final transcribed text offered a different sort of reading, more distanced as if the words had been told by anyone. Changing the interview into a textual representation created the jump I needed to enter the world of analysis, which presented me with the greatest challenge that any of the research stages had encompassed until then...

From the transcripts I found I was reading a definite whole, but if I started cutting and splicing, linking and indexing, I felt that the nature of the story and the social setting disappeared." (Birch, 1998 p179).

This was also a consideration for me and I worked with the transcripts in their entirety, but there had to be a way of presenting the story in relation to relevant theory and so quotes are taken from the interviews in Chapters 4-7 to exemplify links with the knowledge base. However, it did occur to me during the writing up of this thesis that the entire transcripts would assist in supporting the nature of the story and provide further context for the quotes I had chosen. I realised this would need retrospective approval and I made contact twice with the COREC via email but without response and decided not to try again. This decision was not based on a change in my belief that inclusion of the entire transcripts would add to the thesis. It was due to the realisation that regardless of the ethics committee decision, the participants had not consented to this and it would feel as though I had undermined the boundaries of our relationship.

Participants were not given the transcript of their interview to check and although this was a difficult consideration, particularly as it tipped the power dynamic in my favour as researcher, I felt the benefit of the person knowing they would not see me again might be liberating, conducive to the telling of their story and allay potential anxieties at the thought of a future meeting.

I felt a sense of justification in having made this decision when reading Standing's (1998) comments that partly in response to the participants' feedback, she "*tidied*" up transcripts but concedes that doing this homogenized the voices. She then goes on to say that she asked if participants wanted a copy of the transcripts and half did with others asking for articles to see the comments of fellow participants. That said, Standing states most did not read the transcripts or papers and says the comments she did get centred on the style of language used rather than the content.

Additionally, as Kohler Riesmann points out, an event can be narrated in a number of different ways which underlines the interpretive, representational aspect of using narrative from which to derive meaning. The implications of which can be seen to have been illustrated by Yalom (1991; 2004) who recounts an instance were he and a client were engaged in recording a therapy session they had been involved in and discovered each recounted the same event differently.

That said I remain aware that the issue of power in this context remains largely unresolved for me and regardless of what the outcome may have been if I had provided transcripts for comment, I have not given participants the choice to refute or question the representation of their interview.

The transcripts of interviews were as close as possible to the spoken word as I could manage and as such I hoped this would engender a form of authenticity as it enables the reader to judge my interpretations in light of the interview content, particularly as;

"Within writing, researchers have the last - or rather the penultimate (for the readers have the last) - say about what 'the research' meant, found, concluded." (Stanley and Wise, 2002 p218).

Originally when I first thought about this study I proposed to use Burnard's (1991) fourteen-stage method to undertake a thematic analysis of the qualitative data generated from the interviews. The thematic analysis would then be independently repeated in an attempt to ensure I had captured the critical elements of the information shared.

In retrospect, this method and the language (some of which is purposefully included in the above paragraph) contravened the emerging epistemological and theoretical perspectives as previously discussed and I had a growing sense that by following Burnard's (1991) method, the individuality of the stories may be lost. I was also mindful of Hollway's (2001) criticism of the thematic approach where she states *"cherry picking"* statements from interview transcripts can look like an attempt to prove the researcher's existing convictions and additionally this assumes that such statements are independent of their context. I acknowledge that aspects of the story are quoted in the main body of the thesis and so could be accused of such cherry picking and possibly the inclusion of the entire transcripts in the appendices could allay this through enabling the context to be reviewed. However, as discussed above this is not an option but rather a consideration for future studies.

In wanting to keep the individual's story as intact as I ethically could, I chose to represent the participants in separate chapters but was then uncertain how to glean meaning from the transcripts whilst also being true to the story and managing the issue of *"academic rigour."* Sarup (2005 p17) contends that each narrative has two components, a story which is a chain of events, the *"what"* in the

narrative and the discourse which is referred to as the *"how,"* rather like the plot, the order of the appearance of the events and how the reader becomes aware of what happened. I aspired to present such a cogent and clear approach to meaning making from the interviews but recognised the inherent difficulties associated with this, some of which are described below;

"Data analysis is our most vulnerable spot. It is the area of our research where we are most open to criticism. Writing about data analysis is exposing ourselves for scrutiny. Perhaps it is for these reasons that data analysis fails to receive the attention and details it deserves." (Mauthner and Doucet, 1998 p123).

Concern in relation to this was further compounded by comment that data analysis is critical as it carries the potential to either decrease or amplify the respondents voice and is the site at which stories and voices become *"transformed"* into theory (Mauthner and Doucet, 1998).The desire to find a method of data analysis which would fulfil the aims of being true to the participants' stories and withstand academic scrutiny led me to Kohler Riessman's (1993) work on narrative analysis.

This, she states, takes the story itself as the object of investigation. This approach opens up the form of telling about an experience not just the content and appeared in keeping with Sarup's (2005) contention. However, Kohler Riessman (1993) further contends that there is a spectrum of approaches rather than single method and this was frustrating and liberating as in identifying a suitable framework to analyse the narrative, I had to accept that this was not clear cut. That said, it also meant that bespoke approaches, particular to the work I had undertaken could be employed and potentially their use defended, this seemed a good starting point from which to begin the narrative analysis.

A fundamental principle to this approach is that *"individuals construct past events and actions in personal narratives to claim identities and construct lives."* (Kohler Riessman, 1993 p2). It is posited that narratives are representations as they are constructed, creative, rhetorical, replete with assumptions and interpretive. They do not mirror a world *"out there"* and this was in keeping with my fundamental assumptions in relation to this study.

Labov's (1972; 1982) framework was employed by Kohler Riessman (1993) and although she contends

that many narratives do not lend themselves to this framework, it provides a starting point for analysis.

Having performed this process and noting Kohler Riessman's (1993) comments that this takes the story itself as the object of investigation and opens up the form of telling about an experience not just the content, this did not appear to be the case. On scrutinising the *"processed"* transcript the participant appeared to be missing and it seemed to be saying more about the construction of the story than the meaning behind it.

Reflection on my choice to use a narrative approach in the research re-focused attention to the primary purpose. This was to use an approach to gain an understanding of events within the story from the individual's perspective, to hear their voice above all others, at which point the following quote resonated strongly.

"Psychoanalysis tells us why we feel deeply about certain things, certain experiences, and certain people and why these powerful feelings are part of a meaningful life" (Chodorow, 1999 p2). This appeared to offer a way of exploring the stories with a view to understanding the events, their relation to the person and the reasons behind their self harm. Particularly as the stated reasons for the participants attendance at A&E were consistently within the context of other people's treatment of them and their responses. As such intrapersonal and interpersonal processes appeared to be important.

However, I wondered about the compatibility of psychoanalytic theory with other approaches used in the study and in relation to this social constructionism has been discussed previously in Chapter 2. However, a further tension for me was in relation to my reference to feminist approaches as theoretical underpinnings to the study and I needed to consider this more thoroughly.

Flax (1991) argues that from a feminist perspective, post-Freudian psychoanalysis remains partly constituted by the father and son alliance against a return to the repressed mother world. However, Mitchell (1990) takes the view that psychoanalysis is not a recommendation for a patriarchal society but rather analysis of one. I struggled with some notions associated with psychoanalytic theory, such as the concept of *"penis envy"* until I conceptualised this in terms of power and in doing so acknowledged Mitchell's (1990) contention that *"penis envy"* is not a literal concern but one which represents the ideas

that people in society hold and live by. Then it did not seem as remote to me but I needed to explore the utility of psychoanalysis further in the study.

I revisited my literature review concerning self harm and whilst acknowledging that *"causes"* are not definitive, there are numerous accounts of experiences which are thought to be implicated in the expression of self harm. One such paper is McAllister (2003) who refers to the literature regarding childhood trauma in the forms of abuse and neglect. Whilst McAllister acknowledges there is not a direct link to childhood abuse, there are many who contend that traumatic events not just in childhood, can lead to self harm.

Within this context, psychodynamic approaches are thought to offer an insight and object relations theory is named in this article as providing an explanation of self harm. Object relations theory in this context is also referred to in conjunction with Post Traumatic Stress Disorder (PTSD). The proposal being that a child who has been abused may learn that love is conditional, can hurt, and renders the world unstable and unsafe. Yet the caregiver is the object who gives love no matter how disturbed. Without a consistent object-relationship, the child's inability to cope with the notion that there can be good and bad in everyone, including themselves may lead to the defence mechanism of splitting. As such, an unconscious dislike of the bad and an inability to see the good in themselves may be enough to motivate them to self harm as form of punishment or atonement.

The intention in citing this paper is not to state that this is a conclusive cause of self harm but rather to illustrate intrapersonal and interpersonal processes which have been seen to have a place in understanding self harm. This was further substantiated by the experiences shared by Celia, Margaret, Ellie and Riordan as participants in this study and which are discussed in Chapters 4-7 and was further justified by Chodorow (1999) who says that; *"The feelings that concern psychoanalysis are always feelings enmeshed within stories."* (Chodorow, 1999 p239).

Additional justification was given in the form of Bell's (2000) comments that what is recalled consciously by the individual following suicidal acts is usually a rationalisation rather than explanation and whilst all participants noted an event and person as implicated in their reasons for attending A&E, psychoanalytic theory enabled exploration of this at a deeper level. In doing so, I was able to offer proposals why the

experiences leading to the attendance at A&E were crucial, why the characters in the story felt so deeply and why these played such a meaningful part in the narratives I was told.

Further, in Rayner et al (2005) we stressed the importance of attending to transference and counter transference when relating with someone who has self harmed and these aspects of psychoanalytic theory have enabled me to understand my reaction and response during and after each interview.

As stated, placing the participant at the centre of the study was evolving into my overarching aim and I believed psychoanalytic theory to have utility in exploring Celia, Margaret, Ellie and Riordan's stories with a view to understanding the events, their relation to the person and the reasons behind their self harm. I also found that using theory derived from a psychoanalytic perspective enabled other links to be made with the existing knowledge base. However, I wanted to ensure that I had made best use of the information shared during the interviews and was mindful of Hollway and Jefferson's (2003) contention that there are four core questions to be asked when analysing any qualitative data which are;

1. What do we notice?
2. Why do we notice what we notice?
3. How can we interpret what we notice?
4. How can we know that our interpretation is the "right" one?

I felt I could demonstrate transparency in relation to the first three but the latter remained an issue which I wanted to explore more thoroughly. It is perhaps prudent to add that my version of this final question had the added caveat of knowing the interpretation was right only in relation to my perspective, there would be endless interpretations that could be suggested, thereby reflecting the notion of multiple realities.

I had noticed how different it felt to interview participants in the study as compared with undertaking a similar process as a clinician. I contemplated whether this was due to wanting to know the participant as a person rather than feeling compelled to focus on the risk they may pose. I further wondered whether this could be translated into clinical practice and if so whether it would it impact on the quality and content of interviews with people who use services as a result of self harm.

I knew I could not answer this without engaging in a study to explore it, but I wondered how I could project the person to the forefront of the research more effectively as this seemed to be the most striking difference in my researcher versus clinician role. I was struck by discussion relating to a voice-centred relational method of data analysis in Mauthner and Doucet (1998 p136) who state that;

"While emphasizing the dynamic and fluid quality of these stories, we believe there is a person within and telling this story, who – in those minutes and hours that we came to speak with them – makes choices about what to emphasize and what to hold back from us."

Mauthner and Doucet (1998) offer detail with regards to how they analysed their research data by describing two phases. The first was a voice-centred relational method of data analysis involving four readings, case studies and group work and the second, summaries and thematic breaking down of the data. They state this method was used with the guidance of Carol Gilligan, who, with Lyn Brown and colleagues is said to be the originator of this method, but also that Mauthner and Doucet (1998) began to develop their own version of it, representation of which seemed to potentially enable my pursuit of an answer to Hollway and Jefferson's (2003) fourth question regarding interpretation.

This entailed exploration of individual's narratives in terms of their relationships with people around them and relationships to broader social, structural and cultural contexts. Mauthner and Doucet (1998 p125) chart this process as follows;

1. Reading for the plot and our responses to the narrative

   Text is considered for overall plot, the main events, protagonists and subplots. Recurrent images words, metaphors and contradictions are noted. The researcher then reads the narrative on her own terms, how she is responding emotionally and intellectually to the person.

2. Reading for the voice of "*I*"

   Focus is placed on how the respondent experiences, feels and speaks about herself. A coloured pencil was used to physically trace and underline certain aspects of the transcript, namely those where personal pronouns are used to highlight how the respondent sees and presents herself, where she may be struggling to say something and identifies places where the respondent shifts between "*I*", "*we*", "*you*" signalling changes in how they perceive and experience themselves.

3. Reading for relationships

How interpersonal relationships were spoken of was noted at this stage and again a different coloured pencil was used here to identify these instances.

4. Reading to place people within cultural contexts and social structures

At this point respondents' accounts and experiences were placed within broader social, political and structural contexts.

Following this, thoughts and analysis about respondents were formulated into case studies and group work enabled others to highlight aspects which may have been missed or glossed over. The approach described is said to differ from thematic analyses as it delays the reductionist stage of data analysis and coding which implies fitting a person into pre-existing categories, and by tracing voices through the transcripts, Mauthner and Doucet (1998) argue that this helps maintain the differences between respondents.

Additionally they state that detailed and lengthy focus on individual interviews is respectful to respondents and prevents data analysis merely confirming what we already know (Mauthner and Doucet, 1998). These reasons appealed to my sense of wanting to do the best with the information imparted by participants and I endeavoured to use this method.

As described earlier, I had transcribed the interviews and this was achieved through listening to the audio and recording the main elements, the audio was then listened to again with focus on the respondent's narrative. I then noted my own comments, the interview was listened to again and amendments made as necessary. This stage involved rewinding the audio on numerous occasions with sections being played repeatedly. Finally the audio was played throughout in order to ensure the interview had been captured as close to the one-to-one interaction as possible.

In all, and including the actual interview, this means that each transcript was heard at least six times and in this way themes and points of focus emerged naturally, albeit from my own perspective. This hugely assisted in identification of the main elements of the story and an overall view of the plot. The transcripts were then read and notes entered in different font to signify the parts to be pursued. From these, themes emerged and were used as subheadings to denote sections. The sections of spoken word were then linked with theory in an attempt to propose possible meaning behind the narrative. As stated, I wanted to

be as certain as I could that I had investigated all elements to the best of my ability, had avoided missing important issues and it was at this stage that an adaptation of the analysis described by Mauthner and Doucet (1998) was undertaken.

Reading for the plot was a stage which had occurred throughout the interview as trying to remain in the same place and moment as the interviewee required this and additionally was part of the transcribing process. It was here that themes and biographies emerged and my own thoughts and feelings in response to the narrative were recorded. These were presented in the postscript following the discussion of each interview.

I then went back to the interviews and read for the voice of *"I."* As advocated by Mauthner and Doucet (1998) this enabled me to focus on how the respondent experiences, feels and speaks about themselves. Using the *"find"* tool of Microsoft Word, I entered the pronoun, *"I"* to seek all and highlighted them in coloured text. Unfortunately this method does not discriminate between the pronoun and the letter(s) contained in words so this required sifting.

On identifying the pronoun *"I"* the associated text was cut and pasted into a separate document so as to review the use of this within the story and then summarised. I repeated this process using *"we"* and *"you"* to identify places where the respondent shifts, thus signalling changes in how they perceive and experience themselves or are struggling to say something. Additionally, where respondents uttered *"we"* and depending on the context of the sentence, I used this as a gauge of who the person affiliated themselves with.

The next stage in this process was reading for relationships yet within Celia, Margaret, Ellie and Riordan's narratives this was so much a part of the plot and story that it emerged very early in the process. Finally, I revisited the transcript to ensure that cultural contexts and social structures had been sufficiently considered.

As such, the aim was to try to understand the narrative and *"know"* the person who presented it to the best possible ability within the parameters of the research situation. This method also enabled a check of the themes I had previously identified and it placed the supporting characters in the individual's

narrative temporarily at the centre of consideration. As such I was able to ensure the parts they played and the themes identified were those which seemed important to the participant. Having completed this I felt more confident that I could demonstrate the fourth of Hollway and Jefferson's (2003) questions.

However, in retrospect I began to wonder whether I had engaged in this process due to an undulating confidence in the methods I had employed to make links to theory and make sense of the person as characterised by their story. Having undergone the process of searching for the relational voice it did assist in knowing the person and the parts their characters had played in their stories and as a consequence enabled me to feel confident in the themes I had identified. It also provided an overview of the story in conjunction with the person's biography, but may also have represented a need, no matter how small, to conform to *"scientific"* convention in the form of a recognised *"technique"* to analyse data.

Validity and reliability are contentious issues in qualitative pieces of work as the traditional rules such as attempts to eradicate bias, randomly sample and demonstrate rigour through the use of statistical analysis do not apply in the same way. Despite presenting a rationale for avoiding this, being able to demonstrate rigour in qualitative research has been a source of critique. However, if traditional ideas about reliability and validity can be suspended, there are gains to be had in being explicit about one's personal, political and intellectual autobiographies (Mauthner and Doucet, 1998).

Etherington (2006 p32) states; *"One of the methodological issues for me is that our interpretations can be better understood and validated by readers who are informed about the position we adopt in relation to the study and by our explicit questioning of our own involvement."*

This has been a fundamental consideration throughout the research process and I have tried to be as transparent as possible without detracting from the focus of the study. This process has been commented upon by Flick (2009) who states that immediately after an interview notes should be made in the form of a postscript in relation to the impressions of the interviewer, including those of themselves, their behaviour and external influences. Such context information as this is seen by Flick (2009) as potentially instructive and helpful in making sense of the interviews and their comparison.

However, there is a tension between how much of the self to include in the production of an academic piece of work worthy of doctoral study. Etherington (2002) reports on this issue by saying that the academic community has traditionally discouraged the inclusion of the self in writing, although transparency can assist in the soundness of the study (Mauthner and Doucet, 1998; Stanley and Wise 2002). Yet there remains a question pertaining to quality, as the researcher can be transparent yet present information which has little bearing on the advancement of theory and or practice.

In an effort to enable such judgments regarding the credibility of the research to be judged a prescriptive framework could be proposed. However, there is a degree of manipulation in doing this as it would be my chosen framework which would reflect my interpretation of what this constitutes and it seems preferable to leave this to the reader themselves.

Suffice to say my intention was to produce a study which told *"methodologically, rhetorically and clinically convincing stories"* (Miller and Crabtree, 2000 p623). I would also add *theoretically* to this aim and I leave this for the reader to judge in keeping with Stanley and Wise's (2002) contention that it is the reader who has the last say about the research.

In summary and having discussed the method and methodological considerations employed in the study and their links to the epistemological and theoretical perspectives, the practicalities and actualities of *"doing"* the research becomes the focus of Chapters 4-7. Here each of the participants and their narratives becomes the focal point but prior to this I offer the following details.

Contact by telephone was made with six people and four have told me their story. Of the two people who I did not interview, one declined as we were unable to find a mutually acceptable place. She had wished for the interview to be conducted at her house. I was unable to do this as consent had not been sought at that point and so I could not explore whether there were issues I would need to be mindful of by conducting the interview in the person's home. There was also an issue of confidentiality in that I would be party to information that was not essentially needed for the study by knowing where she lived. Unfortunately, the potential interviewee was unable to identify an appropriate meeting place in her local community and declined to come to the university for *"personal reasons."*

The final person informed me that she was unwell and agreed that I could contact her at a later date to see whether she felt able to be interviewed. Before that agreed time I came into work one morning to find a message on my answer machine from a social worker saying my contact details had been given by the potential participant during a period of crisis. As a consequence I made the decision not to pursue this interview for ethical reasons and so four people were interviewed and Chapters 4-7 represent their stories.

Chapter 4

Celia (Interview 1)

Chapter 4 is dedicated to Celia's story and takes the format of a biography in order to provide background information as an introduction to Celia, the other characters in her story and a brief overview of the events which beset her. Reading for the relational voice then follows and enables the biographical information to be contextualised further by highlighting where and how Celia refers to herself and others in her story. The themes I identified as running through the narrative are then considered and links made with existing theory as a way to suggest possible meaning in Celia's story.

Biography

Celia is a 53 year old heterosexual woman who was born in England and describes herself as white British. She has a sister who is 8 years older and their mother died aged 83 having been diagnosed with cancer two years earlier. Celia said both her mother and sister had experience of mental health difficulties and that she had cared for them both during these difficult times. Celia met her ex-husband when she was aged 17, the same year as her father died. She and her ex-husband had one daughter together and Celia sought help from her General Practitioner (GP) for postnatal depression when her daughter was aged 2, three years later the relationship with her daughter's father dissolved. However, Celia and her ex-husband have a long standing and enduring relationship, having been in business together for 25 years and more recently his subsequent partner has also been involved in this enterprise.

Celia expanded her business interests by becoming involved in property development with her daughter's boyfriend. Initially she was very fond of him and whose company she enjoyed, however as Celia's story will reveal, their business partnership led to a number of problems which largely centre around Celia's perception of her daughter's boyfriends treatment of her, which became abusive and aggressive and the consequent rift this created between Celia and her daughter. As a result of this business partnership Celia describes financial worries which culminated in her attendance at Accident and Emergency (A&E) following an attempt to gas herself whilst sitting in an enclosed garage with her car engine running. Celia maintained her attendance at A&E was the first of this nature.

Reading for the relational voice

Where Celia uses the pronoun *"I"* in the narrative her experiences and feelings are presented and it allows an understanding of how she speaks about herself. Celia couches her experiences leading to her attendance at A&E as out of the ordinary for her. By describing these in terms of being poorly and ill she is giving a message of how she regards this period in her life. Celia states she feels better now, but draws on events of her mother's mental health and in-patient admission to signify how she did not recognise her own plight despite having witnessed her mother experiencing something similar. Yet Celia had not made this connection and instead explained her behaviour as a result of feeling angry and tired.

The strength of feeling in relation to her experiences is revealed by Celia when she describes her mother's view that having a mental health problem was worse than cancer. Celia concurs with this using the analogy of it being like hell. Celia reflected on the support she had received and acknowledged future interviewees in the study may not be as well as she is. She clarified this by saying that there are depths lower than she reached as some people actually do succeed, the implication being a successful suicide.

One source of support was Celia's sister, yet this is a reversal of their usual roles as described when Celia says she recognised that her sister had a mental health problem and accompanied her to the GP. When a sense of uncertainty was relayed by the doctor, Celia felt confident enough in her own assessment to leave her sister with the GP feeling sure her sister's problems would reveal themselves. Celia has regarded her sister to be fragile, not well and her care for her sister extended to moving her, her sister's partner and their children into her home to look after them.

When Celia was experiencing her own difficulties she purposely refrained from contacting her sister for fear she would make her sister's situation worse. This sense of care and responsibility is further demonstrated by Celia when she described her mother's experience of depression and for whom she assumed the responsibility for securing mental health input at crisis point. She also moved in to care for her mother and this responsibility as carer for others is juxtaposed with her own need for help and support. She revealed a sense of determination that she will improve her current circumstances, although the events leading to her attendance at A&E clearly had a profound effect on her and the relationship Celia previously enjoyed with her daughter's boyfriend became damaged to the point of

being irreparable.

The issue of trust disintegrating and being replaced by betrayal on the part of her daughter and her daughter's boyfriend is identifiable throughout the story and is described by Celia with a sense of disbelief. The profound effect of her daughter and daughter's boyfriend's treatment of her is reinforced through contrast with Celia's description of being let down by a family who were renting one of her properties. Celia says that such adversity in business is manageable, but indicates the situation with her daughter to be different.

The sense of Celia's loss is clear throughout her story and includes her mother's death, her daughter moving out from Celia's home, the feelings of which were compounded by the dissolution of an intimate relationship a few weeks prior to her bereavement. Loss is not merely confined to that of others. There is a sense that at times Celia lost herself, she describes this in relation to her intimate relationships where she became disinterested in her appearance and sex and also in her business life having become unable to fulfil her role as she would wish to.

The issue of loss then relates to Celia's profound sense of being alone; being without her mother, her daughter, her daughter's boyfriend, her work persona and alone with the accumulated debt from the business ventures she had been involved in. That said she was able to continue to reflect her trust in her business partner, her daughter's father. Of whom she says she trusts more than anybody and certainly throughout the story she presents him as reliable and dependable and who is able to manage the ramifications of Celia's situation and its effect on their established business.

Celia was able to reflect on her own sense of safety, thereby insinuating a degree of mastery in her ability to maintain this and manage potential adversity. However, her experience of insecurity as one ramification of the situation with her daughter's boyfriend is also apparent and relayed through the description of sleepless nights and her need to have a baseball bat within reach as a consequence of threats made towards her.

Where Celia refers to *"we"* in the story it relates to her sister, her ex-husband, daughter and daughter's boyfriend. Her portrayal of these characters in the narrative is in the sense of an affiliation. This differs

from the use of *"we"* as a deflection where difficulty may be experienced in owning aspects of the story. Likewise the use of *"you"* is employed to recount the words of another directed at her, or in reference to me and as a way of connection as in *"you know,"* this is a tactic Celia often uses throughout the narrative.

Where *"you"* appears to be used as a way of distancing herself from the story, this is in conjunction with her mother's death, as in; *"and then she died and you just sort of wander out of the room and you're going well what do I do now you know..."* This sense is also portrayed where she talks of being in business saying; *"and when you're in partnership you don't feel quite so you know alone."* It seems these aspects of the story required a sense of distance, they seemed difficult to talk about for Celia and as such, the themes of relationships, loss and being alone were clear in the story.

Emerging Themes

Family business

The importance of the relationship with her daughter's partner is described when Celia says

" it was my daughter's boyfriend who I loved absolutely like my own son they lived with me for 6 months and err oh I'd really got to like him and we were, my daughter would go out buying I don't know a new pair of shoes and if he didn't want to go he'd stay in with me and we'd watch err Sopranos and I'd crack open a beer (both laughing) and have a video and it was great, really good and he also, because he's a budding business man, he used to ask me things and I used to you know, we used to chat and he used to say he couldn't ask his own mum because she'd never done anything like that, he couldn't ask his dad because he poo pooed it, so I mean we were really close."

Immediately a sense of love and feeling "*close*" to her daughter's boyfriend is conveyed by Celia and reference to theories in this respect can assist with understanding how pivotal this relationship was in the story.

Flax (1991) makes reference to Freud's opinion that part of the oedipal drama lies in the conflict between the sons desire to identify with and overthrow his father and that the successful resolution of the boy's oedipal complex includes identifying with the father and abandoning the wish to overthrow or displace him. To explain this in more detail in an effort to illustrate why it has utility, Bateman and

Holmes (2005) provide a useful précis.

They describe the concept first being mentioned to Fleiss in 1897 and arising from Freud's self analysis following the death of his father. Briefly, it encapsulates the little boy's desire to usurp his father's position in his mother's bed by killing him yet also fearing the retaliatory castration by his powerful father. The ultimate punishment of the loss of his genitals, as symbolically enacted during circumcision and the reality of castration being evidenced by the little boy's discovery that females lack a phallus thereby having been castrated and confirmed by the flow of menstrual blood. Little girls, who Freud assumed had a similar psychosexual world to boys, would want to replace their mother yet in the absence of this organ of power and significance were left feeling castrated and so powerless.

Bateman and Holmes (2005) go on to explain that whilst contemporary psychoanalysis, as influenced by feminism has departed from Freud's original view of psychosexual development, resonance remains with the image of the parental couple who the child both desires and feels cast out from and in the experience of desire, prohibition and ambivalence must be negotiated throughout infancy to adulthood.

As such the parental relationship can be seen as formative in enabling such negotiation through one's life. For Celia's daughter's boyfriend the close relationship with this older woman, as a mother figure in the absence of his own who did not have the knowledge or experience he desired, may have represented this inherent struggle. For Celia the attention of this younger man may have been welcome on a number of levels.

Mitchell (1990) makes reference to Freud's work in relation to oedipal love. Here it is stated that with the birth of a son two strands of a woman's early sexual desires come together as they can be the mother they loved and have the phallus, in the form of a son, which they envied. Whilst this may seem like an abstract concept and whether Mitchell's contentions can be taken literally is a matter for debate, Celia did enjoy the relationship with her daughter's boyfriend. This may be one proposal to explain Celia's closeness to him who she loved like her own son and may in part explain why his betrayal was so painful for her to endure.

There may also be an issue of wanting to show she could relate to a younger man as circumstances

surrounding the break up with her most recent partner had not been altogether favourable as described when she says; *"and then she* (Celia's mother) *died and you just sort of wander out of the room and you're going well what do I do now you know and a few hours later my daughter had said well I've got this date with a boy and I only know where he lives I haven't got his phone number, so I said well, at least go and tell him what's happened and she went in and opened the door and erm burst into tears, because he looked at her and said are you alright and she said my nana's just died and she burst into tears went to sit on the settee cried herself to sleep and this is when he got my vote, he just threw a duvet over her and didn't wake her up and let her sleep and he sat by her on the sofa all night and they'd never met (both laughing) and I thought that was lovely I thought that was the loveliest boy..."*

The impression here is of the daughter's boyfriend as sensitive, caring and protective. This may have connected with Celia's desire for her daughter not to be treated badly in intimate relationships and resonated with a longing in Celia, whose recent relationship, by contrast turned out to be duplicitous.

"...and err I never had a problem with him, never and err, so, but the thing is, she never came home, she stayed and that was the start of their relationship, so I lost my mum that day and I lost, well you know, she moved out and also a few weeks before I'd thrown my boyfriend out because I'd discovered he was having an affair with a young lady on my estate."

Therefore her deceitful partner leaving her for a younger woman may have felt difficult for Celia to manage and may partly have forged her relationship with this younger man who had been so caring towards her daughter.

It is clear that Celia has experienced problematic life events, her partner's affair, her divorce, post natal depression and the loss of both her parents. However, it is the dissolving relationship with her daughter which really seems to create her particular difficulty and in her consideration of the issue of gender in more detail, Flax (1991) states that mothering has differing consequences for boys than for girls.

As girls are the same gender as their mother, Flax (1991) contends that firm ego boundaries are under developed, and so separation from the mother is never complete. This is compounded by treatment of the daughter who is regarded as an extension of the mother and who is seen to discourage the

establishment of a separate identity.

Boys, Flax (1991) states, are experienced by their mother and experience themselves as "*other.*" The mother encourages the son towards differentiation which is motivated by a need to reject the female parts of themselves and the primary relatedness with their mother in order to be male, yet girls cannot and must not reject either of these.

This relatedness is couched in history as Celia too has been a daughter and it is not simply a one way relationship, as described when Celia states; *"I was already close to her we'd had a great relationship me and my daughter… and I mean I loved her to pieces and we just got along terribly well."*

Celia describes experiencing post natal depression after the birth of her daughter and her relationship with her husband subsequently dissolving when her daughter was 5. Parker (2005) argues that men need women and heterosexual women need men in part to fulfil a desire for emotional and physical union. In men especially, this is seen as a replication of the symbiotic union of early infancy however, Parker (2005) goes on to contend that men find it difficult and threatening to satisfy women's emotional needs as they had to suppress their relational capacities to become male. The consequences of such, she states, are that this leads women to turn to their children to satisfy such relational needs. This may be one reason why the perceived betrayal by her daughter exerted such power and intense pain and may assist in understanding why Celia's reaction was extraordinary and outside of her usual repertoire.

Extraordinary circumstances, extraordinary reaction

From the outset of the interview it is clear that Celia saw this period in her life as extraordinary, *"well it is actually, because erm, had you contacted me in the state of mind that I was in at the time, I really would have needed this support, but I feel better now, but I mean some people might be coming who aren't feeling as well as me and I do know now that I was poorly."*

The description of being poorly and the insinuation of an impaired state of mind is perhaps a way of trying to reconcile Celia's public and private self. She is an accomplished woman who possibly feels the need to remain regarded as such by others. Further insight into her private and public self is implied later in the interview where Celia states *"I don't give a shit about where I live it's not me image, I mean*

I've got an image coz I've been in business 25 years, and you I'm a (job title) you know, and you don't drive up to somebody that you're trying to convince to buy style in an old Nissan so I've got a (name of car) and I had a 4 bedroom house and 2 bathrooms and all that, you know, it was my image but I wasn't wedded to it."

As described in the above quote, Celia has been in business for over 25 years which is suggestive of success and where she describes this difficult period in her life she relates it to her work situation possibly indicating its importance as a gauge of how she is. It may be that where Celia feels less capable than customary as portrayed through her public persona, the view of herself as "*poorly*" and "*ill*" may enable her to integrate and own that part of herself despite it being far removed from her usual successful self.

Acknowledgment of these extraordinary events is given when she says *"my sister knew straight away when my daughter described the build up to it, you know, but I'd not been in touch with her for a long time coz she's not well (laughing) ironic isn't it? And I consider her very fragile you know with the two nervous breakdowns I try not to stress her out."*

Yet despite regarding her sister in this way, she is the one who actually helps Celia "*but luckily for me in a way erm, it's helped on this occasion because she is so good, she's been so spot on when the, is it a psychiatrist at the ________? the young man there, when he talked to her, the Dr, he said what it was and he said that if it was at all possible to remove the stressors then that would be the best treatment and she just did it like that, no hesitation, from the moment we stepped out of the hospital she said now we need to remove all this stress so I'm going to deal with this, this and this."*

Perceiving herself as requiring care seems to be removed from Celia's usual view of herself. She describes her sister looking after her, yet previously she has been the one to undertake this task and the roles are therefore, reversed *"oh absolutely I've seen it happen in my sister, you know, she had terribly bad nervous breakdowns and I nursed her through them but that was years ago."* She further acknowledges the role she has played in caring for her sister saying *"I took my sister to her GP when I knew that she completely lost it...*So *she was an outpatient for about 6 months, and that got her through that, but she was in a terrible state and while she was in the outpatient scheme she lived with me for the*

first few months because she was not capable." In some ways it may seem extraordinary for Celia to reconcile that the person who she has regarded as fragile, actually ended up looking after her. One way of dealing with this may be through the use of defence mechanisms.

According to Mitchell (1991) there are four such defence mechanisms which perform this function and derived from the work of Melanie Klein. These are summarised as follows. Splitting enables the ego to stop the bad part of an object from contaminating the good part by dividing it, splitting it off and disowning this part. Projection occurs when the ego fills the object (for example another person) with some of its own split feelings and experiences and introjection where it takes into itself what it perceives or experiences of the object. In projective identification the ego projects its feelings into the object and then identifies with it, thereby becoming like the object. The ego uses these defences to cope with the inner world and the interaction between the inner and outer and the theory contends that such processes begin in infancy.

Anxiety derives from the baby's destructive feelings which emanate from the death drive and fears of the object on which it vents its rage. The death drive is described by Bateman and Holmes (2005) as emanating from Freud's ideas relating to the darker side of human psychology and coincides with the 1914-1918 First World War. The emphasis is on aggressive ideas and culminated in the notion of *"thatos,"* the death instinct.

It is contended that to begin with the object on which the baby vents its rage is typically the breast which goes away and renders the baby frustrated and fearing that the breast will retaliate. In an effort for self preservation the baby splits itself and the object into a good and bad part and all the badness is projected into the outside world so that the hated breast becomes the hateful and hating breast. This is described as the paranoid-schizoid position.

With development and adequate parenting the ego starts to be able to take in the whole person as opposed to part objects such as the breast, thus good and bad can exist together. There is continued rage towards the mother for the frustrations she causes, however, rather than fearing retaliation; there is now the experience of guilt and anxiety for the damage done in phantasy and this is the depressive position.

The paranoid-schizoid and depressive positions are pivotal aspects of Klein's work and in Mitchell (1991) Klein's (1955) paper "*The psycho-analytic play technique; its history and significance*" explains these positions. She states that depressive anxiety arises from the ego synthesizing the good and bad, loved and hated aspects of the object which leads to the development of the concept of the depressive position and which reaches its climax towards the middle of the first year. This is preceded by the paranoid position which extends over the first three or four months of life and is characterised by persecutory anxiety and splitting processes and as stated this later became known as the paranoid-schizoid position.

Klein (1955) states that object relations, as underpinned by these positions, begin almost at birth, arise with the first feeding experience and all aspects of mental life are bound up with such relations. The child's experience of the external world is constantly influenced by and in turn influences the internal world which is being constructed and that external and internal situations are always interdependent as introjection and projection operate together.

At about six months of age the baby is regarded to have the ability to take in the whole mother where as previously the baby has been destructive or attached to part objects such as the mother's breast (Mitchell, 1991). How the baby manages this in terms of being able to identify with an internalized "*good*" mother and repair the damage done by destructive urges towards the "*bad*" mother, is an unconscious and pivotal experience for the infant.

Chodorow (1999, p15) states that; "*In projection and projective identification, we put feelings, beliefs or parts of our self into an other, whether another person with whom we are interacting, an internal object or part-object that has already been created through projective-introjective exchanges, or an idea, symbol, or any other meaning or entity. In introjection and introjective identification, aspects or functions of a person or object are taken into the self and come to constitute and differentiate an internal world and reshape the ego.*" Celia may reconcile views of herself at this difficult time in her life with her perception of her usual self by using defence mechanisms such as splitting and projecting the "*poorly*" self outwards.

The situation with her daughter's partner escalates to the point at which she is in debt, a situation she

had not experienced prior to this *"I'd taken out loans and mortgages to the value of £500 000, half a million quid right, which was extraordinary for me, I've been in business for 25 years but I've never been in that much debt."*

Celia later comments *"my credit rating, because I'd run a business and the way I am with honesty was 990 out of 1000, credit rating starts at something like 100 and it goes up to 1000, mine and I'd always been dead chuffed was 990 out of 1000 and when I'd bought my own and only little house by myself as a buy to let, the erm mortgage broker had come back in to me and said that the mortgage lender had said that was the best credit rating we've ever had (both laughing) I was dead chuffed, so I thought wooo yeah, so of course I could get loads at the beginning I only had to phone up and they'd be chomping at the bit to lend me money, because I'm the bank managers best friend, I'd borrow money I never miss a payment and then I'd pay it back if I get an influx of cash so I was the perfect customer and I knew that and then I told (name of daughters boyfriend) that, so my credit rating started to, phew it is now the very worst, I'm one of the worst risks."*

This is in direct contrast to Celia's business partnership with her ex-husband which is portrayed as an equitable, fair and honest enterprise *"we're straight as a die honestly, we're dead above board honest, we once got a tax refund that we weren't due for £8000 (both laughing) and I can't tell you how tempting it was and we had it in the drawer for about two weeks this cheque, and ohh, but in the end he said to me, he said, we won't sleep and it'll only come back and bite us in the arse and they'll want it when we haven't got any money, so lets send it now, so we did and he was absolutely right, you know, but, anyway that's how we are and we divide the business profits 50:50 to the last few quid (laughing)."*

Yet her experience with her daughter's boyfriend is the opposite of this *"so I went into this thing with (name of daughter's boyfriend) thinking it would be the same, what a fool."* She had become accustomed to working for 25 years in an equitable partnership and was now confronted with the reality of a very different situation and one which was causing Celia to act unusually. *"I just burst into tears in front of him and (name of business partners, partner) and I never do that, blimey, I mean I cried when my mum died and I cried a lot after I gave birth to (name of daughter) so he's seen me at low ebbs but this was different."*

Further, and in contrast to previous experiences *"(name of business partner) and he ahh, he's such a, he's not a judgemental man, he's a lovely placid man"* Celia found that her daughter's boyfriend became aggressive. *"He started to harass me, he started to phone me about once or twice, three times a day, screaming abuse, you bitch! You whore! I'm going to fucking make it up to you, you are, the only reason you're getting away with this now is coz you're (name of daughter) mother if you weren't (name of daughter) mother I'd have a gang of lads round there sorting you out right now you'd be sorted, it was terrifying I am not kidding, I've never experienced it before and it was terrifying."*

This situation culminates in Celia having a conversation with her daughter about the money she is owed *"she said mum I told you (name of daughters boyfriend)'s got it, she said no actually I've got 600 of it, he's got 600 so I said ok, will you phone him up and tell him I'm here and to come back with the 600? It was like about quarter past 5 he comes back at quarter past and erm (laughing) she phoned him, it's not funny, it was terrifying, she phoned him and he pulled up at the end of their drive which is a cul-de-sac and he, I went to the door and I opened it, and he leapt out of his van and ran down the avenue screaming you bitch! You whore! Get out of my fucking house, coming here and shaming me into giving you money and that was it absolute uproar and he smashed his front window, he smashed the glass pane in his front door, he got a piece of metal they were doing up their house, don't know what it was, a sharp piece of metal came within about that far of my face* (gestures) *and I thought shit he's going to kill me, this is it, or at least do some harm and erm, but I didn't flinch, I didn't flinch I thought no, I really stuck my, you know I got stuck in I was determined not to leave without that money and I said, I know you've got that money (name of daughters boyfriend) and it's mine, it's not yours, you've got no mortgage to pay you've got nothing to pay!"*

The final straw as Celia refers to it is not the threat of violence perpetrated towards her, but her daughter's reaction. *"I was just like, I'd lost it I'd totally lost it and it was that row with my daughter that was the the last straw if you like, because no, I didn't row with her, but it was her watching what was going on, you know, for the first time she was seeing him, no the second time actually because he'd done it when he dragged me out to the car and she was sat in the car, I'd got over that but this time was worse and she didn't do anything, now I know she was believing and I know she's in a terrible situation really I really do coz I've been in love with scumbags in my day since I left a lovely dad and my mum just stood by and said nothing you know, because she was a wise woman and she knew that if you're in love*

with them you're in love with them and you won't hear what they're going to say and I always thought well she loves him and she won't hear it even if I tell her he's a scumbag, it'll just go right over the top of her head and at the worst it'll put her in a terrible situation but I'd not had to tell her, she'd seen it this time, she knew what was going on, how he was behaving and what he was capable of and even with the metal thing when he'd gone like that, she was only there (gestures) and she'd not moved! All that was running through my head, ohh this is where (crying) this was the bit that was the last straw..."

The strength of feeling here was immense and the bonds between mothers and daughters as described previously strongly resonated with Celia attributing her actions to her sense of loss in relation to her daughter and she then says;

"I'm alright, I'll be, this is the end now, so it's (sigh and crying) I knew that I'd been out with men in the past who were awful, violent, liars, cheats, you name it, they all found me (sniff) but there's one thing I wouldn't have let them do, I would never had let them talk to my mum like that or have threatened my mum or called her a bitch or a whore and said nothing! Just stood there silently, I never never even if I did love them even if I made it up with them afterwards I wouldn't have done that, I just couldn't believe it really that she was silent and I was just I was driving home from there back to the office and what made me, when (name of business partner) said what's the matter and I said (name of business partner) (name of daughters boyfriend) stealing the rents and all of the financial thing was like a burden and a maze, I couldn't get out of that, I would have got out of even if I went bankrupt so fucking what! excuse my language, but if this boy had come in off the street and done all that to me if some con man had just wooed me up in a haze and got me money out of me and I'd suddenly realised and even threatened me, I would have gone to the police! Or, I don't know what I would have done, I would have done something but I would have handled, but it was the soup with (name of daughter) in, that was the thing I couldn't handle and that was the day when I started to tell myself (sigh) I'm drowning and she just doesn't care (emotional) and that was it, it was just the the message in my head all the time (sigh) she doesn't care I could be dead and then I started to notice that she never phoned anymore and never came round anymore and she knew I was suffering and I was in deep debt and I was worried and all of that, but no mention of anything only would I sell the car to pay (name of daughters boyfriend) and then saying I was a liar and all of that she basically she was believing him you see (sniff)."

Celia returns to the theme of her public and private self when she says "*the truth of it, I wasn't well and I wasn't coping...and I was getting poorly*" followed slightly later by "*I was still trying to present as erm, competent and in control and I wasn't I was just in pieces.*"

Immediately before she turns on the engine of the car she has a distressing telephone conversation with her daughter "*she said we're fucking moving, we're sick of you, we're fucking moving and we're not going to fucking tell you where we've gone (sniff) and then she just put the phone down, ohh (laughing) but that was the moment (sniff) that was the moment my mind said.. I've lost everything (distressed and crying) and I thought he'd got her as well then (crying) I just thought I'd lost everything (crying) I didn't want to lose her no matter what really (sniff) even if she was going out with someone that I hated! I really hate him now ahh (sniff) but I just couldn't see the point anymore (crying) and I didn't want to get out of the garage and open the fucking door (crying and distressed) and I didn't, no not slept I'd not slept for months! And months and (sniff) but that, I didn't see that then as a problem, it was just more time to think and how to get out of the trouble... I said to her, the thing that, what saved me, when she said to me, we're fucking moving and we're not going to tell you where we fucking are I said oh alright then, that's funny coz, and I know I went calm I went really calm inside the the racing in my head stopped and ahh, it was like, just the stopping everything stopped and I said to her, I must have said it in a different voice and I I said oh alright, you won't hear from me again, I'm in the car and I'm going to turn the engine on (sharp intake of breath)...*"

Celia's reference to what "*saved*" her as opposed to seeing this as a failed attempt to gas herself is interesting and possibly reveals a desire to feel cared for and not merely caring. Yalom's (1991) work with cancer patients facing imminent death has resonance here. Yalom contends that the inevitability of death is protected by the idea that we have personal specialness which provides a sense of safety from within. Whilst the belief in an ultimate rescuer permits us to feel cosseted by an outside force and even though we may arrive at the edge of life, there is an omnipotent servant who will always bring us back. Yalom's therapeutic work revealed that an awareness of death can enrich life and in drawing on the words of one of his patients to illustrate this, he recounts how "*the physicality, of death destroys us, the idea of death may actually save us.*" Yalom (1991 p7).

Celia goes on to say "*...that was what I said and you know, oh God, I must have been ill, I put the phone*

down I clicked it off (blowing nose) and err, because of all the to-ing and fro-ing, it's an estate car and the back was down and me coats were in the back (sniff) and it looked dead comfy (laughing) so I just turned the engine on and I thought I'm just going to sleep and I thought, I just really didn't think, and I just wanted to go to sleep and I was (crying) sounds such a cliché but I was just heartbroken that's the only word I can use, I just felt heartbroken and I'd lost everything and I didn't know what the point of going out of the garage would be! What would be the point! Where would I go! (Crying) I just wanted to go to sleep just sleep."

Celia's reference to being ill is again interesting, particularly in the context of an earlier statement where she says of her mother's diagnosis *"and I knew it was terminal and I knew she was very unlikely to get through it she was 81 when she got it and 83 when she died and I think we all knew it was probably the last thing she was going to have, but she always used to say I'd rather have this than what I had before* (reference to a diagnosis of depression) *and I do know it's, ohh, it's like being in hell."* The implication being that to have depression is worse than cancer. It is difficult to gain clarity without asking Celia what is meant here, but one suggestion may be that it is perceived to be worse due to the response and reaction of others and for Celia her experience of "*depression*" has been a lonely, rejected and abandoned one.

"I remember what it was, I'd not clicked the phone off and it was ringing but I wasn't answering it and do you know it didn't occur to me that she'd tell anybody, I just said it, and I thought, it didn't even occur to me that she'd care, I just, I was so so so convinced a real conviction that well, I didn't even have, I didn't have people that cared about me in my life anymore that's what it was like, I didn't have those kind of people anymore, something had happened and they'd all gone (laughing) (sigh) it was like a real aloneness a real just completely alone alone and with no, it wouldn't have occurred to me to ask for help, it wouldn't have occurred to me to actually phone anybody and say how I was feeling." It is possible that by recognising that Celia's daughter may care enough to tell someone of her plight, there may be a glimmer of hope for their future relationship. This aspect of the account was reported towards the end of the interview; however, the theme of being alone is a pervasive one throughout Celia's story and warrants further consideration.

Loss and ultimate aloneness

Celia describes *"a few weeks before I'd thrown my boyfriend out because I'd discovered he was having an affair with a young lady on my estate and basically in retrospect its very easy to erm, you know understand, he got bored I was looking after my mum 24 hours a day I was not taking care of my appearance and I wasn't interested in sex I'd just like not got the, the relationship was totally neglected some young lady invited him to dinner and he went and I mean I was furious, hurt, upset and exhausted, then you know scenes, threw him out, took him back, threw him out, took him back, and then on the, just a few weeks before my mum died, I said, look, I can't do this anymore, you'll have to go and don't come back this time coz I've got to do this! And I knew I didn't have much longer with my mum so that's what I chose I'm glad to say, so I'd lost him I'd lost my mum and I'd lost my daughter in the space of six weeks."*

Celia's loss of her mother, partner and daughter are fundamental to her sense of self and relation to others. Yet it goes further than this, Yalom (1991) states that existential isolation refers to the gap between the self and others. In an earlier text this is explained as even more basic than interpersonal isolation, which derives through loneliness, and intrapersonal isolation when parts of the self are split off, as it applies to existence (Yalom, 1980). Therefore despite engagement with others and having an integrated self, existential isolation refers to the gulf between oneself and any other being and a separation between the individual and the world.

In addition, Celia clearly feels alone and with an acute sense of responsibility. When she says *"and when you're in partnership you don't feel quite so, you know, alone, but what was dawning on me was I was alone with this debt."* This is reminiscent of Yalom's assertion that decisions, *"if deeply considered, confronts each of us not only with freedom but with fundamental isolation-with the fact that each of us alone is responsible for our individual situations in life."* (Yalom, 1980 p323). Celia's sense of being alone is not only in an interpersonal sense but also, given the situation she is in, is her lone responsibility to manage.

Yalom (1991) contends that one way to try to dispel the anxiety associated with existential isolation is through fusion with another. The less positive consequence of this is an eradication of self awareness yet relinquishing interpersonal fusion means to encounter existential isolation with its dread and

powerlessness (Yalom, 1980). It may be such dread that contributes to the difficulty in the dissolution of relationships no matter how problematic they may be. Celia was able to extricate herself from the relationship with her partner but by her own admission this was not without its difficulties for her "*there you know nursing her right to the end and I missed her a lot and missed my daughter terribly and my boyfriend! I didn't have! You know I was going home to an empty house!*"

This theme is returned to later in the interview where Celia states "*I was in the pits of me financial disaster, disbelief about (name of daughter), terrible hurt about (name of daughter's boyfriend) (laughing), I really loved that boy I did and his 2 dogs I thought he made us a family again*" and adds weight to the impression that this sense of being alone was a key factor in Celia responding to these events in a way that was out of the ordinary for her.

Postscript

Taylor and White (2000) consider professional practice in health and welfare to be a messy and complex business. It is also contended by these authors that multiple realities exist within this complex business and that the variety of compelling perspectives will ultimately impact on the subsequent response from professionals working within such arenas.

For me I was liberated from this as I had no need or right to disbelieve what Celia was telling me and as she portrayed the details of her account there was only one compelling perspective. I accepted that was her reality with regard to the circumstances she was recounting. I was however mindful that Hollway and Jefferson (2003) contend that in everyday informal dealings, accounts are not taken at face value, unless one is naïve. To me this seems a cynical position and I am aware of Taylor and White's (2000) arguments that the validity of what people say is not gained from a rigorous process of questioning and clarification, but through the sense we gain of the person's moral position in relation to the topic under discussion. That is to say, the ability to produce an account which is believable is dependent upon that account being heard as morally adequate.

Celia and I met following telephone contact and the interview took place in the faculty boardroom which initially seemed forbidding as it did not have any of the attributes I considered to be welcoming and thereby conducive to the telling of Celia's story. That said this was soon forgotten as Celia embarked on

recounting her narrative and the nature of the room was no longer an issue.

It was interesting to me that Celia was eager to disclose the nature of her story and I wondered whether this might be due to the fact that there was no competition as Celia's is the only version of events I would be party to and perhaps this was liberating. Throughout the interview I had no reason to disbelieve what Celia said, her account remained consistent and for me this was an indication of what Taylor and White (2000) refer to as morally adequate.

That said, I wonder how much I was influenced by the feelings that were evoked in hearing this story. I felt Celia had found herself in a very difficult situation and the pain she had, and continued to experience as evidenced by the emotions and tearfulness during her account, made me wonder how I would have received this story had it been told in a contained manner without the show of emotion. I think the strength of feeling portrayed by Celia during her story engaged me further in its details and in this sense I identified with her projections.

This being the first interview, I was able to make comparisons with my other experiences of the interview situation as a clinician. If I had been undertaking Celia's assessment in A&E my remit would have been around ascertaining the "*facts*" and making a judgment of potential risk based upon them. This activity represents a pressure, as assessing risk is notoriously difficult. In writing up the assessment I would have used terms such as "*appears to be*" or "*it seems that.*" Merely accepting Celia's account without the associated burden of trying to see into the future, which is essentially what risk assessment is, was liberating to me. My role in listening to Celia's story felt very different to that of a clinician and I was also struck by the fact that Celia and I seemed to have a different conception regarding the term self harm. For me I would have referred to the incident prompting Celia's attendance at A&E as driven by thoughts of wanting to end her life and in this respect it seemed more in keeping with suicidal ideation than self harm. Yet Celia made reference to being saved in the interview. This was an interesting juxtaposition and prompted me to think further about terminology and its use.

As a consequence of spending time with Celia, listening to her, sharing that time and the experience of hearing a painful story I was struck by my need to make sure the experience was meaningful to a wider audience and in doing so, that the research findings translate into something productive.

I have considered why I did not follow my semi-structured questions during this interview and with hindsight I am confident that only loosely following the schedule has not been detrimental to consequent interviews. However, at the time of hearing Celia's story I wondered how much my inability to intervene and stick to the semi-structured agenda was due to regarding the situation as potentially cathartic for Celia and therefore respecting her space and time.

In this respect being reminded of Sque's (2000 p26) comments that; *"Therapeutic effects (which alter the account) may occur because narration provides a vehicle through which participants are able to communicate the complexity of their lives. As they are part of the events, telling may illuminate many issues that help them to make sense of their past and present experiences."*

The author goes on to state that narrative allows a full account of experiences to be given and it is rare to have the undivided attention of another who is willing to engage in this experience to the extent of the researcher. As such, it may be that Celia experienced some personal gain from the research process. This was reflected in Sque's (2000) study concerning people who had experienced bereavement and whose significant other had donated organ(s) where being interviewed was acknowledged to be a difficult but not a regretful experience, particularly if it meant helping someone else. The issue of helping someone else resonated with Celia as she commented to me off tape that she was keen to be interviewed as she had received a lot of help and wanted to help others.

I am also aware that my reluctance to intervene during the telling of Celia's story was a consequence of feeling grateful that she had agreed to be interviewed and a sense of relief that I had my first participant. I feel this may also have influenced my refraining from asking the difficult question which played on my mind which was whether she had felt any sexual attraction towards her daughter's partner.

If I had heard another version of this story, told for instance by Celia's protagonist, my response may have been more complex. As it was, I recall that throughout the telling of this narrative and following the interview I had a sense of sadness in relation to the story Celia had recounted. I also felt angry towards her daughter's boyfriend as having enjoyed a successful career and seemingly a comfortable lifestyle, Celia had been pushed to the brink by circumstances outside her control and this poor treatment of her seemed inexcusable to me.

Chapter 5

Margaret (Interview 2)

This chapter follows the same format as Celia's with biographical details to introduce Margaret to the reader, leading to Margaret's relational voice and the events which led to her attendance at A&E. In the final section of the chapter, the emerging themes which became apparent to me whilst working on Margaret's narrative are considered.

Biography

Margaret is a 58 year old woman, and is married with 4 daughters and a son, her eldest daughter was conceived during a previous relationship before she met and married her husband.

Margaret comes from a large Catholic family who are of Irish descent; she was the youngest of thirteen, had ten sisters and two brothers and Margaret's mother was forty-eight when she was born. Margaret remains in contact with some of her siblings but does not find relationships with her sisters completely satisfying. There are a number of difficult experiences from Margaret's past including her father who developed an alcohol problem, beat Margaret's mother and who left the family home when Margaret was a teenager. She describes complex relationships with her sisters whilst growing up, saying she often cleaned and cared for their children from the age of 8 and says that at least 2 of her brother-in-laws abused her when she was young.

As an adult, Margaret primarily stayed at home to care for her children and she and her husband used to have their own business, a shop, which they owned for over twenty years. This seemingly provided them with a good life and Margaret's husband now works in a local supermarket. They spend much of their time together and have lived in their present home for the majority of their married life. Margaret is proud of the achievements her children have attained and describes close relationships with her daughters.

Margaret came to be interviewed by me following an overdose of paracetamol taken with alcohol 3 months earlier. The motive for this action appears to be related to her relationship with her son and the influence of his partner. Margaret first introduces her son's partner in a distant and depersonalized way referring to her as *"this Italian girl"* which appeared to convey Margaret's feelings towards her. However,

as the story unfolds, the *"Italian girl"* is portrayed as a powerful influence on Margaret's son and his growing lack of relatedness to the family. This is a theme which is returned to throughout the narrative but prior to such discussion the relational voice in Margaret's narrative will be considered.

Reading for the relational voice

Where Margaret uses the pronoun *"I"* a number of themes emerge, its use is notable in relation to her recollections concerning her family. These centre on her desire for them to be in close proximity both in a physical and emotional sense.

There are also instances were she feels compelled to defend her family, there is an occasion where her son's girlfriend calls English girls *"slappers"* which results in a vociferous defence by Margaret who, by her own admission, primarily wished to defend her daughters. Conversely she wishes to distance herself from her son's behaviour when it is revealed that he resumed his relationship with the *"Italian girl"* without his current partner knowing. Margaret is *"disgusted"* by this and keen to ensure that the girl in question did not think she and her husband knew anything of this betrayal.

Margaret is able to own the parts of the story where her situation seems hopeless as though everything has become too much and uses statements such as *"I've had enough."* The depth of feeling is acknowledged through the use of the metaphor, *"without a light at the end of the tunnel."*

Margaret's self perception can be discerned by reading for her relational voice and she makes the observation she is a better friend than enemy. This conveys a warning to others that it is advisable not to aggravate her. Margaret as the resourceful helper is also portrayed in the narrative. She talks of *"getting through"* to an ex-girlfriend of her son's and there is a sense of how important this is to her, not just in relation to her self image but also in relation to how she is seen by others, her public self.

She describes a difficult relationship with her mother-in-law but feels that she had *"conquered"* her and felt sure she knew that Margaret was there for her. This may relate to her perception that she had to work hard for love. She then talks of idolising her own mother which may compound her difficulty in accepting her son's treatment towards her, particularly as she can not find the answers she craves to explain it.

Margaret's desire to ensure that her son's ex-partner did not think that she and her husband were implicated in his betrayal of her is not the only occasion where the importance of others perception is conveyed. She wants to be a good neighbour, reliable and thoughtful. The effort she makes for her family is also important to her. Wanting to celebrate the announcement of her son and the "*Italian girl's*" pregnancy, despite her dislike of her son's partner and her view of having always worked for her family are typical accounts of Margaret's story in this respect. This perhaps helps to explain why it is so difficult for Margaret to accept that she has been usurped by her son's partner and that he was listening to *"her"* as opposed to his mother.

Margaret reiterates a need for reasons at different times during the story, when she says "*if someone had been sort of hurtful, I need a reason for it.*" This may reveal her struggle to understand when she sees no apparent explanation. It is also interesting when she recounts considering taking an overdose, she states "*I love my husband and (name granddaughter) but I just can't cope, you know, there's no reason for me son to be the way that he is, because I mean, all he's ever had is love,*" again her need to comprehend is portrayed and clearly couched in terms of her perception of her son and his behaviour.

The power of this perceived relationship breakdown with her son is compounded by her acknowledgment that she always wanted a boy. There is a degree of ambivalence in Margaret's ability to completely blame her son and at times this is projected into the "*Italian girl.*" It is also interesting that her comprehension of surviving the overdose is couched in terms which distance her from it and attribute the reason for this being that God was not ready for her.

Margaret's sense of being alone is conveyed were she talks of feeling there is no one to help her, but also in the sense of being in the car on a day trip with her family, seemingly appearing happy and content, yet planning to take an overdose.

The use of *"we"* in the narrative generally denotes Margaret's affiliation with her family and in particular her husband. Margaret says they are always together and there is a clear sense of this in her recollections. Despite this she clearly feels a sense of being alone at times, such as in planning the overdose and not feeling there is anyone to help her.

There are occasions where Margaret uses *"we"* where *"I"* could have been used. This is illustrated during the conversation with her son's ex partner where as above, Margaret is keen to state that his deceit was not something either she or her husband knew anything about. There is a further occasion where she says "*we all get a bit sort of thoughtless.*" Perhaps this is difficult for Margaret to identify with and in extending it to a collective *"we"* she can acknowledge this without completely owning it. Likewise it is not just her, but her and her husband who can no longer tolerate the treatment of her siblings towards them.

The collective responsibility of being a good family is acknowledged by Margaret and likewise her devastation when the insensitive disclosure of her eldest daughter's paternity is shared by all the immediate family, not just Margaret.

When Margaret's son's imminent departure abroad is revealed and he leaves without talking to his mother, Margaret recalls how she and her daughters could not believe it. Perhaps this shared disbelief feels easier to manage and possibly conveys more weight to the opinion that what he did was unreasonable.

Margaret's use of *"you"* is primarily in the context of describing another person or them referring to her, there are also numerous occasions where she says *"you know"* or *"you see"* or *"what have you"* seemingly to encourage connection with the story.

Additionally there are also instances where one may infer that a certain amount of distance is required from the topic and rather than use *"I," "you"* is substituted. Examples of this include where she feels the *"Italian girl"* is dismissive of attempts to forge a relationship "*and I said, right the past is in the past, let's look to the future and it's just all sarcastic remarks you're getting back, you know as if she's taking your hand and slapping it.*" This is also evident in relation to the overdose *"how can you think this when you've got (name of grandchild) next to you, and, and I thought no, I just don't want to go on"* and the feelings associated with being in A&E as a consequence *"I mean, it's, it, you feel ashamed, you know."*

In keeping with how others perceive her, it also seemed that considerations of how other people would judge the overdose were important to Margaret *"but erm, I mean the sad part is, is that you feel erm, that*

people think, you know, well, yeah it is, it's a cry for help, but if there'd been more tablets there." This also relates to considering that there is a possibility she may not have been a good mother. *"I mean, I perhaps, I wasn't a good mother, and the kids say, don't you ever say that Mam, you know, but I said, yeah but, you think there's something wrong.*"

The issue of mastery and control is interesting in Margaret's story. At times events are portrayed with a sense of inevitability *"you know and er, I know its not right to feel that way, you know, when you've been given your life but you can't help it, when something grips at your heart, you know."*

It is not only the recent past where Margaret distances herself from the narrative, thinking about her place in the family saying *"even now, its like erm, you're different because you're the baby of the family"* and *"but erm, it, it's just like I say, you just feel as though you're fighting for affection.*" There was also a sense towards the end of the interview that abuse was merely something that happened and again links to a sense of inevitability *"I just don't know what, I mean, things, when you were younger did go on like that."* This sense that events merely unfold without the exercising of individual agency was one of the themes which ran throughout the story as discussed below.

Emerging Themes

In the name of the Father, the Son, and the Holy Ghost

The theme of religiosity is referred to when Margaret talks of her sister as a *"do gooder of a kind at church"* who visits people close to where Margaret lives but as Margaret says *"never calls to my home."* This sentence is not simply indicative of Margaret's ambivalent feelings towards her sister but having conceded that all the family were brought up as Catholics and *"I have got a lot of faith"* may also indicate her pervasive moral code of what is perceived to be right and wrong. This may explain Margaret's continued contact with her sisters despite her disappointment in them.

For many people spirituality, whether channelled into a formal religion or not, can be a source of comfort and direction and Margaret alludes to this in relation to her survival of the overdose but also gives the impression of control by a distant other when she states *"I just think God wasn't ready for me yet."* In terms of Margaret's own mastery of her life circumstances and situation this may be a source of concern.

This external locus of control may have implications in Margaret's sense of survival. It may be interpreted by Margaret as a protective factor against further harm as having tried this she has concluded that God was not ready for her. Conversely it may be that she can test and tempt this and with continued survival from harm, God continues not to be ready for her and in a way this is a form of feedback. Clearly this would be of concern in terms of Margaret's health and wellbeing but alternatively could also be the evidence she needs to carry on living. As Bell (2000 p26) states *"many suicide attempts occur in the context of beliefs of indestructibility."*

The theme of three powerful entities, the Father, Son and Holy Ghost is not merely related to issues of spirituality and religion. Karpman's (1968) drama triangle can be illustrated here with the Persecutor, Victim and Rescuer being apparent throughout the narrative. This can be seen in relation to the precipitant factors preceding Margaret's overdose which portray her son as Margaret's persecutor, fuelled by the *"Italian girl."* On asking Margaret what led her to being admitted to A&E she told me *"it was just erm my son, I've got four girls and a boy erm and he's always been erm, I don't know self centred really."*

Immediately Margaret's son is placed at the centre of the story as the protagonist and persecutor, the implication is that he or his behaviour is the reason Margaret found herself in the unenviable position of taking an overdose and in doing so is the victim in this story.

However, it is important to note Bell's (2000) contention that suicide attempts never take place for the stated reason, at most the reason given is a trigger and what is recalled consciously is usually a rationalisation more than an explanation. As such, in the pursuit to understand the context of Margaret's overdose, psychoanalytic theory can be considered.

"Penis envy" is a central concept to Freudian theory and advocates that the girl envies the power the penis represents. However, this has been the focus for much criticism and Flax (1991) notes that there is a reversal in the actual power relation in this theory as assuming the mother as *"castrated other"* is in need of a son to acquire the longed for penis suggests a grandiose view of the son's significance.

That said, Margaret's son did exert power over her, he was longed for and despite Flax's position it

could be interpreted that Margaret's psychological fulfilment did, to an extent, depend on her son. As such, this may help explain why Margaret's relationship with him can be seen as problematic and powerful.

Winnicott (1966) states that all individuals be they men or women, fear '*woman*' not as an individual but as a powerful agent in society. This, according to Winnicott, was due to those who develop well, who are sane and able to find themselves owing a debt to a woman whose devotion was absolutely essential for the individual's healthy development. The original dependence is not remembered nor the debt acknowledged but the woman figure of primitive unconscious fantasy has no limits to her existence or power (Winnicott, 1966 p165). Being influenced in this respect by Winnicott, Flax (1991) argues that the grandiose position of the powerful son also links with a sense of vulnerability in that conversely this may serve as a defence against the son's sense of powerlessness in relation to the mother and his fear of abandonment or injury by her. These contentions may relate to the relationship between Margaret and her son who she sees as having treated her badly.

Margaret says the service she used following her overdose was the first time of this nature and the extreme emotional state precipitating it may make it difficult to come to terms with and take responsibility for. With this in mind it is interesting to note that Margaret implicates her son in the reason for this but does not express this in terms of it leading her to take an overdose. Margaret herself does not feature here, almost as if she has no part to play and her absence may serve to protect her from taking responsibility.

During her story Margaret expresses ambivalence towards her son stating *"he's a good lad but really self centred and thoughtless, he can be very thoughtless but erm he's just err, he was in a relationship with a girl."* This represents the contentions of Parker (2005) who states that maternal ambivalence is an experience shared by all mothers and relates to the coexistence of feelings of love and hatred towards their child. This idea primarily derives from the work of Melanie Klein on ambivalence in children. Klein (1935) explains how the child can negotiate the conflict between love and uncontrollable hate and sadism towards their mother. This arises from the introjection of the whole and real object which is thereby taken into the self and brings the persecuting and good objects closer together. When this happens the ego turns to the mechanism of splitting the *"imagos"* into good and dangerous, loved and

hated and it is at this stage that ambivalence sets in (Klein, 1935). This, she states enables the small child to gain more trust in its real objects and as a result, internalized ones. Additionally at this stage of development each step in the unification of the external and internal, loved and hated, real and imaginary objects leads again to splitting.

However, as adaptation to the external world increases, splitting becomes increasingly nearer to reality until love for and trust in the real and internalized objects is well established. At this point in normal development ambivalence, which Klein (1935) states is partly a safeguard against one's own hate and against hatred towards terrifying objects, again diminishes to varying degrees.

Clearly this focus is on the developing child, yet as Winnicott (1991) states, the health (which must include mental health and by definition the way in which one relates to others) of an adult is being founded throughout childhood, but the foundations are laid by the mother in the baby's first few weeks and months. Thus, the progression of the process described is crucial not only in infancy and childhood but also adulthood and is therefore relevant to Margaret as a grown up and mother.

In taking this position, Parker (2005) applies the notion of ambivalence to mothers and states the problem is not the feeling itself but how the mother manages the guilt ambivalence provokes. One way in which Margaret may manage her feelings of ambivalence is through excusing what she regards as her son's thoughtless behaviour. When she states *"he's a good lad but really self centred and thoughtless, he can be very thoughtless but erm he's just err, he was in a relationship with a girl."* The implication in Margaret's story may be that she is not quite able to place all the responsibility for her son's behaviour on him, there was someone else also involved. There is also the sense that before his relationships with the two women mentioned in Margaret's story, he did attend to the family, this is alluded to when Margaret says of her son's previous girlfriend *"she thought it was like, sick you know, that he was so into his family."* Similarly the "*Italian girl*" is seen as doing *"everything she possibly can to push us out of his life."* It may be that this view enables her relationship with her son to be defended. As such the events are not solely her fault or her sons.

The issue of locus of control is alluded to again and there are further examples of this throughout Margaret's story. For instance she describes her son's previous girlfriend to the "*Italian girl*" saying *"she*

wasn't a very nice person, erm but then she'd had a bad erm home life you see." The reason for her not being very nice in this instance is again seen as being located outside the person.

Conversely when Margaret's son and the "*Italian girl*" lived with Margaret and her husband for 6 months the "*Italian girl,*" as the fuel behind Margaret's persecutor, "*was rude, she was arrogant, she was dirty, she was lazy*" the language here is of ownership. The "*Italian girl*" is seen as being these things, it is not that she acted in this way nor had a valid reason such as a poor family upbringing to excuse her. Interestingly the locus of control does seem to reside within the "*Italian girl,*" it is not seen as being from an outside uncontrollable source and thereby excusable. However, following the final insult being directed at her daughters which Margaret describes saying "*one day she said (name of participant) I said what? She said all English girls are slappers, and I just, I said how dare you, my daughters are English girls, I never even thought about myself and erm I said to me son that's it."*

Margaret proclaims she has had enough and the protection she feels towards her daughters is an example of the importance family has for her. Additionally she was able to rid her home of the "*Italian girl*" and once the couple moved out the relationship between Margret's son and the "*Italian girl*" only lasted 2 months. This is an example of Margaret as victim turned rescuer. However, this was not to last and she was unable to fend off the perceived threat from the "*Italian girl.*" When it seemed to Margaret that things were improving, the efforts she had made were shunned by her son as he did what may have been considered the unthinkable and resumed his relationship with the "*Italian girl.*"

"...and then he just, he was with her 12 years they'd got a house together and everything and then he just said to me, I'm finishing with (name of first girlfriend) and I said why? I couldn't believe it, he said I've been seeing (name of Italian girl)!...I just said how could you do that on a girl."

The fact that Margaret uses the term "*on a girl*" as opposed to a more personal description, such as her name, may be reminiscent of Margaret's negative feelings towards this person. Additionally it may also be an insight into her belief that regardless of who it is, her son should not have behaved in this manner and may resonate with her own experiences of being treated badly by men.

Margaret absolves herself, her husband and family (excluding her son) from responsibility in relation to

her son's actions. *"She was devastated and I got in touch with her and I said I'm so very very sorry and she said, it's not you, it's, you know, she said and I said well, please don't think we knew anything about this it's a first but I'm disgusted you know and I just went into it, erm and then the Italian girl she come back, I said you better bring her down and that erm, and she was so cocky when she come down."*

The use of *"disgusted"* is perhaps indicative of Margaret's sense of what is right and wrong. It may be related to the girl involved, or the negative experiences women endure at the hands of men as derived from Margaret's own history. Perhaps she is also disgusted with the *"Italian girl"* and regarding her as being *"so cocky"* is perhaps added weight to the argument that she is a bad person. This is further exemplified when Margaret says *"when it was my birthday in (month) she went and booked a flight over to Italy for him and her and then Christmas, we always spend Christmas together."* Encouraging Margaret's son to go against family tradition by making sure they were out of the country for Margaret's birthday and Christmas further compounds Margaret's negative opinion of her son's partner.

Again the sense of lack of control here is palpable and Margaret says *"but I just don't feel as though what's happening to me is real."* Feeling disconnected to an experience makes it very difficult to implement change and as such there appears a degree of helplessness in this statement. Antonovsky (1987) states that the components making up a sense of coherence are comprehensibility, meaningfulness and manageability, here Margaret says *"if someone had been sort of hurtful, I need a reason for it"* yet the feeling is there was no reason for this, it made no sense to her. Perhaps her perceived lack of control over the situation and a feeling of betrayal that her son was listening to another woman rather than his mother compounded her lack of understanding.

A further example of the drama triangle (Karpman, 1968) within Margaret's life is the contentious relationships she has with the male members of her family, her father, the absent alcoholic who physically assaulted her mother, the son who disappoints her despite her best efforts and the Holy Ghost or ghosts. These being the men from her past who mistreated her and are dead or absent. These can be seen to include the boyfriend who abandoned her and the brother-in-laws who she said abused her when she was aged 7 or 8 which Margaret describes saying *"two of me brothers in law got hold of me when I was little."*

The rescuers include her mother and in later life, her husband who came to her aid when she had been treated badly and was an unmarried mother. There is also a sense that some members of Margaret's family can be her saviour when she says "*I just thought, well they're just better off without me really, and it's daft, because me girls, I mean really, you know they'd give you their right arm, you know it's it's they're so good my kids, I mean we all get a bit sort of thoughtless and what have you, but I mean, you know, they're always phoning me up, they're always down, down for tea or we're up there for teas, you know it's just me son.*"

Flax (1999) makes the point that within object relations theory the story of human development is told from the child's viewpoint. Yet Parker (2005) turns this around placing the mother as having to negotiate a maternal depressive position. Maternal ambivalence signifies the capacity to know herself and tolerate traits that she may not consider admirable and hold a complete image of her baby. This is relevant as a mother's self esteem is seen to be locked into the feelings she has for her child. As illustrated where Parker (2005) contends that the dominant cultural belief is that a child's personality is determined by the mother as the primary caregiver and is seen as culpable when things go wrong.

Thus women appear to be convenient scapegoats in this respect which is curious as Flax (1991) states that although part of the child's self is constituted through their internalisation of caretakers, the child incorporates more than their experiences of specific persons. She goes on to make reference to Freud's theory of the superego stating the child also internalizes the mother's, father's and other caretakers past and present object relations and that to an extent the parents' entire social histories become part of the child's self.

It is also pertinent to stress that life is inherently difficult. Winnicott (1991) clearly states that all children show evidence of adversity regardless of upbringing. "*Even the most kindly, understanding background of home-life cannot alter the fact that ordinary human development is hard, and indeed a perfectly adaptive home would be difficult to endure, because there would be no relief through justified anger.*" (Winnicott,1991 p125).

Yet this belief around mother blaming, as described by Parker (2005) is even apportioned to the perceived failings of others. "*Mothers are seen as either promoting or hindering the process of a boy*

forming identification with the less accessible father" (Parker, 2005 p264) and that it should be enduring and pervasive is interesting in itself. However, this view has been criticised and Ussher (1991) states that whilst mothers have been a convenient scapegoat throughout the centuries, psychiatry and psychology have taken this to a different level and afforded mother baiting and hating as scientific fact. This Ussher (1991) exemplifies with reference to culpability being levelled at mothers with regard to the development of childhood illnesses, disturbances and delinquencies, schizophrenia, depression, psychopathy, personality disorders, homosexuality, autism, anorexia and child sexual abuse.

Ussher's (1991) argument is attributed in particular to family therapy and leads her to conclude that such models of the so-called normal family are at best androcentric and at worst misogynistic. This argument has credence against using theory which may reinforce notions that mothers' are culpable for their adult children's behaviour. That said, such notions may represent common beliefs and one's which may be held by Margaret.

As stated, Winnicott (1991) proposed that adult health is founded throughout childhood, but the foundations are laid by the mother in the baby's first few weeks and months. As many of Margaret's past experiences of men have been problematic, her absent violent father, her abusive brother-in-laws, the deceitful married boyfriend who abandoned her, the effect of these experiences may manifest in Margaret's feelings towards her son. If he had been perceived as the caring, thoughtful and attentive child her daughters are, in conjunction with the positive experiences she has had through being married, this may have assuaged some of the feelings derived from her past, and Margaret could have considered herself a successful mother.

However, Margaret's son is not regarded in this way but rather as self-centred and thoughtless perhaps reinforcing Margaret's past experiences. The associated difficult feelings may feel unmanageable and in Margaret's mind split, be disowned and projected into her son. The difficulties Margaret experiences in relation to her son may represent feelings of loss that he has not turned out to be different, that he lets her down and may relate to other difficult circumstances in her earlier life.

"when I was 18...me dad passed away... when I was younger he never drank he used to read a book, then he started to drink, he started working at this pub, collecting glasses and stuff, and erm, then, then

from an early age, I'd seen him hit me mum, you know, and erm I've seen him, it was, it was worse, when I've seen him just hit me mum, but erm, when he started drinking he, he, he went quite bad, you know, and erm, me mum started retaliating but me mum was always with us and always did her best for us and erm, I mean, I loved me dad don't get me wrong, erm, but then, when I was erm, 14, he walked out and then he started living the life of a tramp, sleeping on crofts, and things like that, and people would see him from school and what have ya, you know, I was 12 when he first went, and they'd lip ya, and things like that... I say to my husband now, I think he's gone through, I think he went through the same feelings that I went through, I think it was just a case of worthlessness or you know, erm, like for me sometimes I just get fed up and I, I do, I think to myself, at times, I just want to run away, I want to live in a cave."

It is interesting that Margaret said she idolised her mother and yet despite his difficulties, or because of them, she identifies with her father in the passage above. The feelings of worthlessness she expresses may be explained by projective identification and in some ways perhaps when she wishes to run away and live in a cave she is able to do so vicariously through the memory of her father.

The concept of the Father, Son and the Holy Ghost and all that they represent has been shown to feature as a theme throughout Margaret's narrative. Another enduring and pervasive theme is how she sees herself and is perceived by others. Being good enough is crucial to Margaret.

Being good enough

The importance Margaret holds in relation to her family can be illustrated when she recounts her daughter finishing university *"her tutor was saying the best place is London and all this, that and the other, I've always loved my kids around me and I was just sort of devastated."* This sentence indicates a strength of feeling which betrays the importance of close physicality to her children and potentially what that means to her. The fact that Margaret says this following her explanation for attending A&E may relate to feeling she had betrayed her son and needing to redress that balance. As such, the reference here is not just in wanting her daughter close, but all her *"kids."* Perhaps in this sense Margaret may feel she is not only the victim but has also taken on the role of persecutor when she placed her son at the centre of the story.

Where Margaret recounts the events surrounding her overdose almost as an observer, this may accentuate the disbelief that she acted in this way and or, it may be a defence against the pain and realisation of her actions. This may conflict with her image as family orientated, as implied when Margaret says "*I've always worked for me family, I've always been with them, took them everywhere.*" Alternatively it may be difficult to own her actions in respect of taking the overdose and could reinforce her self image as she would prefer to be known. A further example of this possible dual explanation is where the "*Italian girl*" has effectively taken Margaret's son and now grandchild away, which fuels Margaret's rage towards the "*Italian girl*" who has orchestrated this or alternatively it may be that Margaret is simply not good enough for her son and has driven him away.

The notion of being good enough derives from Winnicott (1966) and refers to the mother, environment, experiences and conditions being *"good enough"* in that they are satisfactory enough to meet a need or impulse. Winnicott's notion is underpinned by theories of object relations which, according to Flax (1991) has the basic tenet that human beings are *"object seeking"* by nature and as such proposes the importance of our significant others in future development.

Flax (1991) contends that such theories embrace the need to have real and not just projected narcissistic relations with others and that objects are sought for the satisfaction of relating not merely to reduce drive tension. If objects in the child's environment are *"good enough"* humans will develop into beings which seek and find such relations. The child's bodily experiences cannot be separated from the object and are always shaped and given meaning by and within the child's object relations. As such, there is no drive without an object as instinctual impulses cannot be distinguished from their relational aspects (Flax, 1991).

Flax (1991) has more to say in relation to object relations theorists and gender. She states there is an assumption that mothers or other women are the primary caretakers of children but that the negative consequences of this are not explored. She states that a recurrent tendency in western contemporary culture is to blame relational and developmental difficulties on mothering that is not good enough. However, Flax contends that more attention should be focused on why one gender takes responsibility for such a formative period in human development.

Chodorow (1999) contends that typically mothers (as the primary caretaker) experience sons and daughters differently both consciously and unconsciously because of their similarity and otherness in gender. Flax (1991) explains this by stating that boys are experienced by their mother and experience themselves as *"other."* The mother encourages the son towards differentiation which is motivated by a need to reject the female parts of themselves and the primary relatedness with their mother in order to be male. Where as girls cannot and must not reject either of these due to ego boundaries between the mother and daughter being more fluid. As such, a daughter may be physiologically and psychologically like her mother but a son may contain all the unconscious aspects the mother has not actualised. Separation from her son who represents aspects of herself including agency, activity, and heroism or a striving for power, that she has denied in herself, can be as problematic for a mother as detaching from her daughter (Parker, 2005).

The mother's unconscious phantasies and feelings, as infant researchers have illustrated, can be communicated to the child, Margaret's conception of this relationship can be illustrated when she says; *"Whereas before, it was like, why is he doing this to me? Why is he doing? And I'm thinking well, you know, why have you done, you must have done something in your life, that you know, he, he, he's this way with ya, so I was blaming myself all the time for his actions and the way that he is."*

However, Chodorow (1999) also states it is the child themselves who creates the meaning of these communications. Yet Margaret's quote is representative of the pervasive societal opinion that mothers, as the primary caretaker are to blame for the child's failings, a role which is indicated when she recalls her sisters' opinion of Margaret and her husband saying;

"they call us the posh ones, and that's because we had our own business, but we just had our own business, that were all...but to them we were posh, you know, we'd got our own house and this, that and the other and I'd stayed with the children."

That Margaret was the primary caregiver for the children means that if Flax (1991) and Chodorow's (1999) contentions are accepted, her perceived failure to produce a son with the characteristics she regards as important, including his relationship with her and the family is a crucial issue.

However, it is not only Margaret who is potentially not good enough for her son. Margaret's husband also seems to have a strained relationship with him as illustrated when Margaret says *"he's never really done anything with his dad, it's like he'll go playing golf with other people without asking his dad, you know, and my husband says, it's sad because, I didn't have a relationship with my dad."*

Flax (1991) makes reference to the oedipal drama which lies in the conflict between the son's desire to identify with and overthrow his father and that the successful resolution of the boy's oedipal complex includes identifying with the father and abandoning the wish to overthrow or displace him.

Flax (1991) states that in a culture where gender is an exclusionary category, the son can enter the masculine world only by devaluing the female world. This includes his prior identification and internalisation of his relations with his mother. Margaret's son appears to have distanced himself from his mother as primary object, not least by usurping her with the *"Italian girl"* and Parker's (2005) description of the negotiation of the sequence of separations for the mother and child from birth onwards is pertinent in this context. She states that children move with more or less difficulty towards an increasing sense of themselves as separate from their mother, whilst she will evolve from one maternal identity to another. From supporting her baby's head, including holding their hand to waiting for a hand to hold. That Margaret could be waiting for her son's hand to hold may represent her feelings that she has lost him, he is no longer dependent on her and she is not needed.

As stated previously, Parker (2005) contends that a mother's self esteem is locked into the feelings she has for her child and the theme of being good enough is clearly apparent throughout Margaret's narrative, she further illustrates this when she says;

"I mean the things she was saying, when we get married and I have my babies, this is to me son, I'm going home to my mama and it was all I miss my mama and I said to her well why don't you go home to your mum coz you miss her so much if it were my girl she'd be back."

This may be a slight on the *"Italian girl's"* relationship with her mother. Alternatively and or additionally it may be a defence against the insults Margaret feels were dealt to her, her home and hospitality by inferring that she may not be good enough for the Italian girl, but she certainly is for her own daughters.

There is a hint of how important other people's opinions of Margaret are to her. One illustration is the concern she has in attending her son's wedding and grandchild's christening where Margaret recounts a conversation she had with her husband, stating; *"I won't go to the christening, won't go to the wedding and he said, but why shouldn't we? he said, just go and all you've got to do, is take a back seat, he said and erm, don't say anything controversial, or if anything's said to you, he said, I'm there, and your daughters are there he said, you know, I said well, it just feels as though for me that erm, it'll be, oh it's the mother, you know, and I just think well, it's so unfair, you know, and that as I say, at the time, all these things were going through me head, and I thought you know, I don't want people blaming me for things."*

The fellow attendees include people Margaret has probably never met, has no investment in and yet she is mindful that she does not want to be judged by them. Chodorow (1999) states that transference is the use of experiences and feelings which give partial meaning to the present as well as shape it as the person acts and interprets the present experience in light of the internal past. As such, Margaret may recognise the feelings she initially had towards her own mother in law explaining *"I mean, I had a bad time with my mother in law"* followed with *"I sort of conquered my mother in law really."* She does not want others to perceive her in the same way thereby illustrating how a past relationship exerts an influence over a present experience. There may also be a link with the contention that when people feel shame they are more likely to feel observed by others and more concerned with others opinions (Crowe, 2004).

This would fit with Margaret's narrative as throughout her story Margaret wants to portray that the family and by inference her as the mother are *"good"* she describes her children as *"they've all got good jobs, good homes what have ya and they're now starting families, you see, in their 30s."*

This links to Taylor and White's (2000) discussion of wanting to be seen as morally adequate when giving accounts of oneself. In portraying the family in this way Margaret may be trying to reinforce that she is believable and or, to discourage the sorts of judgments that could be made of someone who has taken an overdose. Margaret summarises this saying "I *mean, it's, it, you feel ashamed"* and it must be difficult to reconcile these feelings with those of family being everything.

Crowe (2004) discusses the notion of shame which she acknowledges as being linked with childhood sexual abuse and suicide attempts. She states shame is linked to the self in relationships with others and this can be seen to apply in the context of Margaret's feelings about the overdose.

There is a further consideration here in that portraying one's self as good enough or morally adequate may influence the response of others such as practitioners. *"They said to me at the hospital, how many did you take? I was frightened because I thought well, I don't want to be kept in, I was saying to my husband please don't let them keep me in you know, I'm sorry and that, you know, he said you're not staying in anywhere and I said I think it was about 10."*

There is a suggestion that Margaret did not tell the truth about how many tablets she took. Particularly when this statement is compared with what precedes it *"I just, well I looked first, we had, I mean, I hate the word now paracetamol but erm there were like 2 tubs and erm they said to me at the hospital..."*

Later Margaret says *"but erm, I mean the sad part is, is that you feel erm, that people think, you know, well, yeah it is it's a cry for help, but if there'd been more tablets "* (do you think you would have taken them?) "*Yes.*"

Perhaps she was seen as good enough and morally adequate whilst recounting her situation and therefore believable by the practitioner. For Margaret this worked in her favour as she clearly did not wish to be admitted to mental health services and she was able to prevent her fear from coming to fruition. This may demonstrate Taylor and White's (2000) contentions around the desire to be seen as morally adequate when giving an account of oneself and which may have influenced the practitioner's decision making process.

During her time in A&E Margaret says; *"I was looking round and I mean, I didn't know what it was at first and my daughter said afterwards mum there's no windows in it and err, I said, oh gosh, and me husband said, I think its for people who, you know, that have not been happy with their situations, you know, but erm, it was just erm, a lot erm, that you know, but erm, as I say, I just thought, keep thinking, did it happen."*

Margaret's statement represents a confrontation between the reality of her situation and the disbelief that her identity is now tied up along with those people who *"have not been happy with their situations."* The feelings associated with this are illustrated when Margaret talks about feeling ashamed but it is not clear if this is because others, including health care professionals are making judgements of her, her situation and the perceived need that she stay in a room with no windows. Or whether she feels she is taking resources from people more deserving than her.

Again Crowe's (2004) discussions regarding shame have utility here, particularly with regard to the perceived link with guilt. Crowe discusses how these are both self conscious and moral emotions however, the key difference is that shame is concerned with the self, whilst guilt with a thing either done or undone. Both of which could be seen to apply to Margaret's circumstances and are perhaps magnified by the suggestion that shame is an acutely painful emotion, coupled with feelings of worthlessness and powerlessness.

The sense of Margaret's loneliness despite having people around is illustrated when she says *"I just thought there's no one there to help, you know, there's no one to sort of, talk to you know, to make me understand what sort of steps to take afterwards, you know, it's just an independent, I listen to me husband, I listen to me daughters. I know what they're telling me, but they're involved like I say, I deal from the heart, you know, not from the head and erm, it was just like, from independent people, I just thought, well they're just better off without me really, and its daft, because me girls, I mean really, you know they'd give you their right arm...you know it's just me son."*

This perceived lack of support may be explained by splitting in that the girls are mostly good and the son is not. Flax's (1991) proposal that mothering is experienced differently by girls and boys also has utility and her son's differentiation away from primary relatedness to his mother in order to be male can be illustrated by Margaret's son's affiliation with the *"Italian girl."* This relationship is based on intimacy of a different kind and one which signals adulthood and maturity to the perceived expense of consideration for his mother and family tradition.

There is an insight into Margaret's self concept when she says *"I just feel as though I've always had to work very very hard to get people's love"* in that she feels she has to make an effort, maybe she feels

unlovable as demonstrated by her son's rejection. The hard work expended to get love may also relate to Margaret's first pregnancy.

The birth of her first child is also evidence that she did not do things in an acceptable way as her children, namely her daughters have done. The fact that she is the mother of these respectable daughters means she would be good enough if only her son would abide by the same conventions. This is especially notable in the sentence "*I mean now it is, it is what is happening in my family, you know, and it's just not fair, because we've been a good family.*" The use of the past tense betrays her beliefs regarding the influence her son and the "*Italian girl*" have exerted.

The idealised view of how it would be to have a son is described when Margaret says" *I always wanted a lad, and that's what makes it so hard*" as the fantasy has not come to fruition for Margaret and she struggles with making sense of the reality. The hint is that perhaps she was not good enough, she questions her ability to be a good mother which is completely flouted by her daughters but her son is a different matter. Perhaps it is his opinion that counts and or, simply reinforces Margaret's belief that maybe she simply is not good enough. The feelings Margaret has about her capability as a mother may indeed be split and the good projected into the daughters who may represent a closer conception of herself and the bad into her son who may be seen as different and potentially dangerous as he undermines Margaret's self image as a good mother for whom family is all important.

The sense of disgrace Margaret feels in relation to her husband and daughter who accompanied her to A&E is clear when she says "*I mean, to see the devastation on his face and on (name of daughters face) you know, was erm, it was just, I just felt so ashamed that I could have hurt them so much, you know*" and is precipitated by a discussion from the much further past. The connection may well be one of shame as Margaret talks of her pregnancy out of marriage and her fear of her mother's reaction. There is a brief insight given in relation to her thoughts surrounding this when she discusses the accomplishments of her children and their endeavours to start a family "*in their 30's.*" It could be that Margaret feels ashamed of a number of significant aspects of her life and in a way has tried to atone for it by being a good mother, neighbour, and person.

Margaret can be seen to be altruistic, caring for family, neighbours, even the son's first girlfriend who she did not like, but there may be a sense that she too can be selfish and the overdose may represent a

part of her which perhaps she is unable to own and instead is projecting into her son.

Margaret's story turns to being looked after when she states *"I've got the eldest one, erm she's 39, and (name) she's 37 in (month), now those 2 erm, are looking after me, sort of thing."* Perhaps this reveals her desire to feel cared for and not rejected as a consequence of doing something so upsetting for the family. Here she is good enough; she is worth investment and care and this may relate to Winnicott's (1966) notion of holding in which the mother provides an illusory environment for the baby. This is delivered through physical care but also impacts on the psychological and emotional development of the baby. This desire to be held psychologically can be evoked in adulthood. As such, Margaret's acknowledgement that two of her daughters are caring for her may allow her to believe they will continue to love and have affection for her despite her perceived failings.

"What does not kill me makes me stronger" (Nietzsche, 2003 p33)

There are painful situations and circumstances from Margaret's past which seem to have an effect on her present, a relationship which has been described by Yalom (1980) as follows;

"The past - that is, one's memory of the past-is important insofar as it is part of one's current existence and has contributed to one's current mode of facing one's ultimate concerns." (Yalom, 1980 p11).

In recounting her earlier experiences there is a sense of being there for others as an unpaid servant and child minder for her sisters or for the sexual gratification of her brothers-in-law. In later life this notion seems to have had a profound effect on her and can be illustrated by her attending to the needs of her sisters and neighbours despite this not being reciprocated.

When Margaret expresses the desire in relation to her sisters that *"what I feel like doing is telling my sisters what our (name of son's) gone like with us so they can laugh at me"* it could be one of feeling more comfortable replicating earlier relationships and or, it may be a desire to convey the feeling that actually Margaret's life is not all that good either. This may enable her to feel accepted by her sisters at a time when she feels alone and meaningless.

The issue of meaning and meaninglessness is dealt with by Yalom (1991) who proposes that this

concern is felt as an existential dilemma for a meaning seeking creature, thrown into a universe which has no meaning. He states that therapy is often sought because life is felt to be senseless and aimless and that meaning provides a sense of mastery. This represents the dilemma that a being who seeks meaning and certainty, exists within a universe that has neither and is a notion concurred with by Chodorow as follows: *"From a psychoanalytic perspective, projection and introjection, expressing and mediating fantasy, act to enliven and make personally meaningful a world that is otherwise intrinsically meaningless."* (Chodorow, 1999 p22).

Chodorow (1999) goes on to say that by investing the external world with emotions whether positive or negative, projective identification animates it for the person and this enables emotional meaning to be found which permits a subjective, rather than mechanical experience of it. The importance of which is suggested by the contention that *"one who possesses a sense of meaning experiences life as having some purpose or function to be fulfilled, some overriding goal or goals to which to apply to oneself."* (Yalom, 1980 p423). Yalom goes on to state that one meaning of meaning, is that it is an emollient which comes into being to relieve the anxiety that comes from facing a life and world without an ordained comforting structure (Yalom, 1980). Additionally, we need meaning because once this is developed values are conceived from it which synergistically augment one's sense of meaning. Values provide a blueprint for personal action and allow us to exist in groups (Yalom, 1980). Margaret's need for meaning may well relate to this anxiety emollient against a meaningless world and her need for the family group to guard against isolation, a further given of existence according to Yalom (1980).

Yalom (1980) refers to three types of isolation, interpersonal, intrapersonal and underlying these, an even more basic isolation that belongs to existence. Margaret describes being there for her sisters and which replays in other relationships as illustrated with the example of being the first to *"care"* about her neighbours seemingly with nothing in return;

"I've got good neighbours and they know that I'm a good neighbour erm, and if they're poorly, or ought like that, I mean, I'm the first one there with flowers and (name of husband) says to me, you're barmy, the way, you know, you know, you let people sort of, get right into there, like, if I talk to someone who lives on the estate as they come past that's not so well, or down, you know blah blah blah, the following day, I just said here you are I bought you these, and (name of husband) says, no one does that for you, I

said, they don't really, I mean the kids do."

Margaret's feelings of being alone are perhaps compounded by not having the support of her sisters yet not being so isolated that they are not beyond relying on her. There are hints as to how Margaret views herself and perhaps her function in life as not only did Margaret assume responsibility beyond her years, but her perceived role as aunty assumes she will engage in the expectations of this despite the fact that some of her sisters' children are older than she is.

As such, it appears that her perceived role in the family was given precedence as opposed to the reality that she was a little girl and in some cases younger than those she was caring for. When Margaret says *"nowadays you wouldn't even think of it, but then, you did, you grew up quick"* it indicates a feeling of assuming responsibility before she was prepared. In a way this is replicated later with Margaret and her husband's reticence to tell their daughter that her dad was not her biological father which could indicate feeling ill prepared for the consequences and responsibility associated with this and a sense of shame juxtaposed with the desire to portray the image of a respectable family. This is recounted in the following way;

"the first thing he said when we got married was, like come on, we're going to change her name to his, you know and I mean, she doesn't see him as anything else, you know she was actually, it was through some of me sisters being nasty that erm, she knew something, and then we, and none of them knew the kids, and we just got all of them together in the house and (name of daughter) was 26 at the time and she's 39 now and err she was 26, and we told her, and they were all sort of devastated."

The use of the term *"devastated"* is again used to convey the strength of feeling and its repeated use perhaps indicates how Margaret views many aspects of her life. That her eldest daughter's paternity was disclosed as a result of Margaret's sisters being *"nasty"* is again an indication of the strained relationship Margaret has with her siblings.

The painful experiences which pepper Margaret's narrative could be summarised with the statement "*what does not kill me makes me stronger*" (Nietzsche, 2003). As assuming care and responsibility at an early age, being abused as a child, witnessing domestic violence, the loss of her father both from the

family home and through his death, having a child outside of marriage and being abandoned by her eldest daughter's father were all tolerable. Yet the situation with her son was intolerable as it precipitated her overdose and when Margaret uses the present rather than past tense to describe being unable to manage. This semantic clue may be an indication that the issues remain unresolved for her. The fact that Margaret continues to allude to an inability to cope three months after she took the overdose could indicate that input from mental health services has been successful to a degree in that the immediate risk assessment appeared valid. However, conversely her recovery remains incomplete as suggested when Margaret states *"but I just can't cope"* and the idea of self harm may have lay dormant for some time.

A personal Insurance policy

The issue of motive preceding self harm, attempted suicide and suicide is complicated and as Bell (2000) states what is recalled consciously by the individual is usually more a rationalisation than an explanation. In Allen (2007) I critiqued evidence which uses terms such as self harm and attempted suicide without explicitly stating to what they refer, in conjunction with the proposed argument that this hinders the use of evidence in practice. However, this is not simplistic and the complexities of self harm and attempted suicide are illustrated in Margaret's story given that she says she wanted to die at the time of the overdose but has presented herself as a participant in a study which is clearly related to self harm.

There may be a host of reasons why Margaret attended for the interview including feelings of abandonment in relation to her perceived lack of help following the overdose and seeking the opportunity to engage with an interested other. She may feel that describing a desire to die conveys how intolerable things were for her and she may need to defend her actions by conveying the gravity of the incident in this way *"I did just want to die and, because I mean for me, running away doesn't solve anything."*

The difficulties in attempting to ascertain motive and desire in such circumstances are clearly complicated and compounded by the ambivalence which may accompany such instances. Despite these difficulties, Margaret's actions do communicate something and may relate to the earlier incident in her life where she recalls the reaction of her boyfriend to her first pregnancy. *" I said to him, you know on the*

phone I'm expecting and it, it was well, if you can't get rid of it, get rid of yourself." This is a powerful demand and whilst I am not suggesting that this thought would never have occurred to her without hearing this, Margaret may have internalised this statement as an insurance policy always available as a potential solution to unbearable situations.

Yalom's (1980) reference to the paradox that a fear of death could drive someone to suicide also has utility here. It could be surmised that Margaret felt her pain so acutely, that to hasten the inevitability of death felt like the most reasonable thing to do and if she could think *"I'm going to go out happy then all the better."* In some ways the thought of an escape route may be a source of comfort as we do not have to endure the most painful situations; we always have the option of *"getting rid"* of ourselves. This further links to Yalom's (1980) notion that the physicality of death kills us but the notion of dying may actually save us. It is interesting to note Yalom's discussion around this issue; he suggests that biologically, the death boundary is relatively precise but that psychologically life and death merge into one, and the proposal that death enriches, rather than impoverishes life, is an interesting one.

Yalom's contention in this respect mirrors Menninger's (1935) earlier proposal that self mutilation represents a compromise with self injury being seen as an attempt at self-healing or at least self preservation. As such, the notion of self harm, injury, mutilation, whichever term is favoured, can, in this sense, be regarded as a survival strategy.

Whilst acknowledging that self harm as a strategy of coping does not fit neatly with Margaret's situation given that she sees this isolated episode concurrently as one of wanting to die and a cry for help; there are aspects of adaptation that resonate with Margaret's story as she states she did change following the overdose *"I feel that since that happened, I feel as though something's been brought out and put aside."* It is as if taking the overdose and the consequent situation which followed, led Margaret to report a shift in her thinking. Whilst this is not resolved and still painful, Margaret describes responding in a different way saying *"because I think, I think what it is, is I've gone harder to me feelings towards me son."*

Whether this consequence is productive is open to debate, but there has been a challenge to the status quo and in that sense a small death (in this case the overdose) may be better than the real thing (Yalom, 1980). This is explained where Yalom (1980) recounts work with people who had a diagnosis of a

terminal illness and who made positive changes as a result of this confrontation with death. Although Margaret's confrontation with death was at her own hand, potentially the same may be said of her situation.

There may also be an element of recouping power as at times in Margaret's story she has conveyed a feeling of powerless, particularly in her ability to influence her son. Perhaps Margaret's confrontation with death is a show of her regaining control and influence over her existence. Conversely the notion of loss runs throughout Margaret's story, she describes a visit to her GP following which she was prescribed antidepressants saying *"I was really really down then, after I lost me mum, me sister, me brother in law, me nephew, me niece, all in a short space of time."* Likewise she feels the loss of her son and grandchild to the "*Italian girl*" and perhaps her self image as a strong resilient woman who is able to cope with adversity.

Later in the interview Margaret says *"you know, but erm, I feel as though I'm coping"* which clearly differs to where she used the present tense to say she was not. Neither utterance can take precedence over the other as both have meaning. Perhaps there is some parity with the feelings of relief reported by some people having used self harm to manage difficult feelings. Perhaps the overdose has acted as a vehicle to dislodge or purge some of the pain which has been problematic to express and as such has helped Margaret to manage these difficult feelings.

A silent voice

In a direct link to self harm, finding a voice is a crucial issue. Connors (2000) contends that self injury is a form of communication for feelings of which there are no words. This reflects the numerous links made in the literature concerning childhood trauma and the development of self harm, particularly in the form of sexual abuse. McAllister (2003) explains this link saying that keeping secrets is a dominant feature in childhood sexual abuse and as the child is unable to speak of it, they may resort to self harm.

As such self harm may, in part, derive from the communication of others, be that through threats to keep secrets but also serve the individual as a communication device by enabling the expression of otherwise unspeakable distress through the tangible evidence of bodily harm. McAllister (2003) refers to this process when she states that self harm may be a way to symbolically cry but concurrently it may also

communicate survival to the individual and others.

As far as can be determined, Margaret's overdose is not a pervasive pattern but regardless of this, Margaret has communicated her distress through this overdose and this communication may be influenced by Margaret's past experiences and her place within the world. The links between the past and present are crucial to a psychoanalytic approach and as Chodorow's (1999) contentions stress, psychoanalysis gives an insight into why certain people, experiences and things hold such importance to us. The use of this approach in understanding Margaret's story also challenges the criticism levelled by Bell (2000) that efforts to comprehend suicidal acts are taken from a view based on the external world of the individual and as such are superficial.

Bell (2000) contends that underlying all self destructive acts is an attack on the self which identifies with a hated object. This enables an attack on that hated object but also simultaneously punishes the self for its sadistic and cruel attacks. The application of this to Margaret's story can be illustrated by the shame she feels regarding her feelings towards her son, but also her desire to attack the internalised hated object through the overdose. This may derive from the inability to get her son to listen and hear her voice. He knows she is upset yet it does not concern him, *"it don't seem to matter to him, you know, he just err as I say he's very, very selfish... and it's like, with the girls they'll give you anything."*

Freud (1925) contends that in melancholia it is not only a current external figure which is lost, but all other losses that have to be endured during development. This may represent the multitude of other losses endured by Margaret with men who disappoint, abuse and abandon her and the above quote could be indicative of Margaret's expectation or wish that her son afford her more consideration. In reading the words as they are transcribed, it also makes me think that she may be despairing of his ignorance of her and that this is reminiscent of earlier experiences where her needs are overlooked as a child and being abandoned when pregnant.

In considering the issue of communication in acts of self harm, it is doubly disenfranchising that this may be used to communicate unspeakable feelings and distress which then go unheard in their entirety by ignoring the internal world of the individual. As such the full meaning is dismissed and any consequent response limited by this. The issue of being unheard is presented when Margaret recounts the story of

her dolls being taken for other children in the family. The fact that as a 58 year old woman she remains mindful of this suggests it is important and may be a significant insight into her feelings of being ignored, meaningless and has resonance in the present.

"even when I used to have toys and stuff coz, they've got children that are a wee bit older than me you know...it was, they'd take it, for their kid you know one of my nieces has still got me twin dolls from when I was 6 and they were just took from the house, when I came home from school, there was a cupboard in the corner you know, one of the old fashioned floor to ceiling and I used to climb up meself and sit in the top and that was my little house with me dolls, and I came home from school, climbed up, and there were no dolls."

When Winnicott (1991) talks of transitional objects he refers to examples such as a blanket, teddy, doll which represent the infant's transition from being merged with the mother to a state of being in relation to the mother as outside and separate. Although Margaret was not in infancy, she recalls being aged 6 at the time of this incident; her dolls may have continued to represent a sense of security and safety for her in an unpredictable world which can be scary. This may be one reason why this incident remains painful and raw for Margaret even as a woman in her 50's.

Chodorow's (1999) contentions fit with this when she states that transference *"is the hypothesis and demonstration that our inner world of psychic reality helps to create, shape, and give meaning to the intersubjective, social and cultural worlds we inhabit...In transference, we use experiences and feelings from the past to give partial meaning to the present as well as to shape the present, as we act and interpret present experience in light of this internal past."* (Chodorow, 1999 p14-15). As such, the taking of her son and grandchild by the *"Italian girl"* may feel intolerable because it resonates with such a powerful early memory and has profound meaning in her current circumstances.

Margaret's views of her son and daughters place in the world are related to her views of herself as a girl and woman. Chodorow (1999) argues that feelings and categories of gender and self are created culturally, in historicized, socially specific contexts and biographically through individually specific projective and introjective phantasy and emotion. The ability to get her son to listen and hear her seems crucial to Margaret. There is a sense that he knows how terrible she feels yet it does not matter to him.

This may feel worse than him having no comprehension at all and may be even harder for Margaret to contemplate when she considers how much she has afforded him as summarised when she says *"it's like there's nothing there, you know, it's just like he won't care really, you know, and it's, I said to me husband it's very hard for me to accept that knowing how I've always been there."*

The sense that even at the point of despair, no one cares is apparent when Margaret states; *"I've not got that help that I really needed there and then otherwise I don't think I would have done that, you know, well, I don't know if I would but I'm surmising I wouldn't, but I just felt as though, well, they're not bothered about ya, do you know what I mean?"* Margaret clearly states she wanted help and on attempting to secure this for herself was left feeling rejected. This may be a consequence of service provision being delivered on the basis of perceived risk, and may be representative of Bell's (2000) notion of focusing solely on the individual's external world with little consideration of any other relevant details, such as trying to access an inner world where a host of information lies.

Margaret's feelings of abandonment, their relation to the past and how Margaret has made sense of it is explained by Chodorow (1999 p271) who states; *"Current feelings, a contemporary sense of self, passions, and felt needs and desires come not only from what really happened in the past but from a web of internal processes that construct the present."*

There are hints of this in the way that Margaret views herself and perhaps her function in life when she recounts her experiences as cleaner and caregiver. *"I must have been about 8 year old when I had to get a train up to (name of town) to help me sister I mean, nowadays you wouldn't even think of it, but then, you did, you grew up quick erm, I used to have to go (name of husband) always calls me Cinderella, and it, one of me sisters, she's passed away now erm, she was brilliant she'd always told the truth about what happened in the past and she told (name of husband) a lot you know, and erm, she used to say, yeah she was like our Cinderella you know and he always says to me Cinderella, I used to have to go and make the fire for them and see to the kids for them, as I say, some are younger than me, there's a few just older erm, and even when I used to go up to (name of town) I'd be helping me sister clean or whatever and her kids, she had 5 children err 6 children and I've got 5, she had 6 and they'd be out playing."* In presenting this experience Margaret is recounting how she assumed responsibility beyond her years by undertaking the role of aunty and caring for her nieces and nephews but begs the

question who was caring for her.

Chodorow's (1999) contentions mentioned earlier regarding the development of one's gender identity mirror Flax (1991) who states that gender partially structures how each person experiences and expresses him or herself. This is an integral part of Margaret's narrative and is particularly relevant here with regard to the Cinderella reference. The identification with Cinderella may represent Margaret's metaphor for her life as it resonates with being overlooked and unheard before being rescued, however there was not a sense of living happily ever after as the postscript will reveal.

Post script

This interview took place after 3 telephone calls to Margaret. She had said she wished to be part of the research but was reluctant to attend the university without her husband bringing her as she was unsure of new and big places. As this was the case, the interview needed to be arranged on her husband's day off from work.

This presented me with a couple of issues, the first was a paternalistic consideration as to whether it was ethical to include Margaret but as she appeared to want to I was mindful that my decision should be based on her wishes in the absence of any other information.

The second issue at this point was the effort Margaret had made to attend the interview which included her husband swapping days off and going beyond her comfort zone. This started to tap into my existing anxiety around the lengths people would go to in order to tell their story and whether I would be good enough to re-contextualise it into a piece of useable research.

Margaret attended at the specified place and time, which was approximately three months since she was admitted to A&E. I was struck by a woman who was not the unduly anxious person I was expecting, but who was friendly and open. With my previous experiences of working with people in A&E following self harm, Margaret did not fulfil my preconceived ideas at all. I was struck by the same thoughts I had during the first interview, in that why are these successful, middle aged women coming forward to be a part of this research?

We walked across the walkway together chatting about inconsequential things and this is where our face to face relationship began. We sat together in a classroom which was unreasonably large and at times could hear students passing in the corridor outside. I was mindful at those times that Margaret's voice lowered in volume and I wondered how the reminder of a reality "*out there*" as represented by people passing by was for her, as for me it felt intrusive and I resented it.

There seemed to be an overwhelming array of experiences from the past being played out in Margaret's present some of which appear contrasting such as issues of forced responsibility as a child as opposed to avoidance as an adult in relation to the overdose. Whilst conversely others seem to be replicated such as care giver, lack of control and powerlessness, ongoing dissatisfactory relationships with her sisters and problematic ones with some of the men in her family.

The importance of how Margaret is portrayed by others seemed vital as did her self image. In this respect, a sense of being usurped as the most important woman in her son's life by the "*Italian girl*" seemed crucial. When Margaret says *"I'd spoken to him and it was a case of, I'm not listening to you, you know, I'm listening to her"* this is described in conjunction with the associated feelings of betrayal and hurt which are peppered throughout her story.

The difficulties associated with definitions of self harm and attempted suicide were apparent to me as Margaret clearly says this overdose was precipitated by the wish to die, yet later says it was a cry for help and has engaged in a study concerned with self harm. It may be because Margaret felt abandoned and saw the interview as an opportunity to discuss some of the issues which were important to her that she was willing to re frame the incident as one of self harm. It also interested me to consider how the practitioner who first saw Margaret and consequently supplied the information regarding the study made sense of her overdose. Lastly, it demonstrates the complexity associated with issues of self harm and meaning.

I felt upset at times that Margaret had found herself in this situation and I was struck by my desire to ensure some good came from her experience and of seeing me. Her choice to attend the interview seemed to be based on the opinion that she felt it would help. This included helping her as she felt she had not been given the opportunity to explore the issues surrounding her attendance at A&E previously

and she hoped she could help with the research project. This weighed heavy on me at times, the sense of responsibility has felt paralysing on occasion and I have wondered whether I am good enough to do Margaret's story justice.

The issue of facilitating the hearing of a voice was profound to me and I was struck by the notion that Margaret had not felt listened to and that perhaps she had found it useful to tell and hear her story. It also struck me that in this situation there were no competing voices and Margaret, perhaps for the first time, was given the time and space to tell how it was for her.

The fact that Margaret came to the interview following a hospital appointment for investigations and was then to return that day for her test results was a bit like a kick in the teeth. I liked her, I wanted her life to improve and yet here she was once again confronted by her own mortality, but this time she had little control over it. Death is said to remind us that existence cannot be postponed, that is, whilst one lives, one has possibility (Yalom, 1980) and I wonder how Margaret is.

Chapter 6

Ellie (Interview 3)

As with the preceding two chapters, this begins with a biography by way of introducing Ellie to the reader. This will enable a context for Ellie's story and provide a brief overview of those parts of her narrative which are then pursued in the relational voice and as emerging themes. This is Ellie's story.

Biography

Ellie is a 26 year old mother of one daughter. She is the middle child of three, with an older brother and younger sister. Ellie has worked in a legal firm for the last seven years as an administrative assistant. She owns her own house, where she formerly lived with her ex-partner who is the father of her daughter but this relationship has since dissolved. Ellie is currently living at her parents whilst her house undergoes some construction work and lives in the same city in the north west of England where she was born and brought up.

When I interviewed Ellie she had previously been treated for depression with medication by her GP but this was her first use of mental health services and resulted from Ellie taking an overdose. Ellie's mum is a mental health nurse who works in a similar service within the same Mental Health Trust where Ellie was assessed.

Ellie says she wanted to die at the time of the overdose as she thought it would be preferable to living. In the interview she sums up the incident as a moment of madness following a number of detrimental life events, which included her daughter's disclosure of sexual abuse by a family member, her experience of a miscarriage and ongoing arguments with her then boyfriend (not her daughter's father). Despite saying the overdose was a moment of madness Ellie concedes she still has thoughts of repeating this, particularly when feeling isolated but her daughter appears to be a strong factor in protecting Ellie from acting on these thoughts.

Ellie became pregnant to a man her mother did not like and discusses this three year relationship during the telling of her story. Ellie also recalls two other partners, one of whom was abusive and the

relationship lasted a matter of months. During her most recent relationship which lasted a year, Ellie had a miscarriage, she also took an overdose. All three relationships were reported as being problematic for a variety of reasons and which are revealed in the following discussion.

Reading for the Relational Voice

Ellie's use of the pronoun *"I"* contains a number of clues regarding how she sees herself as the proponent of her story and there are a number of issues which broadly relate to power and powerlessness. The first of these relates to her vociferous denial that the staff in A&E could contact her mother. Despite being able to exert power within this context, Ellie was unable to prevent her mother from having unprecedented access to the details of her overdose through accessing her clinical notes. By her own admission this made Ellie feel awful, but on reflection says it did mean she did not have discuss the events with her mother and which is seemingly couched in positive terms.

Ellie expressed a sense of disbelief that she took the overdose and also extends this to her description of her mother's response to it where she says *"she can't believe I did it."* It later transpires that at times, Ellie has experienced a difficult relationship with her mother and finds it hard to confide in her. There is a sense that her *"mother knows best"* and that as a confidante, it seems her nana is Ellie's preferred choice.

Interestingly Ellie recounts her mother giving her advice regarding her partner, and then seems to identify with this role herself in relation to her friends. There is a sense of like mother like daughter in this respect and perhaps they do possess more similarities than initially discerned.

Powerlessness features in Ellie's day to day existence for instance living with her parents whilst her house is being extended means she has to fit in with their routine. Also her recent experiences at work where additional responsibilities have been rescinded has dented her self esteem and undermined her sense of pride. Conversely there are other aspects in the narrative where power is exerted such as Ellie ejecting her partner from the family home when his lack of responsibility taking became intolerable. However, Ellie's inability to persuade the police and social services to take action in respect of her daughter's disclosure of abuse, encapsulates her sense of powerlessness. Not only, in her view, did she fail to stop her daughter from visiting her paternal grandma's home and in doing so prevent the abuse,

but once she knew about it, was unsupported in pursing it through legal channels.

Ellie's story contains a perceived inability to protect her daughter but also the child she miscarried. These events led to a sense of hopelessness and are crucial in how Ellie presents her circumstances leading to the overdose. There are aspects of Ellie's story where she clearly talks of wanting to run away, this sense of running reveals what could be construed as feeling unable to manage the circumstances which have befallen her. Interestingly there is also an aspect of Ellie's story where she talks of things not being her fault, this could be interpreted in a positive way, that she is not blaming herself for the difficult intrapersonal and interpersonal events in her life or less favourably, in the sense that things are not within her control to change or resolve.

Given Ellie's view that she was unable to protect her daughter, she said she felt her child would be better off without her. There is a sense of "*for the greater good*" in this statement and Ellie claims to feel her daughter would be better of with her mum (daughter's maternal grandma). This is interesting within the context of how she presents her own relationship with her mother. The issue of power is again revisited when Ellie later says that if she had died, her daughter would probably have ended up with her ex partner's family and this seems intolerable for her.

Ellie's affiliations with others as denoted by her use of "*we*" in her narrative include her family and (ex) partner. Friends are also referred to in this way as are colleagues at work and the organisation itself as in "*we do personal injury claims.*" These affiliations feature throughout Ellie's narrative and portray her roles as (grand) daughter, sister, mother, (ex) partner, friend and "*Admin assistant.*"

There is a part of Ellie's story where she recounts a situation concerning her mother and described as "*the woman in the woods.*" This was concerned with a female client who ended her life whilst having involvement with the Mental Health Service where Ellie's mother worked. This is discussed more thoroughly later but for the purposes of this point, Ellie explains as follows; *"I said is that not what you're for, to stop them from doing things like that? And she said well I knew she was going to do it, but unless she tells me she's going to do it, there's nothing we can do... she said we can't just go off our own feelings and our own thoughts."*

The way this is recounted could reveal Ellie's identification with her mother even though at times their relationship seems difficult and strained. For instance the latter part of the statement could just as easily have been said as follows; *"she said there's nothing they can do, they can't just go off their own feelings and their own thoughts."*

There is a further point in relation to this. Ellie's recall of this conversation is recounted in the first person up until the part where a response, or not is, alluded to and then "*we*" as a collective is referred to. This may reveal Ellie's mother's desire for shared responsibility and a wish to be protected as one in a group of professionals as opposed to being one single practitioner called to account for the death of this client.

Such strategies aimed at *"protection"* during the telling of a story also extend to the use of *"you."* At various times this is used in Ellie's story as a way of encouraging engagement with the details as in *"you know"* but there are also circumstances where this is used seemingly as a way to introduce a sense of distance between Ellie and the story.

Such instances include where she is recounting the abusive experiences of her ex partner's sister *"I remember his sister, because we all used to be quite friendly and we used to go out with each other and one night she was telling me she told her mum, and she told her to shut up, and she didn't know what she was talking about, and she kept trying and trying and it ended up the mum threw the daughter out, and you're like, how can you do that?"*

This strategy is also used where Ellie reflects a sense of isolation *"I have erm coz like I go out at weekends and things and you go home on your own"* and her incredulity at not wanting to be alive *"it's weird it's like how can you not want to be here... mmm it's just, I don't know, you sit and think why would you want to kill yourself why would you want to do it?"*

Her concern that her mother may have inadvertently learnt of her overdose is a further example of this semantic strategy "*but then now you think, how awful it would have been for her to sit there if I'd not told her, and a report had been printed off who had been admitted over the weekend."*

As is Ellie's conflict between motivation and the mundane. *"It's my choice to go to drag myself to work*

even though I don't want to go you've still got to get yourself up, you've still got to do it." This sense of lacking motivation and seeming to feel disconnected, which is revealed at times during her story, may relate to Ellie's admission that she was seeing a counsellor and I was struck with the knowledge that had I seen Ellie in A&E, I would have assessed her for the possibility that she was depressed.

One of the first issues we broached upon mirrored aspects of Celia and Margaret's stories and was related to the use of terminology to describe the reasons for attendance at A&E, this is where the discussion begins.

Emerging themes

Self Harm is what the person says it is

Ellie denied prior attendance at A&E following self harm and when asked of any previous encounters with other mental health services; she stated *"I've had antidepressants before"* confirming that these were prescribed by the GP *"but never been near a mental health..."*

On asking what the overdose had constituted Ellie stated that she had taken *"everything, everything in the cupboard, I'd got the idea I'm going to do it"* and when asked if she had wanted to die said *"yes, I wanted to go, I thought it'd be better."* As with the previous interviews this begs the question why a study concerned with self harm would precipitate Ellie's participation given her stated reasons for the overdose.

In Allen (2007) I discussed the difficulties associated with the term self harm and its derivatives which can hinder the implementation of appropriate evidence in practice. This is perhaps most succinctly illustrated using the example of someone who self harms to survive intolerable distress as compared to someone who attempts suicide and wants to die (McAllister, 2003). Yet these terms may be used interchangeably, as discussed in the literature review. To overcome this I suggested that an operational definition may negate some of the complexities raised (Allen, 2007) yet this may reinforce an adverse power dynamic by the professional dictating the meaning of self harm. For the purposes of this study, self harm is what the person says it is, but this has its own challenges particularly when the reason for attending A&E seems more in keeping with a suicide attempt than self harm. Yet to adhere to my own beliefs as to what constitutes self harm would have reinforced the power dynamic I wished to avoid.

Given this I was interested in what Ellie thought the reasons for self harm may be *"that there's always a reason why they're doing it and it's their way of making, to get what you want from doing it, it's their way of punishing themselves like."* Ellie distanced herself by using the words *"they're"* and *"their"* and when asked if she thought any part of what she had just said applied to her, Ellie was clear that *"no coz I wanted to end it, I wanted to punish myself, my own punishment was to kill myself."* Interestingly the theme of punishment is revealed in Ellie's description of self harm and in her account for taking the overdose, when this was put to her, she said;

"yeah but I did it for a reason I did it because I didn't want to be here I wanted to go, it's like the only thing I had in my mind at the time, (pause) I didn't want to be here, running away from what was going on (pause) erm, it's weird, it's like, how can you not want to be here? It's like, sometimes it's from two different people and just well, this horrible weak thing that just gives up at the slightest thing and then there's me that can sit here and chat away and be me... I don't know, you sit and think why would you want to kill yourself why would you want to do it?"

Ellie's expressed definition of self harm and her reason for taking an overdose reiterates the importance of using language with a shared meaning but takes the point further by illustrating the difficulties associated with labels such as *"self harm"* and *"suicide attempt."* This relates to such terms being used to convey complex messages regarding intent and motivation as though this is always distinct and simply defined. Taylor and White (2000) describe the use of artful language which is designed to put one's point across and undermine the opposition and there may be an element of this both on my and Ellie's part. Her description of what constitutes self harm fits with what she then says was her desire to punish herself through the overdose, yet she refers to this in the context of wanting to die. My discussion here is a desire to present a case for the complexities associated with what it means to self harm, attempt suicide and every other term which may used and also wanting to couch Ellie's overdose as self harm as it fits better with my study, whilst trying not to misrepresent her.

Without wanting to undermine Ellie's expressed motive for taking the overdose, there is a possibility that couching it in terms of suicide may be regarded nobler than in terms of self harm. Ellie appears to be expressing an element of disbelief that she could consider killing herself. This sense of disbelief may be reinforced by the reaction of others which includes her mother and best friend who can not believe she

took the overdose but is perhaps most starkly illustrated in the context of Ellie's brother's reaction.

"*it's like the other day our (name of brother) started ranting and raving at me, that's me brother, I put the phone down on him, I wouldn't speak to him for about two months after that, I ignored his phone calls, ignored his text messages, ignored his emails, emailing me at work, emailing me at home, just ignore it and ignore him...we speak now, rang him a few months ago, hiya ya alright, as if nothing had ever happened it was like, yeah yeah I'm fine how are you? I'm alright. I just thought I don't need him shouting at me telling me how selfish I am and all, I know, don't need you sitting there screaming it down the phone at me, worst thing you need... you don't know anything that's gone on, he lives in (area) and it's like, you don't know anything that's gone on so don't sit there on the phone screaming about it to me, just, I don't know, to see if I needed anything if I wanted anything, if I was alright, why I tried, asking why I'd done it, what was going on? Not sit there screaming and shouting at me. He was alright at first for the first like two seconds, then there was like a screaming, ranting, raving lunatic on the end of the phone I'm not listening to that.*"

The importance of professionals' responses to people who self have harmed has been illustrated in the literature review and expressed motive aside, Ellie seems to be clearly expressing this in the context of more personal relationships. That her brother screamed, shouted, did not ask her why and called her selfish was something Ellie was unable to listen to. That Ellie may have felt ashamed and guilty is linked with Crowe's (2004) discussion of shame which she links with suicide attempts and states that when people feel shame they tend to be more concerned with the opinions of others.

In this context it is feasible that the opportunity to discuss events with an interested other, such as a researcher, may be a risk in terms of the unknown, but also an opportunity to appease that sense of shame, be it through participating in something to help others or through a more contained response typical of one who the story teller does not have a personal relationship with. This may assist in understanding why Ellie said "*I actually feel better sitting here talking to you like, than I do anybody else...*" approximately three quarters into our interview.

It has been noted that the boundary between research and a therapeutic endeavour may not be clearly defined. Hart and Crawford-Wright (1999) comment that there is commonality between the therapeutic

relationship and research interview in the form that both involve the telling of experiences while another listens in an attempt to make sense of what is being told, interpreting, reframing and understanding the narrative.

This observation was made in the context of research where the development of a relationship between the researcher and researched is encouraged and which makes it increasingly difficult to discern the difference between the therapeutic relationship and research interview (Hart and Crawford-Wright, 1999). This was echoed by Sque (2000) who comments that interviewing using narrative may help to make sense of past and present experiences and that a new understanding may be partly responsible for some of the therapeutic benefit derived from interviews.

Ellie's brother and the reaction of her parents may impact on how Ellie sees the experience of taking an overdose, *"but it's just my parent's sit there and think it's just, aw, it's just a completely selfish thing to do and then it's like but it was the only answer I had in my head at the time"* and it is feasible that this may lead to the use of defence mechanisms to manage the resultant difficulty. Mitchell (1991) describes four mechanisms proposed to perform this function. Splitting enables the ego to stop the bad part of an object from contaminating the good part by dividing it, splitting it off and disowning a part of itself. Projection occurs when the ego fills the object with some of its own split feelings and experiences and introjection where it takes into itself what it perceives or experiences of the object. In projective identification the ego projects its feelings into the object and then identifies with it, thereby becoming like the object.

Bell's (2000) comments resonate again with regard to the rationalisation of suicidal acts rather than explanation and perhaps Ellie needed to say she wished to die to project her desperation in the hope that others perceive a need to care for her. There is an interesting point in the story which may relate to this where Ellie recounts the following incident described by her mother.

"it's like last night she's telling me about coroners court, some woman she'd gone to see she'd erm committed suicide and I said is that not what you're for, to stop them from doing things like that? And she said well I knew she was going to do it, but unless she tells me she's going to do it, there's nothing we can do. I said how could you have just left her knowing she was going to do what she did? She said,

she was trying to explain it to me because I knew, she said everybody knew that's what she was planning on doing she said we can't just go off our own feelings and our own thoughts that yes you're going to do it, we're going to have to section her and bring her in, she said we can't do that unless you actually sit there and say look I want to kill myself I want to end it she said we can't act on it she said it's just the way the wards are, it's what happens. I said well what did she do? She said she took an overdose and went in the woods. I said well why didn't, but that she'd done it before previously you see, but they'd found her so I said, I asked why did you have to go to coroners court? And she said I was the last person to see her alive I said do you not feel guilty that you were the last person you could have stopped her from doing it? She was like well yeah course, it's me job though she said, I honesty wanted to get that lady sectioned she said but unless they tell me, so she said, I even, she said, she sent the police to the woods looking for her coz she thought that's where she may have disappeared to but they found her four months later in a different part of the woods, she'd gone to completely different woods, and then I think well I'm sat here asking you all about this and like I didn't tell anybody what I was doing, I didn't say, right I'm going to go home and I'm going to, even though people might have thought, I mean obviously (name of ex boyfriend) thought that was what I was going to do and that's why he came home."

Chodorow (1999) explains projection and projective identification as putting feelings, beliefs or parts of our self into another. Ellie's description of the encounter between her and her mother during the discussion of the woman found in the woods may relate to Ellie's identification with this person, the projection of parts she wishes to disown into the "*woman in the woods*" and a struggle to reconcile the circumstances surrounding her death. Ellie's mother's reasoning around not being able to intervene to *"save"* the woman appears challenging to Ellie and perhaps feels a little too close for comfort, after all, this could have been her. Yet Ellie also identifies with her mother in this part of the passage as discussed previously. Ellie may desire her mother to take her feelings of wanting to be cared for, looked after and kept in mind, identify with them and act accordingly and which may help explain why this event in the narrative was so meaningful for Ellie.

Mothers and daughters

Throughout Ellie's narrative there are clear references to the mother daughter relationship, with her experiences of both roles seeming to encapsulate important aspects of her story. There is a further

dynamic added to this with Ellie's mum being a mental health nurse in the same trust where Ellie was assessed following the overdose. *"I've been discharged from the (service) now, me mum told me, coz she looked it up on the computer she had everything up, I went round at the weekend sort of like a few days after and told her what happened and she went in work the next day and read up on it all."*

This unprecedented access to such information and disregard of confidentiality made Ellie feel "*awful*" although she concedes "*but then I just thought it would be easier if she just went and read it all off the computer, but then now you think, how awful it would have been for her to sit there if I'd not told her, and a report had been printed of who had been admitted over the weekend and things like that and she saw my name on the bottom of the list.*"

The conflicting thoughts regarding this are perhaps compounded by Ellie and her mother not discussing the overdose *"it's never been talked about since it all...* (And is that, is that what you want, is that how you want it to be?) *Not really, not with me mum but I can't speak to me nana, she doesn't know."* Despite not being able to discuss the overdose with her, it is interesting that Ellie's mother performs a protective role when Ellie says "*me dad shouted at me, (laughing) then me mum shouted at him for shouting at me (both laughing) and that was that, he asks me are you alright, yeah yeah fine.*"

That said it seems that Ellie's mother's occupation may actually hinder discussion of the overdose *"I think as well because me mum works with it and that...* (Does that almost make it harder do you think)*... yeah."* In addition Ellie says her mother *"can't believe I did it."* Ellie's mother's disbelief may relate to a struggle in accepting that her daughter felt the need to take an overdose and is possibly compounded by the fact that this is her area of clinical practice. It may be hard for her to reconcile that there may be similarities between her daughter's circumstances and people she has worked with. It also seems that as Ellie struggles to confide in her mother, she may not have had any awareness that Ellie was experiencing such difficulties and as such had no pre-warning that anything was wrong.

Perhaps Ellie's inability to confide in her mother may have led her to convey the magnitude of her situation in "*words*" her mother could understand by taking the overdose and projective introjection may be at play with Ellie unconsciously taking on the behaviour of clients who may have benefited from her mother's care as a way to secure this for herself.

When asked if she was close to her parents, Ellie said "*erm I am but I'm not, now I've moved out it's like they've got their own things that they're doing, I feel sometimes as if they've not got time but erm, but I wouldn't confide in my mum like I would me nana, there are certain things that I wouldn't tell me mum.*" When asked why she thought this was, Ellie said "*I don't know, I think, I just, coz when I was pregnant with (name of daughter) I told my nana before I told my mum, I don't know, she'd be disappointed in me sometimes so I don't tell her things.*" Of her pregnancy Ellie went on to say, "*I knew she wouldn't be happy I mean she was only 20, 21 when she had my brother and she didn't want me to be like that, go and do your own thing and she didn't really like (name of daughter)'s dad either she thought he was no good (pause) and she was right, she hasn't actually said, see I was right but you know she's doing that thing, she knows better, I should have listened but I suppose I've got (name of daughter) so.*"

That history has repeated itself may be difficult for Ellie's mum, she may feel she knows what she is talking about through her own experiences, but this was not heeded. There also seems to be elements of "*mother knows best*" in Ellie's description of her relationship with her mum. Her mother was right to dislike her daughter's partner as her involvement with him has led to grave consequences with their daughter being abused by his brother.

This may undermine Ellie's right to claim to "*know best*" in relation to her child as her daughter's disclosure of sexual abuse may be a slight on her ability to protect her and in doing so support her future development. Warne and McAndrew (2005) state that child sexual abuse has serious adverse effects on the psychosocial development of children. It is feasible that this is a fear for Ellie given that the health of an adult is said to be founded throughout childhood although the foundation of health is laid by the mother in the baby's first few weeks and months (Winnicott, 1991).

Ellie's daughter's disclosure of abuse could represent Ellie's inability to protect her and if Parker's (2005) contentions are accepted, that a mother's self esteem is locked into the feelings she has for her child, this seems crucial in the context of Ellie's story. The sense of responsibility for not protecting her daughter may also signify a loss of the virtues associated with childhood such as innocence. Loss continues to feature for Ellie in conjunction with her miscarriage and possibly the notion that she was not good enough to carry her second child to birth.

Yalom (1991) contends that to lose a parent or lifelong friend is to lose the past but to lose a child is to

lose the future and the loss of one's life project. He suggests this is the reason one lives for, how one projects oneself into the future, may hope to transcend death and as such, the child is an immortality project.

Yalom (1991 p132) takes these aspects of loss and distinguishes between them by referring to the parental loss as "*object loss*" the object being a figure that has been instrumental in the constitution of one's inner world, whilst "*project loss*" the loss of a child is the loss of one's central organising life principle (Yalom, 1991). As Ellie's experiences with her mother seem difficult at times, perhaps her child(ren) represent the opportunity to forge a different kind of mother child relationship. However, this has been compromised through her miscarriage and through not protecting her daughter from abuse.

That said, all is not hopeless, Waddell (2002) argues that there seems to be an underlying drive towards development in every person and that adverse circumstances at one stage or age are not necessarily determinant (Waddell, 2002). In this sense all is not lost, Ellie remains committed to her daughter's development and her "*life project*" and whilst her daughter's disclosure of abuse was one stated reason for her overdose, Ellie's daughter may also mitigate against a future overdose. As such the issues of risk and protection are closely aligned in Ellie's story.

Risk and protective factors two sides of the same?

Ellie described interpersonal factors with her then partner as a reason for taking the overdose "*I'd just had enough really, I'd gone out with my partner to a 21st and just got drunk, ended up having a bit of an argument and that's what set me off, went home and I took an overdose.*" Further that "*there were things which led up to it and then just the argument, we'd been arguing a bit anyway and then that was it, the ultimate argument, we both said nasty things like you do in an argument, and that was it (name of daughter) wasn't there I thought she was best with my mum... I think I had thought about it but never had the guts to go and do it, but then I decided I'd had enough, no one was in the house with me I'd locked myself in.*" Alcohol was also a factor and she said "*no I don't think so*" when asked if she felt she would have acted similarly without being drunk and from this perhaps it could be inferred that disinhibition related to alcohol may have enabled the overdose.

Ellie goes on to describe major life events which she sees as a precipitant to the overdose "*a lot has*

happened because I had a miscarriage in January and a haemorrhage so I've been ill from that and erm in September last year my little girl told me that her uncle had been, so there's all that, so I stopped her from seeing her dad and all the family."

Risk and protective factors may be seen as distinct entities, for instance a strong social network may be regarded as a protective factor where as isolation a risk in relation to mental health difficulties (Department of Health, 2001b). Yet in Ellie's story risk and protective factors seem less distinct. Her daughter is a protective factor yet is also implicated in the overdose through Ellie's perceived inability to protect her.

"I just think (name of daughter) why would I want to leave her because ultimately if I'd have died she would have gone to her dad's and she would have been in that situation, I would never have been able to protect if I'd died and she would have been left on her own and she would have had to deal with always knowing that her mum had left her, I've got no intentions of trying again or doing it again (pause) a moment of madness (both laughing)."

Further into the interview, Ellie said *"I have erm coz like I go out at weekends and things and you go home on your own, and it has gone through my mind again but I think of (name of daughter) and what would happen to (name of daughter) and basically what would she think when she got older that her mum just thought that was it."*

The contradiction in the above passage may be due to Ellie gaining increasing trust that she could be honest as the interview progressed. By saying she had no intention but later conceding that ending her life has crossed her mind, also suggests the complexities associated with intent and motivation which are not always distinct and separate. This passage from Ellie's narrative also indicates that whilst her daughter is a protective factor, preventing her from a further overdose. Ellie's sense of being alone which appears to be profound, may represent a particular risk in keeping with Yalom's (1991) notion of existential isolation. This refers to the gap between self and others despite engagement with others and an integrated self and is as Yalom (1991) contends an ultimate concern.

This understanding of risk contrasts with Hawton et al's (2004) conception which derives from studies

concerning different psychiatric patient populations (although this is not defined) and of which they state a history of self harm is the best predictor of eventual suicide. Conceivably the finding of Hawton et al (2004) may include people who attend A&E following overdose. If so, this would be inclusive of Ellie yet this seems overly simplistic when considering her narrative. To say self harm is the best predictor of eventual suicide does not tell the whole story and risk may be more readily associated with the feelings behind the overdose such as isolation.

A further issue connected to the inability to provide protection for her daughter is a perceived lack of control. Ellie describes going to the police and social services following her daughter's disclosure "*and they said because of (name of daughter)'s age and there was lack of evidence, they weren't going to pursue it because it would be more emotionally harmful for (name of daughter) at the time, so I felt like I can't do anything....*"

Being able to exert the control required to protect her child(ren) seems particularly poignant for Ellie *"then I had the miscarriage in January and I just thought I couldn't protect the children, (name of daughter) that was out in the open, and the one that was inside. I couldn't do it for (name of daughter)...so what was the point in me being there?"*

The issue of lack of control runs throughout the story both with the expressed precipitants to the overdose, the pressure to contact her mother whilst in A&E and now as she is living with her parents. *"I've had to move back in with them, I'm having some work done on my house. It's like a nightmare I've not been there for 6 years and trying to fit back in with them and their routine and you know I've got a younger sister who's 18."* Ellie goes on to exemplify her experiences of this saying. "*I'll say right I'm getting in the bath, and me mum was in, then at 9 o' clock I'll try again, and me dad's in (both laughing) forget it, I needed a bath coz I had all dirt in my hair from my house, I was like. I don't believe it, it was 10 o'clock and I was thinking I should be in bed by now, at home I can do what I want, the joys of being on your own.*"

Despite a perceived lack of control at times within the narrative, Ellie was able to exert her influence over her daughter's father. This may derive from the importance Ellie holds in relation to protecting her daughter which was tangible throughout the interview. Ellie states, "*I've fought with (name of daughter)'s*

dad to keep the house and I've kept it, he signed it all over me, it's like, it's my house, it's mine and (name of daughter)'s house. It's the one thing we've got; it's me, (name of daughter) and our house. I've never really seen it as my home, I always called my mum and dad's home but these last few years, well this last year, it's like, no it is my home, it's our home, it's mine and (name of daughter)'s home, no one can hurt us or get us once I lock those doors and windows it's mine and (name of daughter) its our safety net where I know nothing at all can go wrong with her. It's up to me who I let into the house, I choose who can live there, who can sleep, once the bedroom door's shut I know if anyone can go in and out." This may represent Ellie regaining a sense of control but which may be seen as emerging rather than complete.

Towards the end of our time together Ellie was able to discuss who she would contact if she needed someone following the interview and stated. "*No it's like, since I've done it, there is people there, it's like I kept it all bottled up it's like there's no need to do it, got me mum there, got me dad there, got me sister there, got me friends there and people at work there, it's like, now its weird coz if I don't answer a text message within the space of half an hour with certain people they ring and if I don't answer me mobile they ring the house and if I don't answer me mobile or me house phone they ring (name of friend 1) or ask someone else, have you spoken to (name) yeah yeah been on the phone to her, she's getting in the bath, last time I spoke to her she's in the bath, then I get a text message saying just spoke to (name of friend 1) I know you're alright."* However, Bell (2000) warns that whilst this can be life saving as the individual recruits others to look after them. The more people become responsible for the individual's life, the more the individual dissociates themselves from the wish to live with the consequence that this becomes located in others.

At the end of the interview Ellie's daughter is again alluded to as a protective factor and as such Ellie's wish to live may be located in her "*I just think that if I didn't have (name of daughter) then I don't know what I would have done. I would have tried it again several times, tried different ways of doing it, but I just keep thinking of (name of daughter) and what she would think if I had have done it, if it had been successful and then it would have defeated the object, all the months of basically what we were going through and she'd have been back with them."* It is perhaps only having experienced the overdose and its ramifications that Ellie could gain the sense of survival and death which has enabled her to reflect on the consequences for her daughter. In this respect Yalom's (1980) reference to the symbolic and

magical value of suffering that "*a small death, after all, is better than the real thing.*" (Yalom, 1980 p135) has resonance here. This is reinforced through Klein's (1935) discussion that in some cases, phantasies underlying suicide aim at preserving the internalized good objects and the part of the ego which is identified with the good objects. Further, that by destroying the part of the ego which is identified with the bad, the id and the ego can become united with its loved objects.

Suffer little children

Broom (2008) states that it is widely accepted that child sexual abuse is a prevalent phenomenon and Ellie's experiences of her ex-partner's family do not undermine this statement. "*I mean her uncle was only 13 at the time which made it more, but I was concerned that he was having it done to him because he was only a young age and like the things that he'd said to her were like what you hear said to other people so to me it was like he was having it done to him for him to think its alright at that age it's like a big family with different dads and they go their separate ways and two sisters they've been abused...and the mum, she had a child aged 15 and won't disclose who the father is and it makes you think well, is it her dad, it is her uncle, her brother?*"

Glasser et al (2001) considered the links between being a victim and becoming a perpetrator of child sexual abuse and acknowledge a progression from victim to victimiser, but that there is very little research regarding perpetrators who were not previously victims. In terms of incest, Finkelhor (1984) suggests there are four preconditions that must exist for abuse to be perpetrated. These relate to the motivation to sexually abuse, the lack of internal inhibitors in the presence of motivation, the lack of external inhibitions, and the resistance of the child.

With regard to external inhibitions, Ellie went on to state "*I'm the only one that's in the family that's said no, I'm not having that, that's standing up saying something*" but then says; "*For what though?*" This referred to Ellie's inability to secure legal pursuit of the case as discussed previously and went on to say "*...I remember his sister, because we all used to be quite friendly and we used to go out with each other and one night she was telling me she told her mum, and she told her to shut up, and she didn't know what she was talking about, and she kept trying and trying and it ended up the mum threw the daughter out, and you're like, how can you do that? When (name of daughter) told me I got up and I was physically sick, as soon as she told me my stomach turned, and I went and threw up in the bathroom,*

how can ya?"

Despite Ellie presenting herself as assertive and not accepting the situation, she then also portrays a sense of powerlessness which Strand (2000) states is a central issue for a mother whose child has been sexually abused. She goes on to say that strategies to help children who have been sexually abused by parental figures must include the non-offending mothers (and offenders). For Ellie, this seems crucial, her story pivots on this sense of powerlessness associated with protecting her child(ren) the feelings of which seem strongly implicated in her overdose. Yet it is regrettable that mental health nurses who are often the first point of contact at times of crisis, as illustrated in Ellie's story, are ill prepared to work with issues of child sexual abuse (Warne and McAndrew, 2005).

He's a man so...

"*Unless we actively seek out the effects of gender on society and our thinking about it, our knowledge (about knowledge and societies) will be inadequate.*" (Flax, 1991 p26). This statement is pertinent within Ellie's story as men, particularly in the context of her relationships, feature throughout.

Ellie said "*me dad's still there, but he's just me dad, he's a man so*" which seems to portray a particular opinion with regard to her father in the context of a playful comment. However it may also betray the difficulties she has encountered with other men and for varying reasons the three relationships Ellie talked of during the interview have been problematic.

Her most recent relationship is described as "*he's living in _______ at the moment we've split up, but we're still friends, I'm still speaking to him and stuff, but he has his own problems and stuff. He's gone back on the drinking and that's what the argument was about, about his drinking and stuff, and a few weeks after that he moved out and a few months after that he moved over to _______, that's where his family are.*" In many ways Ellie's description of this relationship was most favourable of the three and in a discussion which begins in relation to antidepressants Ellie revels more of her relationship with her daughter's father.

Ellie had been prescribed antidepressants "*just after I'd had (name of daughter) just because I was a bit a bit low and I think it was the reality of the fact that her dad was this complete and utter nutter who*

didn't care, he didn't give a toss, he didn't go to work just sat round all day playing on his computer. (Where did you meet him?) *In the pub, he was me friend's boyfriend's friend, one of those things and he had his own flat and I got caught pregnant quite soon into the relationship and it was like a big roller coaster. Right, buy a house, I finished work on maternity leave and he lost his job so I went back to work and it was just forever ongoing but he he seemed to just not bother, it was like it'll all all all fall in place, it'll all be alright, and I was like yeah but it won't we've got a mortgage to pay, got bills to pay, got a car out there on finance and you've got this scooter that you're whizzing around on and not working, it all mounts up and I'm like get off your backside and do something."*

Ellie's description above portrays herself as the responsible caregiver, despite being depressed, trying to ensure the bills are paid whilst her daughter's father plays computer games and rides his scooter. The difference in their roles within the relationship may in part be described using the dynamics of gender identity. Gilligan (1998) states that for boys and men individuation is critically tied to gender formation since masculinity is dependent on separation from the mother. For girls and women issues of feminine identity are not reliant on separation but are defined through attachment. This may help to explain why Ellie's ex-partner is portrayed in the above quote as engaging in activities which denote a sense of having time for himself while Ellie takes on the role of fulfilling the family's basic needs for shelter, food and warmth.

The final relationship discussed by Ellie in the interview was also problematic to the point of being abusive. *"I had one in between but he was weird, psychotic, well uses his fists basically when he'd had a drink, but he never actually physically hit me, it was just one night the week before me birthday and I'd gone out with friends from work coz one was leaving and I said oh I'd be home about nine, half nine and because he was sat on the doorstep waiting when I got back at ten half past ten. He started ranting and raving and screaming and shouting and then because he went to hit me, I stepped back and the dog, because it was protecting me, he got hold of me dog and tried strangling it so I ended up hitting him to get him off the dog and then just ran upstairs and put me back against the bedroom door, coz I had me wardrobe and thought it's the only way to stop him coming in. He started kicking the door and the top of the door came over but I had me phone and phoned the police screaming down the phone coz I'd never, me dad had never hit me mum in his life and he's not violent, try and avoid it at all costs, and then the police came and took him away and I've never seen him since. Well I've seen him like a few months*

later and like, oh sorry, I want you back and all that, but there's one thing me mum's always said never let them hit you, never do it, they always say they'll never do it again and they do."

Gilligan (1998) goes on to say that male gender identity is threatened by intimacy and manifests as having difficulty with relationships, while female gender identity is threatened by separation and has problems with individuation. Clearly a vast generalisation, however it may help to explain Ellie's seemingly unfilled relationships with men and link to Yalom's (1991) contention that one way to try to dispel the anxiety associated with existential isolation is through fusion with another.

Having a Sense of Coherence

As stated previously, Antonovsky's (1987) salutogenic theory informed parts of the semi-structured interview schedule with some questions aimed at considering a sense of coherence. These related to component parts of the theory with focus on being motivated to cope (meaningfulness) believing that the challenge is understood (comprehensibility) and finally believing one has the resources to cope and that they are available (manageability). The next section of the discussion relates to these components and is concerned with who Ellie trusts to confide in, her experiences growing up, her self image and her perception of how she is seen by others.

Of her earlier life Ellie said she confided in "*my nana*" and when asked whether she had a happy childhood she said "*some bits weren't and then some of was just a normal childhood really.*" Details of the relationships with her siblings were given when Ellie says "*with me brother I'd say I'm closer to me brother than I am to me sister, I don't know it's different, it's weird, I don't know me brother and me have like a friendly laugh type thing and me sister's more the one, we talk about things, it's like with me sister and me brother they don't get on at all, there's like there's 12, 13 years between them so when (name of sister) was born, (name of brother) was off being a teenager doing what he was doing and when (name of sister) was 8 or 9 (name of brother) had moved out...but it's like they think they are just total opposites to one another, they are exactly the same as each other but they don't do anything together."*

Her sibling relationships are revealed more in terms of punishments within the family which Ellie regarded as commensurate and therefore comprehensible. She stated, "*yeah we never got smacked off me mum or dad, she's not a believer in, or never really shouted at us, just like a slightly higher tone in*

her voice and you knew, it's like a few instances when we were teenagers and I called her a stupid cow or something like that and I felt her coming running after me and that was the only time she ever physically hit me, and me dad says he hit me once when I was about 16, 17 when I was drunk but I have no recollection of it at all. He felt really guilty and me dad was always, if you do that again you'll know about it, if you do that again, coz that was like the childhood thing let's wind dad up see if he actually will (laughing) and it's like, if you do that again you'll know about it, I'll! And 10 minutes later, if you do that again, it's like the ongoing joke."

The safety she seemed to enjoy in relation to the predictability of her parents proportionate responses to ill behaviour did not necessarily mean that she felt listened to, "(when you were growing up did your mum and dad sort of listen to you?*) no not really, dad was always at work mum was busy with (name of sister) really, you know, at school and getting her to read, when I went to high school, was just left to sort yourself out, get up in the morning, get meself to school and do me homework, then go out and come in 9, 10 at night and go to bed and do the same thing the next day."* There was a sense of feeling overlooked in the family and this feeling seemed to pervade into her job where she has worked for seven years.

When asked if she enjoyed work Ellie stated, *"yeah, at the moment it's a bit boring coz there's lots of changes and my old manager's left and took half the staff with him and set up his own business and so we've got this new rival business, and I don't really get on with my new boss, it's like we used to be, basically when my old manager was there I did a lot of his work for him as well, so now I'm just doing me basic admin role and me new ones are like, well that's what you get paid to do, so that's what you're going to do, and I sit there thinking I've seen you two come through the office all the way up and you speak to me like I'm a piece of crap on your shoe...and the thing is, in this new managerial role they're higher and it's like it's not going to work but sticking in there and trying."* There was a sense that Ellie's self esteem was dented by this, and that previously she had derived pride from working beyond her job description and taking on a role which extended beyond that which was expected.

In Ellie's opinion *"I have counselling now because it's only been over these last say two months that anything's ever gone wrong."* Yet Ellie had difficulty identifying something she was proud of *"that's something the counsellor keeps trying to ask me about and I think I can't do it, I want to do it, and I sit*

there and me mind goes blank and, I'm proud of (name of daughter) and the counsellor keeps saying well you've got your job and you've got this, and I'm like, yeah but, they're just everyday, I don't know, that I'm still here, I'm still going somehow, and no matter at the moment they've got a lot to throw at me and I get down, but I just need to, I'm still here, still coping in my own little way." The notion of surviving intolerable distress was particularly poignant at this point in the interview and it was notable that Ellie's daughter is so pivotal in relation to how she regards herself and which reflected Parker's (2005) contentions regarding a mother's self esteem, as noted previously.

When asked whether Ellie struggled to find positives about herself and why this was she said *"yeah... I don't know, I just don't think there is, because the amount of stuff that's gone on it's as if, it must be me that's, I'm the one that it seems to either happen to, or is it me that's making it happen (pause)."* This is an interesting comment which leads to consideration as to where Ellie's locus of control sits and is reinforced when she says *"it just seems like everybody else has this nice happy life, and can have a week where nothing happens and where as me, it's like if something happens it's like, it's me again."*

Yet Ellie's friends would describe her as *"friendly, chatty, like it's weird because if anything goes wrong with them, I'm the person they come to and say help me, tell me what to do, coz at the moment my best friend (name 1) she's going through a separation with her partner and I'm like telling her what to do. I'll sit there and say right this is what you do, this is what you're going to do, when she rings me says I feel awful I've done this and this, and I say, don't feel like that, don't be daft come on pick yourself up it's like why? You can sit there and I know I can do it, I can sit there and tell everybody what to do, but me, I'm like, no, it's not the same, and that's different, that's their thing."*

There appeared to be a conflict in how Ellie saw herself and how she believed her friends did. It may be reasonable to suggest that this could be related to her low self esteem which may explain Ellie's reduced capacity to cope. Particularly as she says she has been the sort of person who was proactive at coping and managing problems previously. When asked if we had met 12 months ago how she might be different, Ellie stated, *"I'd have been me, happy, I don't know, just normal, I didn't care what was going on, I just, everyday as it came, it's just one of those things, don't be daft, come on pick yourself up, don't be daft...it was like things didn't seems as bad as they are, it's like, just get up, you did your own thing came home from work and that was that. It's like the slightest thing, it's a big problem it's like, me again*

it's happened to."

That said, Ellie acknowledged the gravity of the events that had happened over the last 12 months and when asked if her current outlook on life was comprehensible she said *"in a way yeah"* and that *"it's like, as if, I just thought, that's it, I've had enough, I can't cope."* Ellie's ability to cope is perhaps illuminated when she describes how she would previously have done so, saying. "*talk not talk, I don't know just dealt with them differently, like it wasn't as big a deal as is, and like you sit here, and you think, right what I'm going to do is, go and sort this, ring this person, sort this out, go and speak to them. I knew what to do, so then I was like, God how do I get round this, it's like a big thing...it was like people'd ring and say right I've got this problem and this is what I need to do and I'd go right this is how you need to do it, one phone call to them, do you want me to do it, or are you alright with it? Aghh will you just do it, yeah, alright, it's like anything, it's like you go, you get a letter through the door and it's like a bill, right I'll just go and sort that out, I'll just go and pay that. I knew that I had to do it, it had come so I had to do it, but now it's like everything's just a drag, it's like I don't want to deal with it, just leave it and it'll sort itself out why should I bother, it'll just do it on its own."*

That said, our interview drew to a close as follows; "*I just hope I've been helpful for you* (you have, you have it's, you know, and like I say, I don't know how you're going to take this, but you do come across such a warm sort of strong person) *thank you* (I just hope that things really start to pick up for you because you know) *they're getting there* (yeah, and I think if you can kind of hold onto that) *there's only me that can do something about it there's nobody else that, I mean, I have got people there to support me and be there for me, but at the end of the day it's my choice to get up out of bed in the morning."*

Yalom's (1991 p7) claim that whilst the *"the physicality, of death destroys us, the idea of death may save us*" may help to explain Ellie's capacity to find something within her to carry on despite her experiences and current thoughts and feelings. Perhaps her confrontation with death has reinforced her need to live, if not for herself then for her daughter.

Post script

Ellie and I had made contact and arranged to meet. Unfortunately Ellie did not attend and when I telephoned there was no answer, I felt disappointed and anxious that I had not been able to conduct the

interview. When I did speak with Ellie later she was very apologetic, she had been ill and did not have my telephone number to cancel.

When we met and I asked about sexual orientation, Ellie described herself as *"normal straight."* I recall disliking the implication that to be gay was therefore not normal and I wondered whether we would connect in the same way as I felt I had done with Celia and Margaret. As the interview progressed I became acutely aware of the pain and anguish Ellie had suffered and her perceived inability to sort the problems out. I felt as though I wanted to help her and feel this explains my comments towards the end of the interview. I relayed that she seemed like a strong person and when she expressed her hope that she had been helpful, I confirmed this, adding my opinion of her as a strong and warm.

I am not sure if my initial discomfort regarding the issue of sexuality led me to over compensate towards the end of the interview but at the time it felt like the right thing to say. I also felt Ellie was telling me how she had changed in relation to the experiences described in our interview and I wanted to convey that I understood the gravity of how this must feel. Additionally, I had the impression that Ellie regarded herself differently now and whilst some of this was associated with her situation, I also felt she was depressed and that this was having a significant effect on her ability to make sense and cope. I think this might have led me to make the comments mentioned which were more akin to what I might have said had I been working in A&E with Ellie, almost as if *"coaching"* her to see herself more positively.

I could relate to some of Ellie's experiences, I also went back to live with my parents as an adult after returning home following university and a further five years of living in a different city and I could easily share some of the challenges Ellie talked of. Additionally I was struck by Ellie's use of age difference to explain her sister and brother not getting on well and I know I was thinking about my sibling relationships at this point and reflecting on my different experience to the one Ellie talked of. My point in including this does not relate to content as much as comment as this was an example where my narrative became a distraction.

I referred to the semi-structured schedule more in Ellie's interview than I had done previously and I am not sure why that was. It could be our interview did not flow as freely, and or, my initial discomfort might have impacted on the relationship we forged, although we did seem to develop a sense of ease around

each other. Alternatively perhaps it could have related to Ellie's outlook on life at the time we met.

There are times throughout the narrative where I believe Ellie to feel overlooked and I too experienced this sensation whilst working on Ellie's interview. I visited the service to see whether there were any participants for the study, walked into the office only to find everything had moved. This not only included the fixtures and fittings, the services paraphernalia but my participant information sheets and consent forms. I did not know this was to happen, I felt lost, insignificant and that my research did not matter, a potential concern which has emerged at different times and which I have struggled with.

Chapter 7

Riordan (Interview 4)

Riordan's is the final narrative and this chapter represents my attempt to portray the time we spent together and the links I made with theory as I saw it. Using the same format of biography, reading for the relational voice and emerging themes, the following discussion represents my understanding of Riordan's story.

Biography

Riordan is a 25 year old man who currently works in a gallery; he grew up in a working class rural community, his father worked as a bricklayer and his mother in a factory. He however, attended a grammar school for boys but due to bullying found school, up to the completion of GCSEs difficult. He graduated from university with a First class honours degree, has one sibling, an older sister who lives approximately 180 miles away and with whom he has a growing and emerging relationship, but reports difficulties with his parents who now live abroad.

Riordan says that he and his sister were physically abused by their grandmother at an early age but states he is as certain as he can be, that the sexual abuse perpetrated by his grandmother was reserved only for him.

He reports feeling distant and reluctant to engage intimately with others in later life and more recently experienced the breakdown of a relationship following his disclosure of earlier abuse. Such difficult issues experienced by Riordan, which also include a diagnosis of depression, appear to have been unheard by his parents and Riordan says that at various points in his life he has used cutting to manage distress.

Riordan said he first self harmed in adolescence, spent a period refraining from this but which had resumed more recently leading to his contact with mental health services. The re-emergence of self harm followed a number of difficult experiences and it was following four weeks of crisis intervention that we came to meet for interview.

Reading for the relational voice

Reading for *"I"* in Riordan's narrative allows focus on the parts of his story which he appears able to own and in relation to this, there are numerous occasions where he will say *"I think"* or *"I mean."* This is interesting in the context of a later comment where he talks of a split between intellectual and emotional aspects of himself. He uses feeling at a low point and cutting to exemplify his emotional stance whilst the telling of his story during interview is said to be from an intellectual position. He uses *"feel"* in a semantic sense but it is minimal in comparison to *"I think"* and *"I mean."* During Riordan's interview he recollected his abuse just over 20 minutes into our time together. This prompted his need for a break and it is possible that in doing so he was able to assume the intellectual stance he alluded to, return and complete his story without further overt distress.

Issues of power and control are found in relation to Riordan's use of *"I"* and he presents as being able to own his actions, depression and feelings. He is also able to consider options, be stoical and tries to be hopeful. However, he insinuates in this context that he may not always feel completely connected and at times will talk about being blank and floating above things.

He concurred that he has felt disconnected and where he talks about wanting to present himself in a particular way, only to have the *"other person that I left behind"* (in reference to himself) sneak up on him, there is a sense of these parts being separate and having a volition of their own. He also uses this to dispel a girlfriend's concern over scars saying he was a different person when the injuries were sustained.

A sense of power readily emerges in Riordan's tales of his father and again he is able to own these aspects of the story. He also reveals that at times he has endeavoured to make his father feel ridiculous and the disappointment Riordan expresses with regard to his relationship with his dad, may relate to justification for this treatment.

That said, Riordan presents himself in a particular way or rather denies particular ways of being, such as *"censorious," "moralistic"* or *"sniffy."* He also recounts how others thought him to be *"posh"* despite his description of having come from a working class background and it seems that his public self is important.

When he discussed trying to manage difficulties without self harm, it seemed that this can be a struggle. He does talk about distraction techniques but unfortunately this does not always work and he describes cutting in a vicious and frenzied manner when he has prolonged resorting to self harm.

At times Riordan appears to use sentence construction to distance himself from the abuse he suffered but he also refers to this as part of his character. This internalisation of the abuse in this way may help to explain his view of having a hijacked sexuality and difficulty with intimacy. Or alternatively may be a defence against dissatisfying relationships.

Riordan uses *"we"* not as a form of collective responsibility but rather to denote where he is involved with another, be it family, friends, work colleagues and myself where he referred back to something we had discussed earlier in the interview. In a discussion pertaining to his father, Riordan says they were not close but that he wanted them to be. He recounts an earlier conversation about reading books with a view to sharing thoughts about them, but when Riordan broached this, his father was dismissive and this was a significant disappointment for him.

It may be that Riordan does not need to use a collective *"we"* to dilute responsibility when recounting actions and events in his narrative as his strategy is to disconnect himself in other ways. Such as saying he was a different person, or it did not feel like him, that he was floating and so on. A closer exploration of his use of "*you*" adds to this insight.

Riordan regularly uses the terms *"you know" "if you like" "to be honest with you"* and on occasion *"you see"* seemingly as a way of engaging the listener, but there are also aspects of the narrative where the use of *"you"* distances him from the story. Social networks and belonging are examples where Riordan will refer to himself as *"you"* and whilst he is able to own his depression and self harm he does occasionally use this strategy seemingly for distance, for example *"because of the blades, you can sort of work out how deeply you're going to do it," "when you're in a sort of particular state of mind," "when you suddenly realise you've got an enormous gash on your arm which is bleeding constantly," "you don't even feel the pain really."*

The issue of his abuse is also recounted in this way at times and may also relate to the distance placed

in the narrative where issues of sexual identity and sexuality are recounted. "*Obviously you have a kind of sexual appetite so to speak.*" "*A lot of people, you know, would make sort of references to the fact that they would consider you to be gay.*"

Previous mention was made regarding the importance of Riordan's public self and this is also portrayed in his use of *"you"* where he distances himself from displaying a disparaging attitude towards his mother and as a persecutor who makes his father look ridiculous. He also uses this strategy to detract from what seems to be a desire to be aligned more successfully with his father.

As would be implied from the preceding section, a number of emerging themes transpired from Riordan's story and given the focus of my research I was interested in the first time Riordan had self harmed, and this is where the discussion begins.

Emerging themes

Do you remember the first time?

The process leading to the first time self harm is resorted to has intrigued me. I have wondered if any thoughts or feelings could be recalled in an attempt to try to understand the process, and took the opportunity to ask Riordan. "*To be honest with you, I mean, it's a great question, I think erm, you know my personal I mean, I think I heard about it, I do remember having a conversation with a girl I used to know at a theatre group I was a member of and she happened, and we'd talked about bullying you know and all this and she said to me, you know I sometimes, when I get upset I cut my hand you know all this and I remember sort of being quite taken aback by this because I think it was the first time I'd encountered that and I must have been about oh how old would I have been? About 14 I think something like that... it wasn't something that I kind of took on board coz to be honest with you, I do oddly enough, as is always the way, remember thinking that's a bit odd, you know, but not being you know, not saying that to her or being you know sniffy but er you know I think it kind of stuck in my head a bit...*"

In many ways this could represent an inherent worry which has troubled practitioners, and in all probability, since its higher profile through the media, parents of adolescent children. The issue of contagion is reported in the literature and in some ways has been used as further evidence that self

harm is a maladaptive and infectious coping mechanism. In Allen and Beasley (2001) we mentioned this within secure provision but stated it may be an issue related to anecdotal evidence influencing perception. However, work which is suggestive of contagion and self harm includes Garner and Butler (1994) and Taiminen et al (1998). That said, it should be noted that it is far from surprising that individuals living in close proximity within a group setting may encounter similar experiences and use self harm as one way of communicating and managing such circumstances (Marzano, 2007; Shaw, 2002).

Riordan could just have easily dismissed this as something *"odd"* and not to be pursued. The reasons why he did begin to self harm are potentially alluded to when he says "*you know I think it kind of stuck in my head a bit coz when things got quite bad at school.*" And is an issue which is pursued in the section entitled *"suicide a step down."*

In a discussion relating to a build up leading to self harm Riordan goes on to say "*and erm you know, but there's no sense of shock from it, if you like, you just sort of look at it and you just sort of, you know, all of a sudden at that point you just go sort of numb from it, if you like, and you don't even feel the pain...I think I did when I started when I was a teenager, the first few times it really really hurt and then after a while I kind of got used to it, but then when I relapsed in December again it's the same kind of story but I got over the sensation of it pretty quickly if you like and then it, it's almost kind of like lancing a boil if you like, you know there's this kind of ache although it's not a physical ache and then you know...yeah, once you've done it there's a kind of relief and there's a release if you, so you're not feeling down at that moment in time you know, I mean sometimes you can wake up the next morning kind of thing and think what an idiot I was you know, but, sometimes you don't feel that at all really.*"

Contained within this exploration are a number of insightful and useful descriptions. The proposal of self harm as a release has been commented on within the existing literature. It is also interesting that in relation to psychoanalytic theory, Bateman and Holmes (2005) discuss the idea that neuroses resulted from a damming up of painful affect and in a similar way to lancing a boil, relief could be gained as mental distress was released through verbal expression (abreaction).

The use of this metaphor both by Bateman and Holmes (2005) and Riordan seems apt and conveys a

positive image of releasing impurity or infection. Yet the method of this release is different and whilst it might not be unreasonable to suggest that the end could be seen to justify the means, this opinion is not held by all practitioners and members of society in general.

The insightful description regarding the release that self harm offered Riordan led me to ask a question regarding patterns of self harm and difficult interpersonal experiences. At this point the details appeared too difficult to contemplate and Riordan said *"erm, yeah, yeah I think that's probably a good er, fairly accurate summation, because I think, when I started doing it as a teenager I couldn't quite work out why I was doing it erm, I mean, I think there are a couple of erm...earlier experiences, sorry do you mind if I just get a cup of tea or something like that..."* What then followed was a short break from recording after which this issue was explored further.

A hijacked sexuality

It was clear from the onset that issues of sexuality would permeate Riordan's story as when I asked about his sexual orientation Riordan commented "*erm, I probably would say heterosexual, yeah, there was a period over, when I think I was a teenager, when I wasn't entirely sure, but er, I think I've settled into my heterosexuality.*"

The issue of settling into his sexual orientation does not convey an image of this being a smooth process and sexuality and intimate relationships become implicated in Riordan's contact with mental health services. When asked about the events leading up to this he said "*everything seemed to be coming into place for me if you like, erm, then unfortunately by the end of the year things started to sort of go a little bit wrong, erm work was getting a little bit awkward, I was getting fed up with the place, erm I'd formed quite a, well a very close friendship broke up rather erm well acrimoniously, and erm and erm I had a relationship with someone for a couple of months and that, well, for a few months, 3 or 4 months and I was having to deal with some personal details about myself which I happened to disclose which I hadn't really disclosed to anybody before in a relationship context erm, and she felt a little bit uncomfortable about it and unfortunately the relationship sort of ended in December and that kind of, that was sort of like the trigger if you like.*"

Following a break in the interview Riordan was able to disclose significant events from his earlier life.

"yeah that's right, erm, yeah, I mean as I said, yeah, I think that's probably fairly accurate because as I said before erm, a couple of experiences when I was younger and they were unfortunate, I think, I mean in terms of my relationship with my parents, never really been particularly close so, or with my sister, or any other members of the family and erm there was a point when I was 10 and I went to stay with a relative, it was my grandmother and there were a handful of erm, experiences of erm, abuse shall we say, erm, which at the time never really, it never really occurred to me what was going on so to speak or... I was 10, erm, but it didn't really feel erm, I don't know how you put it, unusual as such, although you're kind of aware I mean a lot of people say, not that I've met anybody else, a lot of people I've heard about have said that, you know, that they find it, they they they sort of realise that maybe, there's something going on that they're not sure about, they have, get the impression that perhaps it's not right, you know, it's not something you can really put into words if you like or, sort of understand coz you don't know how to."

Whilst the link between childhood trauma and self harm is not definitive, there is a significant amount of literature pertaining to this possible connection as discussed in the literature review (Glassman et al, 2007; McAllister, 2003; Pavio and McCulloch, 2004). However, there are also those who self harm and do not recall such trauma (Alder and Alder, 2007). As such the intention is not to propose cause and effect here but to illustrate that this is an experience Riordan had and which has created interpersonal and intrapersonal difficulties for him. This passage of his story then continues.

"...I mean coz when I was younger, she used to be quite erm, er, abusive physically I would describe it so, towards my sister and myself erm, and that was probably when I was about pre school, something like that...I mean in a way I did find her a very intimidating personality and she's also very manipulative you know, erm, I'd say that when she started being quite violent to my sister and myself I mean my mum noticed sort of erm bruises and cuts and things on our backs because she used to hit us with sticks but my dad was always rather erm, loathe to believe it, if you like or accept it... and I think his reaction to it was oh you know, it's it's just rough and tumble and all this, but erm, then with the, when it actually did become sexual when I was 10 I think the erm, I don't know, I just never, never really felt the need to sort of say anything to anybody... erm, I mean I can remember some very unpleasant aspects of it, that, you know and at the time they did bother me, you know, as you say, you don't really have the language...."

There are a number of issues contained in this aspect of Riordan's story, his abusive, assaultative grandmother, and the parents with whom he does not feel particularly close and seem unable to hear his distress.

In relation to child sexual abuse, Broom (2008) states that traditional gender roles depicting females as nurturing caregivers may cause victims difficulty in understanding their experiences as abusive. Riordan was able to tell his parents of the physical mistreatment, but he did not tell of the sexual abuse, possibly in keeping with Broom's contentions. It may also be that as his father seemed unable to accept the physical cruelty perhaps Riordan felt it unlikely he would be believed with regard to the sexual abuse.

A further proposal, as highlighted by Broom (2008) is that females are afforded greater physical contact with children and are more likely to be involved in intimate care. This may have left 10 year old Riordan feeling confused about his grandmother's abusive behaviour.

This also relates to the issue of language and as Riordan acknowledges, he might not have possessed the verbal capacity to express what was happening. Etherington (2005) states that childhood trauma can leave the person voiceless and isolated. Experiences may be so overwhelming that the child may disconnect from parts of the experience in order to survive it. When trauma cannot be spoken of directly, either because the person is too young to have language or a frame of reference for the experience, or because threats or refusal to listen has silenced them, a verbal link can not exist between disconnected parts. Etherington (2005) uses this proposal to suggest that in the absence of a verbal representation of the trauma, other ways to communicate separated experiences may be found.

The implications of his grandmother's abuse are explored further where Riordan says." *I think a couple of years ago, erm coz it, I mean it really started playing on my mind again when I was at university, now when I was speaking to somebody at the* (name of service), *I think they said to me, because I said I didn't think about it for a long time, they said to me, well when did you first start thinking about it and I said oh, probably when I was about 18, 19 or so, probably more about 19 and they said, you know the person said, when did you know lose your virginity and I said well it was probably about when I was 18 or 19 so then I started to think, right, ok, maybe that might have been, might have been it, I don't know."*

This part of Riordan's story describes a developmental crisis point, becoming a sexual being seems to be regarded as a trigger for Riordan. Bateman and Holmes (2005) refer to the interplay between the paranoid-schizoid and depressive positions as continuing throughout life and underlying the major crisis points of psychological development. Becoming a sexual being not only invokes this crisis for Riordan but is also hugely significant in his self concept and identity as indicated with reference to the issue of his sexuality.

"I mean one thing I found when I was in school, I mean, I know a lot of people when they go through adolescence there is kind of adjustments to the fact that your body's changing and all that, but I mean I erm I don't want to adopt the, you know, but I always kind of felt as though it kind of hit me a little bit more strongly than it did other people... when you start considering yourself as being you know, a sexual being I think, I kind of felt a certain element of disgust, if you like, for the fact that, you know, obviously you have a kind of sexual appetite so to speak and erm, I think it might have stemmed from, that it might have stemmed from being at an all boys school, you know, almost kind of puritanical view of things, I mean not that I was ever censorious or a moraliser or anything but I always kind of felt as though, you know that that kind of thing wasn't really for me so to speak, and I think because of that a lot of people you know would make sort of references to the fact that they would consider you to be gay and things like that there was a lot of homophobic abuse and there was a point where I, as I mentioned before I genuinely kind of considered, well I mean perhaps that is the case erm, and there was a bit of experimentation but I sort of realised that it wasn't, you know my sexuality, but it kind of felt like...I kind of feel almost as if my sexuality was kind of hijacked at an early age you know."

The issue of feeling an element of disgust and in actively considering what his sexuality might be is of interest. Crowe's (2004) contentions regarding shame experienced by people who have been sexually abused is relevant here. It is also notable that his hijacked sexuality may be a part of himself that is difficult to own and is disconnected from him. Such disconnection is contended by Connors (2000) to be one of the primary effects of trauma. It may also be that as his sexuality is a recurrent theme throughout the interview, Riordan attempts to project this part of himself outwards as the trauma he has experienced renders this too difficult to own, embrace and celebrate.

Riordan's view of his sexual identity is given more consideration when he starts to describe "*erm as I*

mentioned before going to the doctors with a bad back and being examined and then finding erm the cuts... as I say I've read about it and I know it does seem to be you know a sort of female problem you know and the same with anorexia it's generally viewed as being a female problem... I don't know whether there was a kind of element of a struggle for identity if you like coz I don't necessarily feel masculine as such you know, now I don't know whether that relates to past experiences you know, like in some way or another I've been emasculated."

The implications in relation to gender in Riordan's story are interesting given that there is a wealth of literature advocating self harm as gender issue. This is reinforced in the literature review given the number of studies reviewed which specifically focused on women (Batsleer et al, 2003; Bohus et al, 2000; Corcoran et al, 2007; Huband and Tantum, 2004; Kemperman et al, 1997; Maghsoudi et al, 2004; Paivio and McCulloch, 2004 and Shaw, 2002). However, McAllister's (2003) contention that feminist discourse advocates the consideration of power and resistance as the crux of the issue in relation to self harm, as opposed to gender, has resonance with Riordan's description above.

Riordan's statement *"like in some way or another I've been emasculated"* can be seen to further relate to the issue of power. If the oedipal complex is considered, Riordan's declaration betrays a sense of literally being castrated and if this is considered metaphorically in the context of power relations, Riordan's grandmother who has hijacked his sexuality and castrated him albeit in a metaphorical sense, is portrayed as an intimidating and powerful character who not only abused him, but exerted an influence over his ability to speak of this issue.

Riordan's sexual identity permeates so much of his life and he questions the impact of his experiences of being bullied at school. *"I don't know if there was that element of erm, element of suspicion, if you like really I mean it's simplistic to say, but if you're not into you know football or what have you then you must be suspect... I think there is a kind of element that in those sort of environments there is that kind of animal farm aspect where I think they do feel they have to wheedle out who they perceive to be the weakest, if you like...I mean my philosophy was, I was never sort of, I never sort of responded in kind. I never sort of hit back at them although sometimes I would say things to them which wasn't always the best option but was quite pleasing I suppose (both laughing) but I think, I think erm because I sort of tried to float above it, even then in a way that probably wasn't the best solution... I think that meant they*

had to up their efforts a little bit, you know, so then when it really started to get quite vicious later on... it was the point when it was getting really out of hand and I was sort of getting really low."

The connection between Riordan's suspicious sexuality and the implication of increased bullying perpetrated towards him contains interesting imagery. The notion of him *"floating"* above it conjures up a picture of being removed and distant. As previously discussed, Riordan's sexual identity seems to be a disconnected part of himself, one which feels difficult to embrace. This lack of connection is pursued throughout Riordan's story and there are a number of instances which allude to it. These are not solely related to being disconnected with parts of himself, there is also a feeling of disownership and dislocation from family members and at times his friends.

Disconnected, disowned and dislocated

Riordan recounts how friends had become concerned about him and which led them to contact his GP and when asked how that felt, he replied "*erm I just felt rather blank about it really.*" Followed by *"I'd exhausted myself talking to the person before hand and it was at that point you know, when he said I tell you what I'm going to do I'm going to get in touch with your GP...and erm at that point I just felt as though I'd washed my hands of it completely, you know, it just didn't really feel like it was me."*

On asking if he had experienced the feeling of being disconnected before he stated *"yeah, yeah there are lots of, I mean I generally feel rather disconnected anyway to be honest with you especially amongst my age group and especially when I was younger I felt very disconnected."*

Again reference may be made to Connors (2000 p45-46) who states that; "*traumatized people, children in particular, struggle with a fundamental sense of disconnection from self and others, overstimulation and disrupted boundaries."* This seems to be an issue which pervades throughout Riordan's story, although he is not completely disassociated from interpersonal processes.

Riordan describes as an adult telling his mother about his abuse "*I really felt as though I should say something, you know, and and I mean I had to get drunk actually before I told my mum and erm and she kind of, she didn't act like she was surprised, but I mean she had the sort of classic line to it which was, oh don't tell your dad, which erm kind of annoyed me a bit really... I mean as I say with the grandmother*

thing anyway, with the abuse, it's never said, but you hear it quite a lot, you know, from other people who have experienced it, but oh it's our little secret you know and then I think erm you know, with relationships, sexual encounters there's that kind of feeling when you know it gets difficult to talk to somebody after that, and again there's the feeling of it's our little secret and then with my mum it was the same kind of thing I kind of got, it goes round in a cycle if you like...I mean I did actually erm, I mean, I did erm tell my sister actually last week...I kind of figured with all the, all the rubbish with my parents recently and the fact that, you know, it sort of emphasises exactly how much they do not er give a damn, erm, I kind of felt, well I kind of need some kind of family support and even though we've not been really close, I think since my parents moved away my sister and I have started to get on a lot better."

That Riordan's parents are particularly distant from him in both an emotional and physical sense, as they live abroad, is illustrated when he says "*I mean it's like, when I told them I was erm, I told them about the recent diagnosis and the fact I was on antidepressants and my mum, my dad sort of tried to take it in but I think he struggled, erm, and I think my mum just sort of immediately dismissed it outright and then we had a bit of an argument and I happened to mention about self harm and suicide although I don't think she actually paid too much attention, but that wasn't a kind of sympathy vote or anything I was just telling it like it was, and erm I think she sort of came round to it after that, but when we have talked about it it it well its always in a very circumlocutory way you know there's no, you don't directly confront it, you know, so the question's always erm, is everything alright, you know with that? You know that that kind of conversation...and I mentioned it to my sister and I think she sort of, I think she was totally shocked...*"

Riordan's lack of confidantes is hinted at here and when asked outright if he felt he had people he could confide in he said;

"*not really no, sounds kind of quite bad, I mean, I think erm even with friends as I say, because of the environment in the school I think there was this need for people to somehow survive it... even when things got quite vicious at times it didn't bother me and I kind of felt as though I floated above it, if you like, you know erm, so that was my way of sort of dealing with it, but then there were other people who I think kind of felt that they had to sort of join in...and even friends...the term fair weather friends sort of pops into mind in a way, coz it sort of, they kind of felt they did have to sort of protect themselves, which I understand a little bit better now, I mean at the time I was a little bit, well, irritated by it, I do remember*

erm between GCSEs and A levels I was studying with some of these people, some of these friends, they were actually surprised that I still wanted to know them or was actually able to forgive them...but no I didn't have a sort support network as such."

In a discussion relating to trauma, Rothschild and Rand (2006) discuss the propensity to freeze when under threat, to experience a dissociative episode and no longer feel afraid. As such, the authors contend that this response is a valuable survival defence. The image of floating above during times of threat is used more than once by Riordan and it seems that this implied distance assists as a strategy for coping in a similar way to that described by Rothschild and Rand (2006).

Although Riordan describes limited social networks which, according to the Department of Health (2001b) is a risk factor for impaired mental health and includes unsatisfactory workplace relationships and isolation. This is not a wholly consistent feature of his social life and there are circumstances where he feels accepted and which can be regarded in a protective capacity (Department of Health, 2001b). One such instance is where Riordan recounted his experiences of working in a factory in his home county saying;

"I mean the people that you're mixing with, I mean I'm not (pause), well they're not interested in er Proust or anything like that (laughing), but I mean it was ok though coz I was kind of accepted there...I mean even though I didn't have a lot in common with them, you know, and erm it sort of gets a little bit tiresome hearing about such and such's sexual conquests last night and you know... I feel like I could have a laugh and a joke with people you know, and they kind of kind of did accept me in a way really coz I, I, in terms of the fact that I could come out with a quip or something, you know, or, or a joke...in terms of the place I work now, there's a very kind of bitchy atmosphere, you know and all sorts of you know, it's to be expected in the arts because of everyone trying to outdo each other."

However, despite feeling he could relate to some of his co-workers in the factory, his home surroundings remain problematic for him *"I mean when I did, when I was back there I think Christmas... I think that was for a party at someone's house on new years eve and the attitude that I got from a lot of people was, it was kind of the sort of thing you'd have expected in the 60's really, erm if somebody had say gone from a working class rural community to go to university kind of thing...and again I was on the*

outside of things, there were erm, a lot of comments made and a lot of erm, there was a real kind of attitude in the room towards me because I wasn't from there anymore if you like...ok, well I sort of cut myself off from there if you like really, I mean it wasn't necessarily, I mean there was an element where I did want to cut myself off completely from the place but then again I kind of thought to myself well it would be nice to go back and see people again...and although I have been in contact with a couple of people from there recently, I mean, you know, I don't really feel as though I could go back, even just to visit, I mean I don't have any family there now as such anyway, I mean even up here to be honest with you."

This caption from Riordan's story portrays a feeling of fitting in neither here nor there and seems significant in relation to how he locates himself in conjunction with others. Yalom's (1991) notion of existential isolation appears to provide an insight into a sense of ultimate aloneness in Riordan's story and he alludes to this in relation to feeling disconnected when he says "*the first tablets I was on citalopram I took those for, well the first couple of weeks, I mean the first week especially was fantastic... you know they gave me this really wonderful sort of sense of listlessness and you know er, going back to what we said before, disconnected but even more so, you can just sit back and watch things you know, but then I think as the weeks went on they clearly weren't doing what it says on the box and erm I think, and that was the point when I was referred to the (name of service) because even though I was taking them, I was taking them in the morning erm, and then in the evenings sort of cutting you know and getting upset."*

Cameron (2007) describes how some people cope with uncontrollable stress by dissociating. Once in a disassociate state, an awareness of pain is said to diminish in conjunction with the experience of difficult feelings. Alternatively Cameron goes on to say that paradoxically other people may use self harm as a way to end dissociation by using pain and the physical act of injuring oneself to bring back an awareness of one's body. Whilst Riordan's descriptions are more akin to feeling disconnected than experiencing a dissociative state, he seems to enjoy some benefits of feeling he is not completely connected to the world around him.

The ambivalence Riordan feels in relation to belonging is particularly evident where he claims, *"I mean again going back to self harm and depression, I don't know whether that stems from a need to belong or*

not feeling like you belong, or what have you, I don't really know, I mean in a way I do kind of quite enjoy the feeling of being on the outside of things if you like it it kind off makes you a little bit more, not interesting as such (laughing), but I think erm, you're not kind of roped into things so to speak so you're not erm, you're not seen in a particular way." This ambivalence is also reflected in how he feels about his self harm as there are times when self harm feels problematic for Riordan but also when it represents a sense of reassurance and pride.

"I mean that's one of the occasions when you do feel quite pathetic about it really coz it sort of erm this is my crutch if you like." This conflicts with his desire to be strong and not weak and there are occasions when he tries to refrain from self harm in the form of cutting, but as the underlying issues remained unresolved for Riordan this manifested in an alternative form whilst staying with friends during Christmas *"I know alcohol is a depressant in itself and its not sort of a good thing to go down that path of using that as a crutch in itself but at least it kind of did distract me for a period of time."*

Yet as stated above, self harm is something Riordan seems to feel reassured by *"and I mean the strange thing is once I stopped doing it which would have been in about 99 or so, erm just before I went to university. When I was at university I do remember the scars had sort of erm settled to the point where, as I say they were not really all that noticeable erm, but I mean at the same time there was the kind of feeling of adjusting to it if you like, and, in a way it sort of became part of my identity so to speak...you sort of recognise yourself and elements of your personality through them...I suppose there's a perverse sense of pride if you like in the fact that I have them, because it wasn't as if I was showing them off to erm, I genuinely felt sometimes I'd wake up and I didn't notice them you know for months weeks what ever, years in fact, and I would kind of catch sight of them one day and I'd kind of think, ah well, I'm stronger that that, you know erm, little did I know (laughing)... it's as I mentioned before it's the fact that I'd kind of reinvented myself or tried to reinvent myself before I came to university and became you know the person I genuinely felt I was, rather than the person that other people thought I was."*

This aspect of Riordan's story reveals an ambivalent relationship with his scars from self harm, there is a message of survival being portrayed in Riordan's sense of pride yet conversely a connection with needing a crutch, being weak and not strong. Riordan's public and private self are fleetingly reflected here and this becomes particularly poignant in the following excerpt from the narrative.

Fathers, sons and a private communion

"I'm prone to depression anyway, I mean the first time I had depression was in 2002 I think, something like that, while I was studying and I didn't really pay any attention to it really coz that, I don't know I've never judged other people who've told me they've got depression or anything like that, but in terms of myself, I suppose my upbringing, I've always been led to believe, you know, what a load of rubbish you know all this... the type I have you sort of go from real lows to sort of real highs and when the highs are there you know, you're sort of invincible if you like, you know erm and I think I'd reached that sort of low point and I think erm a lot of rubbish started pouring out so to speak."

That his upbringing led him to deny his experience of depression possibly because of how it might affect others views of him is interesting. As is his description that his family rubbish the issue of depression, and a lot of rubbish started pouring out from him and despite his disconnection with them, they continue to exert an influence. This may represent the difficulties Riordan experiences with his immediate family which are revealed in a later discussion concerning his father.

"I got a telephone call from my parents, who had been speaking to my sister who I'd kind of opened up to a little bit about certain things, and the fact that I'd been off work and all this, and my dad was kind of er, well, livid but I don't think he could really understand why I was off, because I mean to be honest with you, it would have been completely impossible for me to have been in work at that point, you know, doing anything, I just wouldn't have been any use whatsoever and erm it was the usual, oh you know, depression what a load of rubbish you know all this pull yourself together, you know, and what you going to do about money, he seemed more interested in my financial status than, you know, my well being, and that really, really pissed me off you know."

This passage in Riordan's story may expose a number of issues, perhaps a desire for his family to care in a way he wishes they could, but also the justification he offers as to why he was unable to go to work, which may link with Riordan's views on wanting to be strong and is further revealed in a conversation relating to his grandmother.

"she did have a, well, it was a guy that she'd been having an affair with when my granddad was still alive and he sort of still looked after her for a long time, he sort of came round to her house quite a bit

but you know, he was one of those sort of people, I always felt quite, I felt quite close to him in a way, because on the one hand he was like a substitute grandfather in a way, but at the same time, I think in hindsight I actually feel quite annoyed at him because in terms of how manipulative she was you know, in terms of her attitude towards him erm, I always kind of felt that he was quite weak, in a way really for allowing himself to be manipulated in such a way ...I'm not saying he knew what had been going on, but I think he knew what she was like."

This male character in Riordan's story who has been manipulated by his matriarchal, intimidating, aggressive and abusive grandmother may represent a part of Riordan who identifies with this treatment and here he may not only be deriding his grandmother's lover, but also himself. Additionally this may also explain why he wishes to be perceived as strong and why his father's negative response to aspects of him which could be interpreted as *"weak"* are so hurtful.

Riordan allows further insight into his interpersonal relationships and *"public self"* when he says; "*so it makes sort of interpersonal relationships, perhaps using the word relationships in the most recognised term, erm, probably quite difficult, you know erm, I mean I very rarely get involved with people, erm, in a relationship or in a kind of sexual sense, but then I mean I was fairly promiscuous I suppose, but that was because I was trying to sort of, you know, make up for lost time (both laughing). I suppose, or I was coming to terms with myself if you like, I mean I stopped I stopped cutting before I went to university because I think there was this kind of feeling...this is my chance to kind of, not reinvent myself in the sense of lying about myself, but reinvent myself to be the person I really wanted to be, that I feel that I am, but the annoying thing is, that I think you know that other person that I left behind in ______shire, I think sort of sneaked up on me you know...you know you erm make divisions between...it's hard to describe, I mean if I can get all literary for a moment (laughing) I mean there's a moment in erm Edmund Gosse's book "Father and Son" it's about the relationship with his father where he says at an early age, he sort of recognises there are two sides to himself, the public side which his father gets to see, quite a puritanical father and oppressive, and then there's the other aspect of his personality which is the side which he keeps to himself, and I think he mentions it as a kind of private communion of things, erm, because I kind of feel quite energised by it, I feel kind of, it's an accurate description..."*

There is a sense of desiring an escape contained in this passage almost as if going to university would

provide Riordan with the opportunity to leave aspects of himself behind. Yet he was sneaked up on and in a way the lack of perceived control implied by this sentence in the narrative resonates with other aspects of his story. The experiences relating to his grandmother's abuse, his parents disparaging views concerning his mental health and his desire to be the person he wanted and believes he should be. This perception of split parts may again reveal a sense of disconnection and as previously alluded to, this relates not just in an intrapersonal but interpersonal sense.

This is referred to when Riordan continues the above passage saying " *I very rarely sort of got involved with people and then this last relationship, last year, erm, was quite special in that, I think there was one particular evening I happened to mention when we were in bed together about the abuse, you know, I mean I hadn't set out to say anything, it just sort of came out so to speak, because I felt really comfortable with the woman in question and she was ok with it to begin with, but then I think it quite clearly sort of played on her mind...So that kind of led to the thing (pause) ending really...it was awkward because well, I mean erm, as I say I think that was the kind of trigger if you like, erm, for things as I've mentioned before, I mean I think it, erm, that the cutting started again because it was a kind of feeling of, it did kind of feel like I was trying to rediscover myself or reclaim myself if you like...*"

The need to rediscover and reclaim seems particularly important to Riordan and again is reference to a private and public self. It could be regarded as Riordan giving the most private part of himself to this woman through his disclosure of abuse and in the form of a sexual relationship. These are aspects of himself that he rarely gives, and her inability to cope with it and rejection of Riordan may reflect a need to reclaim these parts.

Intimate relationships are pursued in Riordan's story but are so within the context of a power dynamic within the family "*...when I was talking to my sister the other week, erm, we did have a bit of a conversation about my grandmother and her violence if you like, and erm, and she made, my sister made a comment about how it had rubbed off on my dad and I do remember one point when I was a kid, er, hearing a lot of shouting from downstairs and you know getting out of bed and going down and seeing my dad holding my mum against the wall, and erm, you know he was shouting at her and she had this sort of gash in her forehead, you know, and I mean, that was quite, erm, you know an odd thing, and I've never adequately been able to explain it, and I did broach it with my mum, one of the times*

when we were talking about my grandmother actually, you know of course she vehemently denied it ever happened, you know, ahh no, no, no I don't know what you're talking about and all this..."

Riordan's mother's denial of this is reminiscent of her inability to hear his distress, as if such denial may protect her from the associated pain of admitting these incidents may have occurred. It also ties into the issue of not being heard as discussed previously. The portrayal of power perpetrated in a physically abusive way must resonate with Riordan's own experiences with his grandmother and when asked whether violence perpetrated by his father extended to him, Riordan said;

"erm, no, no I mean, I think it's the fact that, I mean, he has got a kind of manipulative quality and I can see elements of my grandmother's personality within him, you know, and I think, er, what used to irritate me when I was growing up was this constant kind of power struggle going on between us if you like, or at least I wasn't trying to...I wasn't sort of, trying to buy into it myself, but it seemed really important to him for some reason to be the one who was the, I don't know if that's just a male thing.. if power is sort of wrestled from him in some way or another... if you can make him look ridiculous, he sort of recoils a little bit, coz he suddenly sort of realises that...I don't know really... I don't think he likes that, sort of being reminded of the fact that he's being ridiculous..."

This description of the power struggle between Riordan and his father seems to conflict with the image portrayed and critiqued by Flax (1991) of father and son forming an alliance to resist the return to the repressed mother world. There seems little sense of an allegiance between Riordan and his father, with their relationship being characterised by conflict.

"...I mean again, another example is...I have a tendency sometimes when I'm having a conversation with people to use the word, well, and I'm aware of this, you know like when they say something about the weather or something I'll say, well, oh you know...and we were having a conversation, well, he was telling me about something that really narked him in the news, polite conversation, and I said, well, and he said what do you mean? What do you mean? What, what, what? Are you saying I don't know what I'm talking about? All this kind of stuff, you know, which just seemed so stupid, and I leapt on that immediately and just said calmly to him, well, you know, I said for Christ sake, if you want to have a discussion about semantics we can have a discussion about semantics but for goodness sake let's just

shut up, you know, I don't really see why you're so frightened of words..."

When asked if Riordan thinks his father fears his son knowing more than him "*erm, I think there may possibly be an element of that, yeah."* This may be an aspect of the difficulties within their relationship, however, an earlier recollection may underpin much of the conflict from Riordan's perspective as he recalls an instance where he felt disappointed and let down by his father.

"one of my big disappointments was when I was really young, I remember he had this, I mean, I remember we were up in the attic one day and he had all these books and er, they're all books about sort of science and art and erm, classical music and all this kind of stuff, and erm, he said to me erm, oh one day you'll have read all of these and then we can have a really good talk about them, you know and all this... you know, sort of stuck with me for a long time and I think after university... I was at the point where, oh we could have a discussion about that and I tried to and it's like, oh no that's just a load of old rubbish that is...and it's like, oh, right, ok, well why did you say that then when I was a kid, I don't know, those kind of things stick with you a little bit."

The importance of this recollection as an insight into Riordan's relationship with his father is particularly poignant. In one way it represents successful resolution of the boy's oedipal complex which includes identifying with the father and abandoning the wish to overthrow or displace him. Yet in a sense Riordan has been abandoned by his father who may fear him, his knowledge and ability to articulate himself and whose solution is to change the rules of the game.

To be accepted and appreciated by his father seems important and in many ways Riordan has kept his side of the bargain. He developed a healthy interest in literature, he has the capability to read and understand all the books in the attic, yet the rules of the game have changed. In his discussion pertaining to meaning and meaninglessness Yalom states that "*one who possesses a sense of meaning experiences life as having some purpose or function to be fulfilled, some overriding goal or goals to which to apply to oneself."* (Yalom, 1980 p423).

For Riordan his application to attaining this goal has been shunned by his father and if one meaning, of meaning, is that it is an emollient to relieve the anxiety that comes from facing a life and world without an

ordained, comforting structure (Yalom, 1980) perhaps it is not surprising that Riordan found himself in crisis. The fluid rules in his relationship with his father in a sense replicate the abandonment of such convention by his grandmother through her abusive and assaultative treatment of Riordan and is perhaps insight into why, for Riordan this represents "*one of my big disappointments.*"

In terms of his mother "*erm, she's always been in the sort of periphery (laughing) that sounds like a bad thing to say, but it's like erm, and I mean to be honest with you, and again it sounds really horrible, but I can't necessarily see what my dad sees in her as such, I mean that's not criticism about my mum so to speak, it's just they are sort of chalk and cheese really coz I mean she's a fairly standard kind of ______Shire (pause) woman you know ____shire lass in the sense that...I don't mean that in a snobbish way, you know, but or intellectually snobbish way, but I do kind of feel a bit, it's difficult talking to her about stuff or talking to her about interests if you like.*"

That Riordan describes his mother as always being on the periphery, may relate to Parker's suggestion that, whilst it is not inevitable "the *need to separate out from his mother, denigrating her in the process, may be a feature of the son's struggle.*" (Parker, 2005 p265). There may also be a part of Riordan that blames his mother for being unable to bear his distress and in keeping with Parker's (2005) statement that "*raised in a society where primary responsibility for childcare is placed in mothers' hands we are, inevitably, marked by our mothers, and inevitably we will blame those mothers when things go wrong.*" (Parker, 2005 p259) this may help to explain his expressed opinion of her.

Riordan does however, enjoy positive feedback from others "*I know it sounds like I'm blowing my own trumpet, but when I arrived at university and we had meetings with our designated personal tutor in the first year, the first week I think, and er she sat me down and she was looking through my form and file and she said to me, oh you got 2 A's and a B at A level and I said yeah, she said what you doing here then? (laughing).*" It also felt notable that Riordan was eager not to be perceived as condemnatory, snobbish, sniffy, or downgrading others, and which seemed to represent difficulties in owning all parts of himself. In fact this also related to his accomplishments of which Riordan said "*sometimes they sort of play quite strongly in your head, other times you sort of disown them if you like, depending on your mood.*"

Riordan's desire to be viewed in a particular way can be related to Winnicott's (1966) notion of the true

and false self. This relates to the contention that if mothering is *"good enough"* the infant's development is personal and real. Conversely where such conditions are not *"good enough,"* Winnicott (1966) describes the infant as becoming a collection of reactions to impingement where the true self fails to form and is hidden behind the false self. According to this theory, a true and false self exists in everyone and whilst the true self, which expresses authenticity, will be hidden to varying degrees, the false self is a compliant adaption to the environment. The intention in making reference to this concept is not to reinforce Ussher's (1991) criticism with regard to mother blaming and Winnicott's (1991) contention that all children show evidence of adversity regardless of upbringing may be seen to mitigate against this criticism, but rather to consider that for Riordan his desire to be seen in a particular way, which appears apparent at different times in his story, may relate to a true and false self.

Suicide a step down

Riordan summarises the development of his self harm saying *"I'd mentioned to the erm doctor that I had to speak to, that the self harm had reached a kind of peak if you like, it was a little bit more, it wasn't just kind sort of cuts or scratches it was getting quite aggressive, and she put it to me quite bluntly, she said either you go along to (name of service) tonight, or you can wait until erm I can't remember, a couple of days later to see the psychiatrist at the surgery, or you can not do anything and I can get a telephone call from the coroners office which you know...I used to do it as a teenager erm, and that was from about 97 to 99... it was just scratches really and occasional cuts which left some scars but nothing too noticeable unless you were up close... it sort of gradually built up till I was doing it more and more, erm and it got to the point where there were a couple of occasions where maybe erm, I couldn't do it for a while because my arms were sort of covered if you like, with cuts and scratches...it comes out of nowhere say in the evening because it's normally in the evening that I do it, it'll start of with a feeling of anxiety about something, and then it turns to frustration, and then in a way, kind of rage if you like, but that turns to a kind of, if I can be melodramatic about it, a kind of impotent despair if you like, you know, and it's at that point normally when, you know, I sort of reach for the scissors."*

Riordan is able to expand on the above and also reinforce the association between self harm and interpersonal issues, by describing a telephone conversation with his father who expressed disquiet regarding his sons depression;

"it didn't end on a particularly happy note, I knew that if I stayed in the flat then I was going to be in for a, you know, I was going to make a cut or something like that, so I thought I'll take control of it, if you like, er, and I thought right, I'll nip into work... It's like a kind of grim joke, my ex walks in with her new bloke, lovely, you know, and erm, and then I'm informed that er my sick pay isn't quite as I'd hoped it would be, and erm, I kind of made the decision not to go home, I kind of thought, well you know, I'll go and talk to somebody, so I went along to speak to someone at the (name of service) which was ok... Thankfully I felt like I'd nipped that in the bud at that point if you like, then it got to a week later and I think because I hadn't managed to express the feelings, if you like, from that particular day and the sort of build up of it all, you know, then it sort of came out in a rather vicious cutting frenzy... which did involve, you know me going into A&E to have stitches."

As stated, these aspects from Riordan's story represent the interpersonal processes pertaining to self harm and how important they are but also highlights the current debate around harm minimisation, otherwise referred to as safer self harm. Riordan appears to be saying that his cutting was frenzied following difficulties in expressing his feelings before that point. The implication being that more severe harm resulted than might otherwise have been the case if such feelings had been expressed sooner.

When asked about the difference between self harm and suicide Riordan said "I *genuinely had, I suppose you'd say, thoughts about suicide if you like...and I suppose it, it just sort of seemed a step down from that if you like really...I mean it wasn't going all the way... I'd really like to be able to pinpoint exactly what triggered... but no it's it's a smart question really. It's one of those things I've not really sort of thought about too much...I think erm, with suicide you know obviously there's a finality to it, and I suppose sometimes with self harm...when it has become more aggressive if you like, there is this kind of genuine feeling of I don't care about what happens...at the same time I think that once you've actually made a particular cut as I say you can kind of almost stand back from it if you like, and as I say, going back to lancing the boil thing the, the ache or the pain or whatever is gone for that moment and there's an element of calm that sort of comes in...I think in terms of having suicidal thoughts, it sounds like a very glib answer but I mean, I think you know if you're going to kill yourself or if you intend to... there is something holding you back which is a kind of survival instinct."*

That self harm can be a survival strategy is clearly articulated in this passage from Riordan's story and

in this sense it is something that has helped keep him alive. The issue of self harm and suicide was pursued later in relation to the comment Riordan made regarding suicide as finality and I asked if this was the case, was self harm a way of carrying on. To which the issues of survival and strength were again referred to;

"yeah, I'd say it is really in a way, I think in the back of my mind there kind of is, a fear that maybe one day I sort of reach a point where I take it even further, but I think it is er it's a temporary survival mechanism really, I'd say more than anything else, I think it is the sort of thing whereby you know that if I make a cut tonight, right ok that's fine, and then you can go, in a way you've kind of disowned the cut once you've made it, almost then you can go on after that, then when you make another one say like a week later, 2 or 3 weeks later something like that, then you might sort of get the same kind of feeling, even if you do feel a little bit embarrassed about it the next day, you know, you kind of, it's like anything you just kind of grow and adjust to it really."

This notion may challenge dominant discourses in relation to what it means to be healthy, but Martins (2007) argues the importance of understanding and respecting the ways that someone finds to survive adverse experiences. This includes recognising that such strategies are adaptive rather than problematic and at the risk of being repetitive "*a small death, after all, is better than the real thing.*" (Yalom, 1980 p135).

The previous discussion has centred on the meaning of self harm for Riordan and an account of the difficulties he had experienced. I was also interested in what kept him alive and on asking him this question, it led to his tale about a llama called Steve.

A Llama called Steve

"Well I mean this is the question I, I think it's hard to say really, I mean, I think in a way I'm, I'm quite lucky in terms of the sort of sense of humour I've got, you know, I think that is a real sort of life saver you know...I mean sometimes when I'm down it's difficult to sort of feel that, but sometimes it, you know, there was a period well, bank holiday Monday I mean erm, I wasn't feeling particularly good, wandering around the flat and there wasn't anything to do, and erm, you know it was difficult to get in touch with people and erm, I saw something earlier on that day on the TV about Longleat safari park (laughing) and

it kind of erm, I had this thought that the keepers there were obviously having a bit of a cheap laugh at the animals expense, at the names they'd given them, things like, there was an ostrich called Trevor and a llama called Steve and a rhinoceros called Kevin (laughing). I mean it's either they're having a cheap laugh or it betrays a real lack of imagination and erm, I mean I think erm, as the day went on I sort of got to feeling a little bit worse, I remembered, it was at that point when I was kind of thinking, oh God, you know, and then that kind of popped into my head again and then immediately I kind of snapped out of it and had a good half an hour giggle about a llama called Steve..."

As discussed previously, Riordan makes the link between self harm as a step down from suicide and in this way can be regarded as a survival strategy. However, in response to my question about staying alive, rather than alluding to self harm, Riordan acknowledges and demonstrates his sense of humour. As a mature mechanism of defence, humour (Bateman and Holmes, 2005) in this context, makes it difficult to regard Riordan, as unconventional, (Anderson et al, 2003), nor is it easy to reconcile Riordan as someone who is undeserving and a drain on resources (Batsleer et al, 2003), manipulative, attention seeking and wasting time (Johnstone, 1997). All of which have been used to denote people who self harm within the literature and clinical practice. Riordan then went on to say;

"there's sort of separating emotion if you like, from the intellect again, the division of the two sides of your personality, because I know on the one hand, you know when I am at a low point or when I am cutting or something that's me being sort of overly emotional, erm, but then, I know when I can look at it or talk about it like, I'm doing today, I've looked at it from an intellectual perspective you know and sort of yeah sort of separate the two really."

This passage in Riordan's story refers to his emotional and intellectual parts as separate aspects of himself and just as he makes this distinction there is a parallel process in relation to his self harm. There are times when his *"overly emotional state"* is most apparent and when it seems he is more likely to cut whilst at other times he has refrained from self harming, such as before going to university, seemingly through closer identification with his intellectual side. This intellectual, reflective side of Riordan was contemplative when he expressed a sense of hope regarding his available resources, yet he also worried about self harm becoming habit;

"I think there was a period when I was getting a little bit concerned which was not too long ago, I wasn't feeling low, but I wasn't feeling, but you know I wasn't feeling anything, and I think I made a tiny little cut and I thought what did I do that for? You know, I don't need to, you know so I just put the scissors away and just carried on, you know which is, which concerned me if you like, coz it kind of worried me that perhaps you know if I sort of carry on with it it'll become habit...you know at the moment I'm trying not to, you know slip back into it, hopefully you know."

As Riordan was expressing what could be inferred as a desire to stop self harming in the passage, I asked what he might do if self harm was not an option *"I don't really know, throw a party (both laughing) I don't know, I mean, I think it erm, I mean it kind of er, kind of, I think probably the way things are at the moment, it amazes me if you like, that I managed to get all the way through university well from 2000 to 2006 without doing it, yeah you know, and the fact that it was shear effort of will if you like... I honestly have no idea exactly how I got through certain other times that were leading up to it....I mean, I think to be honest with you getting back to the writing aspect, I mean one thing I've found is erm, I mean I've had a couple of things published here and there on a small scale and I've got a little bit of money from it I've done alright with it.. I mean don't get me wrong none of it is autobiographical I think that's the lowest of (both laughing) but erm at the same time for me, erm I sometimes, with that, have drawn on feelings that I've had so to speak."*

The reference to refraining from cutting throughout university is reminiscent of the point made earlier in relation to his intellectual side and Riordan seems to be saying something important about his use of creativity, in which he is not alone. Etherington (2005) states that the value of stories as a means to stay safe in childhood despite being in unsafe environments may not be fully recognised. She goes on to say that her writing of stories helps herself and others to understand her and make sense of her life. In a similar vein, it can be inferred that through his writing, Riordan is enabled to channel feelings into other characters and as such may be projecting the parts of himself he wishes to disown through use of his creativity.

In reflecting back to Riordan's comment regarding his sense of humour, towards the end of our meeting I asked why he had attended for the interview *"erm, nothing on television, you know (both laughing) well no, I mean, I think it, I sort of thought well, when (name practitioner) first sort of suggested it, I thought*

well it might be quite useful you know... I mean when I've been talking to the (name of the service) for instance, or maybe even the doctor, or just a friend and like they've picked up on something that I've said, and er it's erm, sort of made me think about it in different way if you, and I think you've done that a couple of times today as well (laughing) which is useful." In many ways this felt reassuring and I wanted to believe that the potential benefit of our time together was not just one sided.

Postscript

Riordan's interview stayed with me for a long time, it took a while to be able to transcribe his words as I know his story affected me and at times I ruminated on his narrative and found that aspects of our time together made me laugh and moved me to tears.

We appeared to have developed a rapport early in the interview and I was struck by how quickly he began to disclose his abuse and in fact remarked on that during the interview. I wondered how it felt to be doing this given his previous disclosure of this, albeit in a very different scenario, had ended so negatively for him. I felt his ability to be open in this way was admirable, yet I also had and have a sense of how vulnerable one can be through such openness.

Riordan talked about being different within his family and amongst other areas mentioned politics within this context. This resonated with me as I have many memories of being the one saying something different or just being out of step with others in my immediate family. This recollection in conjunction with Riordan's story has led me to consider the human capacity to appreciate another's opinion which does not need to be regarded as right or wrong it can merely be different to our own world view and seems to fit with the idea of knowledge being constructed.

There are many aspects of Riordan's interview which were fascinating for me, at times his recollections regarding his self harm were reflections of many stories I have heard previously and I had an image almost of a walking textbook, bringing the detail to life.

I was also interested in one aspect which I interpreted as almost like sticking his toe in the water of his sexuality, which made me consider where one's sexuality resides. To me Riordan's description went beyond experimentation which is inherent in exploring this part of oneself. The way Riordan described it,

it felt to me as though he was discussing his (hetero)sexuality as something to be considered on an intellectual level rather than emotional, physical and innate and so it felt like a distant part of him.

Saying good bye to Riordan was difficult, he had been very engaging throughout and I felt he had been so giving with his story that it almost felt disrespectful to have taken it with no immediate reciprocity and I think this relates to my reassurance that he viewed the interview on one level, almost as a sounding board enabling consideration of the issues from a different perspective.

I did not expect to see Riordan again but coincidentally came across him in the gallery where he was employed and although I knew this was his occupation, I did not know where he worked and it had not consciously crossed my mind that we might meet at a future time. I worried about how this might make him feel. After all I engineered the interview process so there was no further contact in the hope that this would feel more liberating for participants and less anxiety provoking. Seeing Riordan contradicted this and I positioned myself in such a way that I knew he would be able to see me without my looking at him. I hoped this might give him the opportunity to leave the room seemingly without knowing I had seen him, if he wished. As it was we exchanged a polite hello which felt a very strange experience given our previous meeting.

Interviewing Riordan has given me an alternative perspective and has challenged some of my suppositions. Previous description of abuse in Margaret and Ellie's interviews was perpetrated male to female. Here the situation was very different and I had betrayed my own prejudice by asking whether his grandmother's lover had been involved in his abuse. That said I have been marginally reassured by Broom (2008) who states that sexual abuse by males has been more readily incorporated into our psyche, so it seems I am not alone in jumping to conclusions in this respect.

This was not the only point at which the previous interviews appeared to have infiltrated into Riordan's. I said to Riordan " *I know you work in a gallery at the moment and I think you said you'd worked there for quite some time...about 7 years now or?"* The actual answer was 5 and it occurred to me when I was transcribing the interview that had been the length of time Ellie had worked in her job. To me this is further evidence of the need to be open and transparent with the process and not presume that as an interviewer I can be a blank screen on which the person projects their story, there is always a past from

which we can not detach ourselves.

Chapter 8

Emerging Ideas

Prior to full discussion of the emerging ideas it is imperative to justify the potential that a study based on four peoples stories can have in effecting change. Generalisation, according to Flick (2009) is the transfer of research findings to situations and populations that were not part of the study. To propose an argument based on the unique and personal stories of four people in this way would gain little credence within the academic community.

However, by characterising a problem in terms of personal experiences, the audience to which it is directed is enabled to imagine how they might respond and it becomes less abstract (Best, 1993). If the point of research is whether it says something that might make a difference, as proposed by McLeod (2008) then engagement with the material is necessary, and it is here that unique stories have something to offer.

To progress this argument further, previous discussion has highlighted the hierarchy imposed on evidence and the implications that this may have. Hollway (2001) suggests that the dominance of quantitative methods has led to the exclusion of questions which can not easily be translated into this format. This has led to a bias towards this methodology with RCT's regarded as the gold standard (Rolfe, 2006). The ultimate aim being to generalise these findings beyond the sample population which is clearly contrary to the study being reported in this thesis and whilst the reliance on statistics has much support, it may also be misleading.

Lee (1999) states that estimates of the prevalence of a given issue often follow the emergence of it being regarded as socially problematic and that academic researchers assume that producing reliable estimates is important with respect to policy decisions. Lee (1999) goes further to state that large numbers are newsworthy thus attracting media attention and stating that usually the reliability of statistics is unquestioned provided the figures can be attributed to a credible source. He goes on to say that issues with the largest estimates or most horrific examples are likely to win attention and resources, possibly at the expense of other deserving areas.

Similar comment is attributed to Best (1993) who argues that the bigger a problem, the more attention it deserves and as such incidence estimates help to make the case for a widespread problem that demands attention. Yet this depends on how the problem is defined and the parameters which identify it. For instance, using the example of missing children, Best (1993) illustrates how various official agencies did not have a standard set criteria for defining this which impacted on reported incidence. He states that by showing the problem is getting worse and that unless action is taken it will continue to do so, the issue is presented as an epidemic. This allows the suggestion that the problem extends throughout society, thus claim makers can make everyone feel they have vested interest in the solution.

A further consequence, Best (1993) contends is that figures strengthen a claim makers argument as they can be presented as facts not merely opinion. Once the number is repeated by the press it takes on a life of its own, it becomes part of the public's image of the problem and may help justify new policies and by definition I would contend that this also relates to their generalisation. In contrast, Frank (1997) argues that reliability is not a good fit with stories and given these contentions it is not surprising that the potential worth of four people's stories may be brought into question.

However, rather than see this assertion as detrimental, Frank (1997) goes on to say that life moves on and stories with it, the truth of stories is what was experienced and what becomes experience in its telling and reception. Further, that if referring to true stories means there must be those that are false, he is unsure what a false personal account would be. He exemplifies this with the example of reading stories which were evasive, but argues that evasion was their truth.

Frank (1997) argues that postmodern times enable the reclamation of the capacity to tell one's own story. He states that the medical story takes precedence in the modern period and the postmodern divide is crossed when one's own story has not secondary, but primary importance. As such, there is a contemporary importance in relying on individual's stories and which is illustrated by their use in the literature (Alder and Alder, 2007; Briggs et al, 2008; Etherington, 2006; Jones et al, 1998; McAllister, 2001; McAndrew and Warne, 2005; Martins, 2007; Turp, 2003; Yalom, 1991; 1994). These examples, taken from books and journals go beyond quotes from interviews to offering biographical details of participants and feature here as a way of illustrating the point being made. Interestingly in the forward to

Warne and McAndrew's (2005) text, Professor Gary Rolfe reflects on his learning both as a student and qualified nurse, remarking that he learnt almost nothing from anyone but patients.

The preceding discussion clearly illustrates the potential implications on practice that individuals and their stories can have. A further illustration of this is the user led perspective, which in relation to the progression of practice concerning self harm, has been undeniable. Spandler and Warner (2007) chart the progress of the self harm survivors movement from its initial beginnings in the late 1980's/early 1990's where concern focused on challenging misconceptions regarding self harm, to the critique of interventions and the ultimate influence brought to bear on policy and practice. Yet the potential of individual experience in bringing about change seems incongruent with its lack of credibility when compared to RCT's and the generalisation of research findings. However, perhaps individual experience has the final say in this debate as after all, an individual case cannot establish a generalisation but it can invalidate one and suggest new research directions (Reinharz, 1992).

What's in a name

"I did it for a reason I did it because I didn't want to be here I wanted to go." (Ellie)

The issue of terminology and language has been broached in the literature review and the complexities highlighted by the participants in this study. In Allen (2007) I argued that there is a lack of consensus in the literature regarding definitions of self harm and that this is indicative of a wider issue which impacts on the use of evidence in practice.

This was also stressed by Shaw (2002) who exemplifies the problems associated with mixed terminology where she states that studies considered to be seminal are limited in the fact that they were based on samples of people who had attempted suicide and so may not be comparable to people who cut their wrists in the absence of suicidal ideation.

The findings of this study do little to rectify this issue but do illuminate it further. I regarded self selection as important in designing the study and in a sense this did illustrate who considered themselves to have self harmed rather than this being ascribed by others. Yet this also represented a tension, because from my perspective, the majority of the participants seemed to be describing a desire to die, no matter how pervasive this thought or desire was. This highlighted the complexities associated with my well meaning

intention to incorporate self selection in the study and which warrants further exploration.

At the beginning of the interview with Ellie the discussion revolved around self harm and she appeared to connect this with her own experiences. However, she later distanced herself from this by referring to "*they're*" and "*their*" in her descriptions. Likewise this pattern was also observed with Celia and Margaret as by attending the interview, self harm seemed implicit. However, both stories contained reference to wanting an end to their situation which could be construed as wanting an end to their lives and in Ellie's and Margaret's stories this was explicitly stated.

The complexities associated with intention contained in Celia, Margaret and Ellie's stories are also reflected in the literature to the extent that some studies decline to include motivation in their definition of self harm (Cooper et al, 2005; Cooper et al, 2006; Cooper et al 2007; Cooper et al, 2008; Hawton et al, 2007; Johnston et al, 2006 and Kapur et al, 2004). These examples represent one method of dealing with the difficulties associated with definition, meaning and intention but in the pursuit of understanding the individual and their situation has limitations. This may also impact on the use of evidence in practice if findings relate to people who have wanted to die whilst those implementing the research have assumed they are derived from people who self harm to survive (Allen, 2007; Shaw, 2002).

In trying to make sense of Celia, Margaret and Ellie's motivation behind their self harm and agreement to be part of the study a number of interpretations could be drawn. It could be that inclusion in the study represented an opportunity to discuss the issues with a captive audience, as discussed in Sque (2000). The importance of which may be deepened if pertinent issues had not felt to have been explored sufficiently prior to the interview. This may have meant reframing the experience as one of self harm to take advantage of this opportunity. That said Celia also made reference to being saved in the interview which may be suggestive that self harm and suicide are not mutually exclusive but can coexist (McAllister, 2003).

A further interpretation of the willingness to participate in a study concerned with self harm whilst concurrently expressing a desire to end one's life, may relate to how an admission of self harm may be perceived by others. As such, self harm as opposed to wanting to die could be seen as less worthy, less serious and less indicative of the difficulties experienced by the person. This is not only illustrated

through the content of studies associated with the attitudes of health care professionals and service responses to working with people who self harm as explored in the literature review (Anderson et al, 2003; Johnstone, 1997; Batsleer et al 2003); it is also indicated by the sheer number of such studies which focus on this area, a sample of which includes; Anderson (1999), Bailey (1994), Barstow (1995), Clarke and Whittaker (1998), Ghodse et al, (1986), Holdsworth et al (2001), Huband and Tantum (2000), McAllister et al (2002).

In actuality the reasons why these participants attended for interview could be a mixture of all those proposed and Bell's (2000) comments that what is recalled consciously by the individual following suicidal acts is usually a rationalisation rather than explanation is brought to mind here. What this means is that the issues associated with understanding the meaning behind self harm, attempted suicide and all the other terms which may be used, can not simply be equated to wanting to survive or hoping to die. Yet clinical practice dictates this need in order to introduce suitable strategies for intervention. Given the issues highlighted in relation to the lack of consistency regarding terminology and self harm, this may prompt consideration as to whether self harm (or any of its associated terms) should be a diagnosis in its own right.

In this respect, Muehlenkamp (2005) contends that adopting a deliberate self injury syndrome within DSM-IV-TR (2000) may be beneficial. She states that having a distinct diagnosis of self injurious behaviour would be advantageous as it would highlight a requirement for more research and ensure it is considered as separate from borderline personality disorder, thereby reducing the number of people who are stigmatized by this diagnosis (Muehlenkamp, 2005).

Bowers (2000) offers a critique of the diagnostic system in mental health care, but also contends that diagnosis is useful for a number of reasons including research purposes, the prediction of further symptoms and behaviour, the likely course, outcome and response to treatment and that despite the imperfections of the diagnostic system it remains essential.

However, designating self harm as a diagnosis in its own right should be proceeded with caution not least because self harm is not a mental health disorder, but may more accurately be regarded as a communication strategy (Connors, 2000; McAllister, 2003). Additionally, diagnosis should lead to useful

intervention and much of the literature derived from those who have used services following self harm indicates this to be otherwise. Shaw and Shaw (2007) summarise the service response to people who self injure stating this can loosely be grouped as dismissive, hostile and punitive.

The limitations of a self harm diagnosis can be further contended through consideration of language as a form of social action. Burr (2005) describes the practical consequences, restriction and obligations associated with the use of language and its relation to social action using the example of a judge passing sentence on a criminal. Once the sentence is passed, the offender is subject to certain conditions and a diagnosis can be thought of similarly. Language is not a passive vehicle for thoughts and emotions (Burr, 2005) and the prescription of a diagnosis has implications for the recipient and those who deliver mental health service provision. It can lead to access or denial of services, treatment with or without consent and restrictions on where a person can and cannot go. With specific reference to self harm, if the care offered is not acceptable to the person, potentially it not only has limited use, but may feed an existing belief in the practitioner that the client who self harms is difficult to deal with (Anderson et al, 2003). Thereby deepening a chasm between recipient and deliverer and perpetuating existing difficulties.

There is also an associated issue to consider here. It is proposed that explanation centres on the dynamics of social interaction with emphasis being placed on processes rather than structures (Burr, 2005). Thus the aim of social inquiry is removed from the nature of people or society, towards consideration of how certain phenomena or forms of knowledge are achieved by people in interaction. Therefore, knowledge is not something people have, but is something people do together (Burr, 2005). As such, the meaning of self harm becomes constructed when we engage in consideration and discussion. It may be that those conducting assessments and those who have self harmed have contributed to the links made between self harm and suicide as conflicting ideas can be held at the same time, and because it can be difficult to clearly articulate intention, particularly if admitting to self harm leads to a dismissive, hostile and punitive response (Shaw and Shaw, 2007).

It follows that if being open and transparent did not risk the fear of a poor response, perhaps trust could be established to enable the disclosure of inner most thoughts and feelings without fear of judgement. This is unlikely to resolve the issue where intention is unclear for the person, and as Freud (2002 p4)

acknowledged *"it is not easy to treat feelings scientifically."* Nor where there is a desire to keep suicidal intentions hidden whilst planning to end one's life. However, it may be of use to those people who describe their self harm as a method of survival, particularly if reports such as Owens et al (2002) are to be believed as they appear to represent the majority of those attending A&E as a result of suicidal acts.

Protection, promotion and a number of small deaths

I suppose it, it just sort of seemed a step down from that if you like really, I mean it wasn't going all the way (Riordan)

One of the questions I posed centred on what kept people who had self harmed alive. This question embodied the opposite approach to that more often taken, particularly in the gathering of statistics, which involves a retrospective exploration of the experiences of those who had died through suicide and which sometimes reveals previous self harm. Focusing on life rather than death enabled an exploration which is otherwise impossible using retrospective processes and which revealed interesting disclosures.

It seemed that all the participants in the study could report some sort of change in their lives following their attendance at A&E. For Celia she allowed others to take a degree of responsibility and to care for her which she had not done previously. Margaret talked of something being brought out and which appeared cathartic, she also reported a change in how she viewed her relationship with her son, and for Ellie it was perhaps feeling afraid of the consequences of leaving her daughter which proved pivotal and arguably endorsed her need to survive.

Riordan was able to articulate a process which seemed to echo Yalom's (1980) notion of a small death being better than the real thing. This highlights the existential dilemma which derives from confrontation with the dreaded knowledge that one's death is inevitable. That said, he also contends conversely that confrontation with death rather than its actuality, can result in a productive experience. Yalom (1991) explains this using the example of people for whom transformational experiences seem to result from seriously questioning goals and reviewing one's life as a consequence of their confrontation with death.

The resonance of this and the stories shared by the participants in this study is remarkable and for Celia, Margaret and Ellie the event precipitating the interview with me appeared to be a pivotal experience which precipitated reflection and review in keeping with Yalom's proposal above. Where as for Riordan,

he was self contemplative, but rather than presenting as one crescendo event, his attendance at A&E could be seen as being precipitated by a series of small deaths.

Bell's (2000) critique of the predominance within the psychiatric literature of consideration which solely centres on the external world of the individual who performs suicidal acts led him to proclaim that this focus is insufficient for understanding and management of the suicidal patient. He makes the point that all suicidal acts take place in the context of human relationships, real and imagined as explained in Freud's (1925) description of how the object of a patient's absent loved one becomes incorporated into the patient themselves.

This derived from Freud's observation that recriminations made by the patient during therapy related to someone other than themselves who they love, had loved or should love (Freud, 1925). This lost object is not given up but identified with by the ego and as such becomes the target of all hatred that originally belonged to the object. As such, in melancholia, it is not only a current external figure which is lost, but all other losses that have to be endured during development. The root of which is the primary object and all that this represents (Freud, 1925).

Bell (2000) contends that this process underlies all self destructive acts, that there is an attack on the self, which identifies with a hated object thereby enabling an attack on that hated object but also simultaneously punishing the self for its sadistic and cruel attacks. Bell (2000) also contends that no matter how strange it may sound, some acts of suicide are aimed at preserving what is good. This also fits with Wahl's (1957) notions of suicide as a magical act that may be seen to be temporary and reversible. This can be seen in the circumstances surrounding Celia, Margaret and Ellie's self harm and to refer back to Riordan's *"step down"* this may represent a desire for survival despite, or to spite, adversity.

The experience of loss of another has also been considered by Klein (1940) who states that; *"The poignancy of the actual loss of a loved person is, in my view, greatly increased by the mourner's unconscious phantasies of having lost his internal 'good' objects as well. He then feels that his internal 'bad' objects predominate and his inner world is in danger of disruption."* (Klein, 1940 p156).

Klein states that any pain caused by unhappy experiences, whatever their nature have something in common with mourning, it reactivates the infantile depressive position and overcoming adversity entails similar mental work to that of mourning. When a baby experiences grief following the loss of the breast or bottle, they do that despite the mother being there. As an adult, grief is brought about by the actual loss of a person, but assistance with managing this loss is achieved by having established and internalized a '*good*' mother. If the mourner has people to love and who share the grief and can accept their sympathy, harmony in the persons inner world is restored and fear more quickly reduced.

However, when the internalized mother is a disappointment such as in Riordan's story or when as a mother, one's life project, the child, is disappointing as in Celia and Margaret's narrative or as a mother you are unable to protect your child, Ellie, then this restorative process may be disrupted and the subsiding of fear protracted.

This issue of one's life project was previously proposed in Ellie's narrative but is also apparent in Celia's and Margaret's stories. To recap, Yalom (1991) contends that to lose a parent or lifelong friend is to lose the past but to lose a child is to lose the future and the loss of one's life project. He suggests this is the reason one lives for, how one projects oneself into the future and may hope to transcend death and as such, the child is an immortality project. Loss can be experienced in a number of ways and is not solely confined to loss through death. Ellie, as it was noted, may feel the loss of her daughter's innocence, for Celia her close and loving relationship and Margaret the son she had longed for. Considering this proposal within the context of Celia, Margaret and Ellie's lives, may enable a greater insight into why these circumstances were so powerful and resulted in all three harming themselves. Yet there is gain to be had as, "*Although the physicality of death destroys man, the idea of death saves him.*" (Yalom, 1980 p30).

This is exemplified by Rosen's (1975) interviews with six people who had survived jumping off the Golden Gate Bridge. The interviewees reported changes in their views on life and this notion is replicated in Yalom's (1980) descriptions of therapy with people who were terminally ill with cancer. Such shifts and changes were likened by Yalom to personal growth and are in keeping with death reminding us that existence cannot be postponed, that is, whilst one lives, one has possibility (Yalom, 1980). It may seem paradoxical that such contemplation may actually be one's saviour but as stated

previously, there are elements of this in all four narratives as "*a small death, after all, is better than the real thing.*" (Yalom, 1980 p135).

Suicide, indestructibility and survival

"I just couldn't see the point anymore" (Celia)

The use of psychoanalytic theory to explore the issues associated with self harm and suicide in this study illustrates its utility and how its application can add to the existing evidence base in offering such perspectives. For instance self harm may be the best predictor of eventual suicide (Hawton e al, 2004) but due to the complexities involved that does not mean it is an accurate predictor, it may just be the best available. This may be contextualised by Bell's (2000 p26) proposal that "*many suicide attempts occur in the context of beliefs of indestructibility*" and Wahl's (1957) contention regarding the magical view of suicide as reversible and temporary. It is also an issue discussed by Klein (1935) who proposes that in some cases, phantasies underlying suicide aim at preserving the internalized good objects and the part of the ego which is identified with the good objects.

In taking into account ideas derived from psychoanalytic theory the complexity of intent is exposed but rather than acknowledge this it seems the task to care is made more difficult (Bell, 2000). This may be considered further by Seager's (2008) contention that where professionals' minds are linked to a general surveillance mentality derived from risk-focused government policies and performance driven managerial styles, anxious, defensive and paranoid professional practice thrives. The difficulty in assessing risk is also compounded by the simple fact that people may chose to hide their intentions. Margaret describes sitting in the car with her husband, daughter and granddaughter on a day trip to a safari park. Laughing at comical things her granddaughter said, loving her family yet planning to go home and take an overdose.

In the pursuit of the assessment of risk, the circumstances surrounding an event are often collated as a way of understanding the context of the self harm. Yet Margaret's description illustrates the limitations of this approach as arguably, the best that could be inferred, is that people do things that are unpredictable.

Even where there appears to be a logical link between the person's circumstances and the consequent

expression of risky behaviour such as Ellie's argument with her partner following a host of other interpersonal and intrapersonal difficulties, Celia's desperation in the face of abandonment from her daughter and Riordan's disclosure of abuse and relationship break up, this still does not explain why, on that day, at that time, self harm was resorted to.

As such, it is perhaps not that self harm occurs, but why it occurs when it does, that would be more helpful. Yet this information is problematic as it will be expressed from a particular perspective and understood through one's own filters and beliefs. Thus there is a risk that what is heard and its interpretation may not be that intended, and due to the potential response of those perceived to have power, such as the health care professionals in Margaret's story, there may purposely be an attempt by the person to mislead.

To acknowledge that people may behave in unpredictable ways is far from in keeping with the notion of science and rationality on which many aspects of healthcare is based. This prompts further consideration as to why simplistic links are made with regard to risk and intent and why these links seem so readily espoused in the literature. Thompson (1998) makes reference to reductionism as the process of reducing complex, multifaceted reality to simple, single level explanations. He further contends that without a well developed theoretical basis, a reliance on reductionism and oversimplification is more likely (Thompson, 1998). This may help explain why simplistic notions around risk and self harm are clung to, despite their limitations.

In Allen (2007) I argued that proclaiming an increased risk of suicide following self harm is akin to stating there is an increased risk of being run over when crossing the road. That is to say that death may be the outcome in both cases and whilst this may have been the intention, it also may not have been and whilst it may be declared, within degrees of certainty based on the available evidence and probability, that someone died as a result of suicide, determining that someone was suicidal prior to death is even more problematic. Yet, this relationship largely appears to be unquestioned and merely accepted.

It may be reasonable to suggest this lack of critical appraisal could be related to an age of government targets and the part that such measures may play in modern health care (Seager, 2008). As mental health is difficult to measure, at first glance suicide may appear a tangible entity on which to measure

individual and societal happiness and contentment. Yet such interpretations may be misleading and ultimately do more harm than good particularly if over controlling responses to self harm are provoked by fear of suicide.

There may be a further consideration regarding this which relates to work conducted by Best (1993) who argues the necessity of identifying claim makers interests. This stance derived from Best's review of children who go missing in America and highlights the strategies used to create the impression that the problem is of huge proportions and involves many children who are subject to horrific experiences.

However, Best (1993) argues that most children who go missing are teenagers who have argued with their parents and return in a few hours without harm having befallen them. Conversely a small proportion of missing children are kidnapped by someone who means to harm them. This leads to consideration of possible explanations for this induced moral panic and Best contends that by blaming perverted and sick individuals it detracts from having to consider more intractable problems, such as taking responsibility for the other reasons for child suffering, such as growing up in poverty.

The notion of inflating claims in this way may be reminiscent of the statistics associated with self harm and eventual suicide and in a similar vein, by focusing attention on self harm, the more intractable questions concerning what causes people to end their life remain unanswered. This becomes more poignant when consideration is given to the artful use of language as a form of persuasion to one's way of thinking. Burr (2005) has an interest in how people actively construct accounts in interaction emphasising the performative and action orientated nature of language and the way that accounts are built in interactions to suit purposes.

Gergen (2000) also considers the performative role of language stating that when we say something, we are also performing an action within a relationship and uses "*I now pronounce you man and wife*" (Gergen, 2000 p35) to exemplify this point. He also proposes that social understanding is not a matter of penetrating the privacy of another's subjectivity, as if it were, we could never understand. Rather, it is a relational achievement and depends on coordinating actions as specified in a tradition. If emotions were private events, it is contended that we could never understand each other's feelings. Gergen illustrates this with the example of a smile which represents happiness. However, he states it is not the result of

looking into one's being that this is discerned but rather because of participation in a culture that holds happiness to be evidenced in a smile.

It seems reasonable to suggest that accounts following self harm can be given as a means to an end that is to secure what the person desires, for instance in Margaret's story to make sure she was not considered for inpatient admission. Additionally it is fair to suggest that practitioners also have the propensity to use performative language when assessing risk. An examination of such summaries in clinical notes might illustrate the tension between doing what seems to be in the individual's best interests, acknowledging one's duty of care and supporting the purpose of the organisation in which one works.

The complexity of denoting intent was illustrated by Gergen (2000) who uses the example of suicide to demonstrate this point, stating that typically some deaths are treated as natural and some as suicide but that such distinctions are problematic. The reasons being, that suicide is the intentional choice to end one's life but he questions how one's intentions can ever truly be known, making reference to unconscious drives, lacking control and whilst one may believe they freely intend, Gergen contemplates the part that conditioning may play in encouraging us to think this way.

Of a natural death he contemplates the thought that if one truly wanted to live for as long as possible life would be different, junk food avoided, crowds and alien bacteria avoided, frequent health examinations, taking no chances in athletics. As such, he wonders whether every natural death is really a small suicide given that most of us are less than attentive to these concerns.

This message being conveyed by Gergen centres on the complexities of language using suicide to exemplify this. The issue is compounded further by notions loosely reminiscent of a self fulfilling prophecy as exemplified by Kushner's (1990) work which takes a historical perspective on women and suicide.

Kushner (1990) makes reference to reports which consistently state that the completed suicide rate for men is higher than women and that these are contextualised differently in accordance with gender. For women suicide was reduced to an individual, emotional act whilst for men it was taken as a barometer of

national and social well being. An important point is made that official statistics cannot measure the difference between conscious and unconscious intentions and the complexities associated with discerning accidental death and suicide.

As such, there may be a case to suggest that patterns of suicide which indicate predominance in men reinforce this conclusion and enable the gender divide to be more readily accepted, because it is felt that the knowledge base supports this. This process is reminiscent of comments made by Gergen (2000 p51) who states that because "*scientists*" make claims to the truth, their accounts creep into society and have a way of forming society's conceptions of what is the case. Gergen goes on to state that such truths are then reinforced for example in news headlines an example of which maybe the reporting of suicide rates in relation to gender.

Bringing the inside out and other projections

"*but it was the soup with (name of daughter) in*" (Celia)

In Freud (2002) it is stated that suffering derives from three sides, these being, our body, the external world and that which perhaps causes us most suffering, from our relations with others. Every story in the study has a sense of such suffering and it is not only those portrayed in the present time which are important but also an appreciation that these present experiences link with the past.

"History is much more than a chronological listing of names, dates and places. It is a story about how the past came to be and how, ultimately, it gave birth to the present." (McAdams, 1993 p102).

Our past has a connection with our present selves and how we respond to events in our lives. This is one reason why psychoanalytic theory has been used in the study and interrogation of the stories from this perspective has helped to glean meaning as to why certain experiences, relayed through the narratives, were felt so deeply and why certain characters evoked such powerful feelings.

It is also reasonable to suggest that the events leading up to Celia, Margaret, Ellie and Riordan's attendance at A&E were precipitated by confrontation with what Yalom considers to be the ultimate concerns, mention of which has previously been within individual narratives, but to contextualise this here, these concerns derive from an existential position and with reference to psychotherapy Yalom

describes this as *"a dynamic approach to therapy which focuses on concerns that are rooted in the individual's existence."* (Yalom, 1980 p5). Such perspectives are concerned with considering one's existential situation rather than exploring the past however, Yalom (1980) does concede that; *"The past - that is one's memory of the past-is important insofar as it is part of one's current existence and has contributed to one's current mode of facing one's ultimate concerns..."* (Yalom, 1980 p11).

In this sense, Chodorow who states that; *"The past does not cause the present, but the present includes and incorporates the past"* (Chodorow, 1999 p60) concurs to an extent with Yalom and in this study links with the existential dilemmas Yalom (1980; 1991) described, seemed apparent in the narratives. However, the stories oscillated between current, future, recent and distant past and in this sense, formative experiences such as those which could be explored using object relations theory seemed important and related to the more recent experiences presented in the study.

Throughout the narratives there was a sense of the inevitability of death and which, in varying degrees, also related to personal specialness and belief in an ultimate rescuer (Yalom, 1980). The notion of enticing and tempting death could be distilled and whilst individual belief systems differed, a sense of being rescued could also be identified. For Celia it was that her daughter cared enough to get help and she refers to what "*saved*" her in this context, Margaret concludes that God was not ready for her and Ellie is saved by her partner who returns home due to his concern. For Riordan, this seemed slightly less obvious, there was a sense of his friends assuming some control by expressing their worries to him and which culminated in him seeing his GP and as a consequence mental health services, but it is he who then takes responsibility for this.

In this sense one's locus of control may be important and represent a crucial difference in the narratives. For Celia, Margaret and Ellie there was a sense of desperation as though there was an erosion of their agency and control. For Riordan, the experiences in his narrative seem to have a different complexion. He remains mostly reliant on himself and may have little expectation that others might be able to "*save*" him, particularly as his formative relationships and those in later life appear to have let him down. There may also be a difference in the expression of self harm as for Riordan it has played a part in his life at different times and stages, whilst Celia, Margaret and Ellie describe their attendance at A&E following self harm as the first of its kind. In this way it may be symbolic of a certain set of extraordinary events

outside of the usual. This differs from the interpretation of self harm as a mechanism used to manage what Riordan describes as a continuum from anxiety to frustration to rage to impotent despair and which, in his experience, has resulted in cutting. That said there is a part in Riordan's narrative where he insinuates that he might have gone too far, and his survival of this may be related to a notion of personal specialness and a belief in his ability to rescue himself.

Yalom's (1980) notion of personal specialness, which provides a sense of safety from within and the belief in an ultimate rescuer is said to permit a feeling of protection by an outside force and even though we may arrive at the edge of life, there is an omnipotent servant who will always bring us back. This is said to represent two diametrically opposed responses to the human situation; autonomy through self assertion, or the seeking of safety in a superior force and may help to explain how such pinnacle experiences as those described in the narratives can be made sense of and construed in acceptable terms to the story teller. It may be that survival from this experience is interpreted as "*it was meant to be*" and in this sense it may also represent the discovery that an awareness of death can enrich life as "*the physicality, of death destroys us, the idea of death may actually save us.*" Yalom (1991 p7).

Following the pinnacle experiences described in the narrative, Celia is able to relinquish some responsibility to her "*fragile*" sister, Margaret concludes that changes have occurred in the way she thinks about her son, Ellie's realisation that without her, the likelihood was that her daughter would end up in a potentially abusive situation never really understanding why her mother left her, and Riordan's "*small suicide*" are all illustrative of the idea of death as a potential saviour.

There is a sense of ultimate aloneness in all four narratives, be it through a perceived betrayal, isolation or disconnection and which also links to an absence of any obvious meaning or sense to life. Celia, Margaret and Ellie have all experienced a degree of loss in relation to their "*life projects.*" Whilst for Riordan, a hijacked sexuality may link to a perceived ability to project himself into the future via his, as yet, unborn children. This is not to suggest that one's meaning can only be derived through progeny, but it does appear to be a pervasive theme in the narratives.

The anxiety associated with having the freedom to make our lives as we will, may also be compounded by such questions around meaning and meaninglessness and for Riordan may also embody his quest to

portray different selves. Riordan clearly talks about leaving a part of himself behind when going to university in order to become the person he believed he was. That one must assume responsibility for the person they are and the life they lead is fearful in itself, but also appears to have been compounded when Riordan found he was not totally in control as illustrated where he says his abandoned part sneaked up on him.

Having referred to psychoanalytic theory throughout the study the intention is not to assume that such ideas are a panacea. In relation to scientific credibility and psychoanalytic theory, Bateman and Holmes (2005) state that psychoanalysis might best be seen as a craft as opposed to a science. As such, its findings, whilst clinically valuable do not constitute scientific knowledge. Yet they go on to state that the use of single case research, as is the concern in psychoanalysis, is increasing within the literature.

Moodley (2001) takes this further and states that practitioners of counselling and psychotherapy have argued that the rational, objective and scientific methods favoured by researchers are not a good fit with a discourse which is subjective, imaginative and psychic. Additionally he also offers an alternative perspective that every counselling and psychotherapy session could be said to be a "*(re)search session*" (Moodley, 2001 p21) as it is through the use of a cognitive, empathetic and analytic process that the therapist contextualises distress, extrapolates data for interpretation and offers this as a hypothesis which may then be reconceptualised on the basis of the client's feedback. There is, however, a further point to be made in relation to using psychoanalytic theory as it could be seen to locate issues as largely residing within the individual, a process of which Johnstone (1997) is a fierce critic.

Johnstone argues that by individualising a problem it renders diagnoses as being attached to an individual, not a couple, family or social group. This, she argues, has the effect of locating it within a small pathological percentage of the population which prevents acknowledgment that as a culture, self harm pervades, and that we are all involved in these dynamics.

The consequences of locating the problem within the individual is that experiences, such as trauma, are diminished as the self harm becomes the focus of attention, as discussed by Pembroke (2007) and Shaw and Shaw (2007) among others. Additionally, given that self harm may be a communication strategy in speaking what Connors (2000) refers to as the unspeakable, it is far from a surprise that the

underlying distress is not resolved when a lack of understanding exists between those who use services and the practitioners they meet. This issue was discussed in the literature review but to add to this with suggestions as to how it could be rectified, Reece (2005) describes how women who self injure and nurses assign meaning to shared discourses about self injury. She comments that for some women their body is lost to them emotionally, psychologically and even physically and that cutting may serve to bring together the body, feelings and emotions (Reece, 2005 p564). However, she further contends that failure to see such integrative meanings of self injury can lead to painful encounters between nurses and women who self injure.

It is this lack of understanding which seems to be the crux of the issue for those who self harm and use services. Reece (2005) suggests that one solution is for people who use services to have more involvement in the education of future nurses and from personal experience of witnessing this first hand, there does appear much to be gleaned. However, there is a further and pervasive issue that no matter how a nurse or other health care practitioner may be prepared educationally, the context in which their practice sits has a huge bearing on the type of service offered. That is to say, real shifts are required at an organisational level.

For Celia, Margaret and Ellie, their need was not seen to fit with the services on offer, that is to say they may have actively communicated that existing mental health practice was not what they wished to engage with and for the practitioners who were involved with them, their remit, primarily driven by notions of risk, means they have little to offer. Kapur et al's (2005) contention of the scarcity of interventions following self harm and Lilley et al's (2008) suggestion of a discrepancy between what people need after self harm and what service offer is brought to mind here.

Reece (2005) then goes on to state that nurses can experience a feeling of inadequacy when dealing with self injury and draws on Freshwater's (2000) contention that nursing as a profession is under stress, feels oppressed as evidenced through inter-group conflict with patients and that any group excluded from power, turns on another perceived to be weaker. It is proposed that this may in part explain the negative response of some nurses to people who self injure.

Mothers fathers sons and daughters

"it is what is happening in my family" (Margaret)

Parent child relationships were pivotal in all four participants' accounts and links to McAdams (1993) contention that power and love are the two great themes in stories. As mothers Celia, Margaret and Ellie described perplexing events associated with their child. For Celia and Margaret maternal ambivalence as described by Parker (2005) is inferred by both towards their daughter and son respectively. However, there is a degree of unacceptability in concurrent feelings of love and hatred towards one's child, possibly due to the element of hatred and a fear of it (Parker, 2005). Yet there may be a positive outcome associated with a state of ambivalence. Parker (2005) states it is not the ambivalence itself which is the problem but the mother's guilt and anxiety associated with it. The concept itself can be seen to derive benefits as ambivalence can be regarded as a safeguard against hate and this may prove crucial for the future of those relationships described in this study.

Flax (1991) states that in contemporary Western culture, the girl has a continuing ambivalent tie to her mother, in part because of their shared gender which means she can not so thoroughly repress her pre-oedipal experience and relational capacities as can the boy. In Celia, Margaret and Ellie's narratives there was a chronological sense of themselves, their mothers and their children in conjunction with a timeless sense of connectedness to their experiences of their mothers and as mother's themselves. This encapsulated not only the past and all that brings to one's present but also through one's *"life project,"* the future. As such, the sense that what happens has future consequences and so matters, was immense. For Riordan, there was also a sense of this, but as the only participant without children, there did not seem to be the same sense of projection into the future and as the only man, there is also an issue of gender to consider.

Flax (1991) states that by the age of 5, a boy in contemporary Western culture is likely to have repressed the *"female"* parts of himself. Thereby developing a normal contempt for women that is fundamental to the male identity in male dominated cultures. For Riordan, this position seemed less apparent than is presented here by Flax. He did not seem to have contempt for women per se or at least not that was revealed during the interview. However, his difficult relationship with significant women in his life, these being the abusive, intimidating grandmother and the *"simple"* mother, always on the periphery may in part be explained by Parker's statement that *"the need to separate out from his mother,*

denigrating her in the process, may be a feature of the son's struggle. But it is not inevitable." (Parker, 2005 p265).

Chodorow (1999) makes the important point that a mother will experience her daughter and son differently both consciously and unconsciously and attributes this to similarity or otherness in gender. This may seem a curious statement, particularly in light of Chodorow's encouragement to refrain from collapsing individuality and difference into universality and similarity. However, she goes on to argue that the ability to generalise is acceptable providing it does not go beyond our database or that we specify the basis of such generalisations (Chodorow, 1999).

Chodorow (1999) then makes compelling points about how mothers typically experience sons and daughters stating that the mother's unconscious phantasies and feelings are communicated to the child, but the child creates the meaning of this communication. She goes on to say that she does not seek to define absolutes in terms of gender identity but to generalise about the ways women and men operate psychologically and experience and define themselves.

For Riordan, the distress experienced in relation to his grandmother may be projected into his mother and the denigration of her may help him in the sense that Parker and Flax describe but may also relate to attempts to overcome his early abusive experiences. Of such violent and sexual child abuse, Meyer's (1991p 31) statement *"it seems as if love itself has been raped"* is poignant in relation to Riordan's narrative, his reference to a hijacked sexuality, the power dynamic implicated as a result and which leads to the second of McAdams key themes in stories.

A power not for pleasure trip

"There's the feeling of it's our little secret" (Riordan)

Power is a recurrent theme throughout the participants' stories and an integral aspect of so called feminist approaches to research. However, claiming adherence to such methods is not always straight forward and can pose questions for the researcher. Marzano's (2007) research concerning self harm by male prisoners led her to wonder whether her study was *"feminist"* enough. Marzano's (2007) own conclusions mirror those of mine in that she states, there is no one unitary feminist theory or methodology and goes on to say that the purpose of feminist work is not necessarily or exclusively to

focus on unitary notions of woman, but to construct analysis in terms of power and power relations.

This echoes Stanley and Wise's (2002) contention that research from a feminist perspective should not solely be confined to using women as participants, they argue that feminist research should be concerned with all aspects of social reality and by definition all participants within it.

To refer back to Marzano (2007), she states that not all men are powerful, oppressive or equated with patriarchy. Further arguing that feminist research with a social constructionist view can open up and challenge oppression within and across gender. Broom's (2008) work which focused on female perpetrators of child sexual abuse is pertinent here and encapsulates aspects inherent within Riordan's narrative which exemplify the complexities of gender and power. It also reinforces the need for focus on the interrogation of power and power relations rather than gender as a point of inquiry (Marzano, 2007; Stanley and Wise, 2002). However, as stated previously, much of the available literature concerning self harm does focus specifically on women and as such forms a significant part of the evidence base.

Shaw (2002) presented a historical review of girl's and women's self injury, and makes compelling points which stress that self injury has meaning on an individual, social and cultural level. That the bodily idiom through which women express psychological distress is meaningful and that how self injury is conceptualised and treated, as well as how women are portrayed, is socially and culturally embedded.

Shaw (2002) draws on work which describes studies of middle and high school girls and college women who function well in many domains, yet self injure. This relates to Menninger's (1935) contention that self mutilation is an attempt at self healing or at least self preservation and Klein (1935) who proposes that in some cases, phantasies underlying suicide aim at preserving the internalized good objects. Shaw (2002) further posits that historical shifts in the use of language to describe characteristics of women who self injure is also evident in the literature with a move from adjectives such as *"attractive" "talented"* and "*intelligent*" to pejorative terms including *"manipulative"* and "*attention seeking*."

Having provided a historical overview of the shifts inherent in understanding self injury, Shaw (2002) then argues that clinical literature reproduces the violating experiences of a patriarchal culture that facilitates the emergence of women's self injury. She considers why clinicians feel the need to remove

themselves given the contention that self injury is aimed at life preservation and assists with the reduction of psychological distress.

Further, that if through self injury experiences of relational and cultural violations are re-enacted, perhaps it is as a symbol of the struggle against the dominant cultural belief and what it is to be female, which is so distressing. Women and girls express their distress through self injury because they learn that they are valued for their bodies and turn the cultural and relational objectification on its head by objectifying their own body (Shaw, 2002). She goes on to say that girls and women are subject to humiliating and sometimes abusive treatment which may dissuade them from getting care, and it was the issue of getting help and being helped that was illustrated further for me through engagement with Celia, Margaret, Ellie and Riordan.

To help and be helped

"I feel that since that happened, I feel as though something's been brought out" (Margaret)

McAdams highlights the importance of telling and hearing a story when he states that *"In some instances, stories may also mend us when we are broken, heal us when we are sick, and even move us toward psychological fulfilment and maturity."* (McAdams, 1993 p31).

The benefits of this may be derived from a shared understanding and the joint pursuit of meaning making and in this respect Sque's (2000 p26) comments that the therapeutic effects of narration may help make sense of experiences. Not only has resonance, but may also be indicative of my preferred interpretation as it shifted the power dynamic from me as the taker of information to Celia, Margaret, Ellie and Riordan potentially deriving benefit from being interviewed and in this sense was more comfortable.

Sque's (2000) study of people who had experienced bereavement and whose significant other had donated organ(s) indicated that being interviewed was a difficult experience but not a regretful one particularly if it meant helping someone else. Sque (2000) goes on to state that narrative allows a full account of experiences to be given and it is rare to have the undivided attention of another who is willing to engage in this experience to the extent of the researcher. Again this reiterates my level of comfort but

does connect with what the participants of the study said.

Celia commented that she was keen to be interviewed as she had received a lot of help and wanted to help others. In Margaret's case, she explicitly stated she thought being interviewed might be helpful. For Ellie, knowing that she would not see me again seemed to induce a feeling of liberation. Whilst for Riordan, using the interview as a sounding board with a view to finding new ways of considering the pertinent issues seemed to connect. This desire for help and to help others in whatever form it took, can be seen to conflict with judgements that those who have taken overdoses and self harmed by other means, are unconventional as described in Anderson et al (2003).

The underpinnings to a desire for help and to help may be exemplified by Etherington (2006) when she proposes that using stories in research gives testimony to what we have witnessed and creates a voice. The issue of voice is a theme that runs throughout all the stories in his study. In Celia's narrative, her daughter seemingly can no longer hear her in favour of her boyfriend and this represents the rejection of her mother. This issue of voice and being unheard also resonates in Margaret's story in relation to her son. Ellie, who is unable to secure justice for her daughter's abuse, despite her vocal attempts to do so and Riordan, whose expression of pain, despite his best intentions, seems to be unheard by his parents.

Research has the potential to enable participants' voices to be heard if a balance between paternalistic tendencies and a desire to disseminate individuals' stories can be struck. This is illustrated by Etherington (2001) who discusses her experiences of writing research with two ex-clients who she had seen in a counselling capacity and who had been abused. She discusses the complexities associated with the role of researcher as opposed to counsellor and how this presented a discomfort in relation to feeling she may be using her ex-clients. An alternative is then posed by Etherington which centres on her worry that in avoiding perceived exploitation, she may become enmeshed in trying to take care of her ex-clients, thereby putting herself at risk and denying their ability to care for themselves.

Yet despite these ethical dilemmas it is also important to recognise that such methods enable the sharing of experiences and as such, powerful messages may be attained for dissemination not least because the voices here are not in competition with others, the participant's story is the only one that is heard, and despite the criticisms of subjectivity in research, it is difficult to dispute this portrayed

experience and in this sense, the value of using stories as indicated at the beginning of this chapter is reinforced.

In relation to the help that was offered following attendance at A&E, there is the related issue of risk which has been alluded to but which warrants further consideration. By her own admission Margaret was desperate not to be kept in hospital and the insinuation is that she minimised the overdose. Yet in her narrative many of the issues which seemingly brought her to the attention of services appear to be unresolved. However, one hypothesis is that the decision to discharge Margaret may have been based on the assessment that she did not appear to pose an immediate concern. Likewise, Celia described the advice she was given to reduce stress and which was acted on by her sister. For Ellie, her mother as a mental health nurse may have been interpreted as a protective factor. This is not to imply that services should be involved where they are not necessary, but to illustrate the potential part that risk assessment may play.

Interestingly the only participant for whom it can be said with any certainty, did have input as a direct consequence of his attendance at A&E was Riordan, conjecture could lead to the assumption that as a man who self harms, this was seen as extraordinary and warranting intervention, but it is merely conjecture. However, it is interesting that this mirrors the finding in Horrocks et al (2003) that there was a high proportion of men who had injured as opposed to poisoned themselves and that those who had injured were more likely to be in contact with mental health services at the time of the injury, and if they underwent a psychosocial assessment were more likely to be admitted to mental health in-patient care. Further, results from Cooper et al (2005) suggest that there may be a perception by clinicians that self harm is not as serious in women as in men and so target interventions at young men in particular.

Self harm, social constructionism and an antidote to dominate discourses

Having discussed pertinent issues relating to the stories told in this thesis, attention now turns to issues associated with methodology. One of the aims behind this study was to interrogate the role that self harm may play in relation to health promotion and if regarded from the position of the medical model, this may appear paradoxical. However, as the literature review highlighted, limitations are associated with a medicalised approach to self harm. As such, views of the world which embrace alternative approaches may enable consideration from a different perspective and in Allen (2007) I suggested that

social constructionism may be a position from which to achieve this. The relevance of social constructionism to the underpinnings of the study has previously been discussed, but here, the proposed arguments are progressed as a way of encouraging new questions to be asked and considerations formulated.

Gergen (2000) states that the enlightenment encapsulated the desire to grant all a voice as opposed to the privileged few which primarily referred to royalty and those with recognised roles within religion. He goes on to propose that science had become the model for equal rights to reason, for all to have the privilege of independent observation, reason and reporting and that if a rigorous method of investigation is followed then he or she can demand an audience. The benefit of this in relation to the development of medicine with the ability to diagnose, treat and in some cases cure disease and injury is undeniable.

However, Gergen goes on to state that science is not the epitome of equality. He exemplifies this by referring to the use of jargon and the fact that scientific inquiry is out of bounds to many. He further contends that ironically, this former bastion of equality now serves to remove parity as all other voices bar its own are moved to silence. As such, Gergen (2000) wonders whether the consequence of this is that we are witnessing the emergence of a new breed of high priests, in reference to earlier comment regarding the privileged few. Within this context, the debate around hierarchies of evidence in clinical practice and methods of research is reignited here and Wilkinson's (1988) views resonate that when a definition of what is legitimate is proposed, such as favouring the dominant positivist paradigm, anything outside of this, becomes easier to dismiss and devalue.

This is not to vilify scientific principles on which the medical model rests. However, as introduced at the beginning of Chapter 2, people who self harm have often received a poor service from health care provision (Pembroke, 1994), service provision has often responded to perceived risk rather than the individual's expressed needs (Bell, 2000) and there are occasions where the response of health care professionals has been precipitated by their own beliefs around what it means to be healthy (Anderson et al, 2003). As such, this approach as the dominant model on which healthcare rests is open to critique in relation to self harm.

Gergen's (1985) paper refers to the argument that knowledge is historical and culturally specific which

suggests knowledge is not fixed but susceptible to change. Shaw's (2002) illustration of the historical shifts in the reporting of women and self harm exemplifies this. As such, what one thinks they know about self harm is open to critique as a critical approach to one's clinical practice is required in conjunction with acknowledgment that personal values and beliefs may profoundly impact on the experiences of people who use health services following self harm.

Reframing one's perspectives in relation to self harm may present a challenge. However, arguments proposed from a social constructionist perspective that knowledge is not fixed and rigid but is historically and culturally specific (Gergen, 1985) can engender a sense of liberation from previous ways of knowing and doing. This leads back to comment made at the beginning of this thesis regarding the conference I attended on harm minimisation. More latterly harm minimisation as an approach to self harm has gained support and the publication of books such as Spandler and Warner (2007) which stress the need to move from a position of control, aimed at stopping self harm to working innovatively to support people, are testament to this. Additionally, the existence of the Care Services Improvement Partnership (CSIP) working party in the North West with the assigned task of exploring the issue of harm minimisation and its implications on behalf of the Department of Health is further evidence of the move towards increasing support for this strategy.

This leads to illustration of Gergen's (1985) proposal that knowledge and social action go together, that descriptions or constructions of the world sustain some patterns of social action and exclude others. As such, change is gaining momentum but there still remains the ever present dominance of the established medical model perspective underpinning service responses to self harm.

That said, social constructionism is not immune to critique and one of the criticisms is related to the notion of personhood. Issues of which have been considered in Chapter 2 and the intention is not to replicate this. However, there are additional considerations to be made in this respect. Burr (2005) questions whether people can be said to have agency if they are merely products of discourses, as propagated by a social constructionist perspective and if this is so, the risk is that individuals are unable to change themselves or their world. This quandary, as to how human agency can be addressed within a social constructionist framework is one which Burr (2005) states has not been neglected, but is not resolved either. She further contends that social constructionism can not explain the desires, wants,

hopes and fantasies people have and their role in the choices that the individual makes in their lives.

Burr's concern, that more attention may be bestowed on discourses as opposed to people, may be found in my portrayal of harm minimisation as the antithesis of the established medical model approach to self harm. It would be a mistake to wholeheartedly endorse this without taking into account its impact at an individual level, as to do so would be to embrace the discourse at that expense of the person.

To explain this further, not all who self harm would welcome such an approach, for some it may portray the message that they are hopeless, not cared for and unworthy of intervention. Whilst for others input from health services other than a harm minimisation approach may be regarded as paternalistic, degrading and damaging and leads back to Burr's warning in relation to discourse taking precedence over the individual. This point was also made by Komter (1991 p47-48) who states that;

"...too strong a fixation on the constructed character of social reality may lead to a lack of attention to other relevant characteristics of human beings like, for example, their 'agency' and capacity to transform social reality by giving it new meaning or intervening in social practices."

There are other difficulties associated with a social constructionist stance as illustrated by Taylor and White (2000) who state that once objective truth is disregarded and social constructionism embraced, we find ourselves plunged into the abyss of relativism. That is, if a number of competing accounts prevail with no objective criteria to establish their validity, a meaningful distinction between them is problematic to make.

Given this, the view of the person who advocates an alternative approach to self harm cannot prevail over more traditional approaches aimed and diagnosis, treatment and cure. However, where traditional attempts to assist people who self harm have been limited or even legitimised poor and ineffectual treatment (Pembroke, 1991; 1994) this seems a valid argument in seeking alternative approaches. As such, practices within health based on the medical model are dominant but not definitive and it follows that dominant ideas can be considered as local, provisional and situated (Taylor and White, 2000) just as any other form of knowledge.

Gergen (2000 p169) echoes such critiques levelled at the medical model and traditional therapy for its focus on cause and effect stating that from a constructionist therapist standpoint there are no pre-fixed facts and the assumption of causes-producing-effects is viewed as one narrative among many. The facts are inevitably constructed and whilst this does not make them any less significant, it is not essential to get clear what is happening but rather to focus on the constructed meanings by which we go through life.

Bell's (2000) consideration of the issue of suicide from an organisational position derives from a psychoanalytic perspective and has some relevance here. There is a likening to the notion of constructed knowledge in his contention that it is often the person for whom there is little concern that actually commits suicide. One can only assume that such concern or not, is related to an assessment of this issue and hence, the available evidence base. He goes on to say that being suicidal then covers a wide range of clients both those for whom concern existed and those for whom there was little concern. Bell gives an example of how this judgement eventually led to the incorporation of all the people under his care being subsumed into the category of suicidal.

For Bell, the anxiety prompted by this process eroded the desire to improve care and was replaced by a wish to escape blame from an omnipotent organisation which would hold staff responsible in the event of a suicide and who would consequently be punished. The events described here are indicative of how knowledge is constructed not discovered. This is illustrated by deeming a person suicidal seemingly due to a lack of concern regarding this risk and is couched in relationships and social consequences given the part that potential retribution seemingly played in this process.

Such difficulties associated with accurate risk assessment were also highlighted by Kapur et al (2005) who found that most people who repeated self harm had been assessed by emergency department and psychiatric staff as low or moderate risk, the conclusion from this study thereby rendering the predictive value of risk assessment after self harm as low. Yet risk assessment forms a significant part of practitioners' work and in this respect, Bell (2000) states that insisting mental health personnel accept responsibility that is unrealistic, seems increasingly evident in mental health policy. The point being that such policies which project unmanageable anxiety on those who already have a difficult task leads to the deterioration in care for clients. As such, management plans serve as defence against blame rather than

acceptance of the complexity of the task and an attitude of inquiry is transformed into protection of the self (Bell, 2000).

Johnstone's (1997) remarks can also be referred to in this context and which highlight the professionalisation of self injury and how this then becomes the property of the professionals. This is at the expense of those who have experience of it, assuming no overlap within these groups, who consequently lose the power to define it, to say what it means to them and how they would wish to be helped. This is clearly the antithesis of the approach I was hoping to engender in my study and in contrast to Johnstone's (1997) observations regarding the professionalisation of self harm, Alexander and Clare (2004) emphasise the need for research to be designed around the voice of the participant. Reiterating that they are primary experts in their self injury and their perspectives are invaluable in enabling a greater understanding of these complexities.

These comments by Bell (2000), Johnstone (1997) and Alexander and Clare (2004) aptly summarise some of the crucial issues discussed in this chapter and which are concerned with the emerging ideas from the study. Whilst in the preceding sections I have attempted to draw together key concepts from Celia, Margaret, Ellie and Riordan's stories, in conjunction with the literature. In this section I have presented an argument for social constructionism not as a complete answer, but as an antidote to the dominant medical model premise on which current clinical practice relating to self harm rests. This leads to the use of seemingly divergent approaches and as the final section in this chapter will argue, is one of the strengths of this study in terms of the original contribution to the existing knowledge base.

A match made in Heaven or Marriage of convenience?

Previous chapters have charted my journey through this study and attempted to make the choices made transparent. In doing so the intention was to influence the soundness of the study (Crotty, 2003) and produce convincing stories (Miller and Crabtree, 2000). The theoretical underpinnings of the study have been illustrated through their application to the stories in this thesis but there remains a need to provide further defence of their use and in doing so, argue that this is a strength of the study in terms of its original contribution to the existing knowledge base.

A search of the terms "*Self Harm, Social Constructionism and Psychoanalysis*" using the combined databases of Applied Social Sciences Index and Abstracts, MEDLINE, PsychINFO and Sociological Abstracts revealed only one study. The focus of this study, published in 2004, was on the Social Constructionism of Motherhood and Mothers on drugs (Litzke, 2004) and so does not directly relate to my study. As such the search revealed that a methodology which combines aspects of social constructionism with elements from psychoanalytic theory to explore stories related to self harm was an original contribution to the evidence base. However, it is not good enough to simply make this claim and so the proceeding discussion will demonstrate the benefits of using a psychoanalytic approach in research and justify the use of mixed theoretical approaches with specific reference to self harm.

Flick (2009) states that psychoanalysis attempts to reveal the unconscious in society and the research process. Given the aims of this study which were concerned with the health promoting and survival function of self harm and which evolved into a concern with the storied lives of people who self harm. This reference to the unconscious is apt and has enabled the participants' stories and that of my own to be interrogated in a way they would not otherwise have been. This relates to the proposal of possible unconscious processes associated with the participants' stories and self harm, but also the research journey I have taken. As an approach this can be seen to be beneficial, not only with respect to Flick's comment above, but also in relation to the argument posed in earlier chapters for taking a reflexive approach within research (Finlay, 2003; Mauthner and Doucet, 1998; Taylor and White, 2000; Stanley and Wise, 2002; Wilkinson,1988).

In keeping with a reflexive and transparent approach, attempts to reflect the journey within this study have offered a rationale where methods were revised such as the choice to use an alternative following application of Kohler Riessman's (1993) approach to narrative analysis. Flick (2009) states that in interpreting text not every method is appropriate in every case and the decision concerning methodological alternatives should be grounded in one's own study, the research question, its aims and the data which has been collected. Where problems are encountered with the interpretation of the text Flick (2009) urges reflection on it and the way the text has been worked with. If it is impossible to remedy such problems, then consideration should be given to changing the method. This replicates my experience of working with the stories and the difficulties associated with data analysis described by Mauthner and Doucet (1998) and referred to in Chapter 3.

Publications such as Flick, (2009 p457) offer what could be construed as "*recipes*" to signpost the reader to particular methods of data collection and interpretation based on different research perspectives. Had such guidance been followed, arguably, academic rigour could have been demonstrated through reference to the existing evidence base concerning research methodology. However, key questions specific to this study and related to meaning derived from the stories would not have been elucidated in the same way and this would have limited the study as a consequence.

On considering the nature of the study, the research question, its aims and the data which was collected (Flick, 2009) the choice to use psychoanalytic theory was made and was explored previously in Chapter 3. Without repeating this in detail, suffice to say that many techniques used in qualitative research are employed within therapeutic endeavours, such as gathering stories, listening sensitively, generating an understanding and clarifying ones interpretation (McLeod, 2008) and in this sense the compatibility of these approaches is largely indisputable.

Using perspectives from psychoanalysis as opposed to alternative theories which underpin therapeutic endeavours derived from the notion that psychoanalytic theory can offer suggestions why certain things, experiences, and people are so important, whilst unconscious process such as projection and introjection make a world which is essentially meaningless, meaningful (Chodorow, 1999) and which relates to the events described in the participants' stories. Additionally the use of psychoanalytic theory represented an attempt to address the proposed limitations of the available evidence stressed by Bell (2000), McAndrew and Warne (2005) and Shaw (2002) by focusing on interpersonal and intrapersonal processes in relation to self harm.

However, whilst arguments have been presented in relation to the use of psychoanalytic theory in research and specifically this study concerned with self harm, justification for the mixed theoretical underpinnings used in this study has yet to be fully addressed. Whilst the dual use of social constructionism and psychoanalytic approaches in relation to a study regarding self harm appears to be a rarity, the use of seemingly divergent approaches is not and the following discussion will exemplify this is an effort to present a cogent argument for mixed approaches and by definition those used in this study.

McLeod (2003) states that there has been a lack of interest in counselling and psychotherapy research regarding language as words have primarily been used to signify something else such as expressions of unconscious processes. However, he argues that with the expansion of qualitative research and the increased influence of social constructionist ideas, the use of language in therapy has become a focus for inquiry. The main point for the purposes of argument at this juncture is the observation of social constructionism as having an increased influence in psychoanalytic research.

Arguably this increased influence relates to the perceived benefits of using social constructionism with psychoanalytic theory and is illustrated by Modell (2009). This author states that each of us constructs our own inner world of private meaning as derived from our experiences, what we know and value. He goes on to say that applying the belief that reality is socially constructed to the psychoanalytic relationship, has led to an egalitarian view that transference is the product of two subjectivities or put another way, knowledge is something people do together (Burr, 2005). This example of seemingly divergent perspectives being embraced in the pursuit of meaning making illustrates the evolution of psychoanalytic theory and the acceptance of ideas taken from social constructionism.

That is not to suggest the issues concerning agency and essentialism, as discussed previously in relation to social constructionism and psychoanalytic theory are completely resolved, but neither are they completely incompatible. Frie (2009) contends that agency is located neither in the individual nor contexts, but in the interactive generative space of affect, imagination and embodiment. To take this point further, subject and context depend on each other and neither can be understood without the other (Frie, 2009).

By using Kohler Riessman's (1993) approach to narrative analysis, Frie's (2009) contention was illustrated as within the *"processed"* transcripts the individual seemed to be lost. More could be said of the construction of the story than the proposed meaning relating to the storied lives of the participants, which meant the aims of the study would be met only in a limited way. Referring back to Flick (2009) consideration had to be given to changing the method to better answer the research aims and this was achieved by using elements from psychoanalytic theory, underpinned by a critical approach to knowledge engendered by social constructionism and offering further justification for the identified themes using the voice-centred relational method described by Mauthner and Doucet (1998).

Justification for the approaches used is not to suggest that they were wholeheartedly endorsed without question. The issues of agency and essentialism in relation to social constructionism have been highlighted and aspects of psychoanalytic theory which I found problematic such as "*penis envy*" were discussed in the main body of this thesis. However, Hacking's (2003) contention that there are grades of commitment to social constructionism (and as stated above, for me aspects of psychoanalytic theory) has utility here. An example of this is the work of Nancy Chodorow relating to gender. Chodorow (1995) contends that gender can not be seen as entirely linguistically, culturally or politically constructed. She states there are individual psychological processes in addition to and which are different to culture, language and power relations that construct gender for the individual. As such, Chodorow (1995) states that each person's sense of gender is an inextricable fusion of personally created (emotionally and through unconscious fantasy) and cultural meaning. Chodorow (1995) goes further to state that in keeping with a psychoanalytic position, people use available cultural meanings and images but experience them emotionally, through fantasy and in interpersonal contexts. In a similar vein, Frie (2009) argues that the experience of sexual difference is without a doubt filtered through societal power relations and cultural practices but that it is questionable whether more basic biological differences can be attributed merely to cultural artefacts.

When regarded in the contexts proposed by Chodorow (1995) and Frie (2009), it seems that seemingly divergent perspectives such as social constructionism and psychoanalysis are not incompatible after all. To take this point further there is also an argument in favour of mixed theoretical underpinnings and methodologies.

With specific reference to sensitive topics, of which self harm can be regarded as one example, Lee (1999) states these tax the ingenuity of the researcher and that the difficulties surrounding sensitive research promotes beneficial borrowings from other disciplines. Whilst Flick (2009) states that triangulation is a strategy for improving the quality of qualitative research, and can be done in a number of ways including studying the issue using more than one research perspective. This strategy can attract critique, particularly if those perspectives used are seemingly divergent in their underpinning assumptions. However, in his text regarding qualitative research in counselling and psychotherapy, McLeod (2008) acknowledges the different versions of social constructionism and states that there is no reason to maintain a rigorous and consistent social constructionism but rather takes a pragmatic

approach stating that the important point of research is whether it says something that might make a difference.

It is not only theoretical perspectives where seemingly divergent approaches have been used, Gough (2004) marries the method of discourse analysis with psychoanalysis and contends that at first glance, these appear to share few similarities. However, he goes on to state that both are concerned with language and interpretation and his paper illustrates how psychoanalytic concepts can inform and enrich the analysis of texts. In this respect he argues that psychoanalytically informed research can get behind or in between language to personal experience. This observation is derived from the author's experience of conducting research which used a purely discursive approach to its analysis. On returning to the transcripts Gough (2004) reports the rich emotional tone and imagery which was present in the text and which would lend itself to elements of psychoanalytic theory to provide insight.

In contrast to discourse analysis, a psychoanalytic approach to the text is said to enable language to be connected to (inter)subjectivity through defensive emotionally laden manoeuvres as opposed to staying solely within the realm of language (Gough, 2004). This mirrors my own experiences as detailed in Chapter 3 in relation to my desire to find a suitable way of proposing meaning whilst maintaining Celia, Margret, Ellie and Riordan as the central focus for consideration and reflects Turp's (2003) urge to consider the underlying state of mind behind acts of self harm.

Taking a multidisciplinary approach such as that exemplified in Gough's study was also advocated in a discussion of emotions by Clarke (2003). This author acknowledges that sociology and other related fields have become fixed between a social constructionist perspective and the view that emotions have an innate character. To remedy this he suggests taking a multidisciplinary approach, arguing that psychoanalytic theory can compliment sociological analysis by addressing the affective component of human social relations, through emphasis on the psychological relatedness of individual, society and social phenomena and by addressing the complex interrelationship between socio-structural and psychological factors.

As such, Clarke (2003) argues that this approach, referred to as psychoanalytic sociology, compliments traditional methods of social research, qualifying this by stating that sociology offers insights into the

structures of modern (or postmodern) life which uphold phenomena such as inequality and social exclusion, while psychoanalysis offers equally rich insights into the affective forces and embodied nature of these phenomena. Clarke (2003) specifically states that to gain an understanding of the emotional life of an individual, both the social construction of reality and the psychodynamics of social life need to be addressed. A contention which I hope has been illustrated in relation to Celia, Margaret, Ellie and Riordan.

Much of the previous discussion has focused on the need to adapt in order to answer specific questions and McLeod (2008) argues that the demands of qualitative research require the researcher to improvise and create their own techniques for collecting and analysing material. He states that this notion is captured by the concept of the researcher as bricoleur. The benefits of bricolage according to Warne and McAndrew (2009) are that it affords a greater opportunity for sense making, more specifically, it is said to provide enhancement to the exploration of participants' life experiences, the dynamics in the research encounter and the opportunity to use a number of philosophical and theoretical positions (Warne and McAndrew, 2009), clearly a desirable goal in keeping with the aims of this study.

The preceding discussion has offered justification for the use of mixed theoretical underpinnings to this study and presented an argument supporting it as an original contribution to the evidence base. However, I can neither subscribe to the view that this is a match made in heaven, nor is it a marriage of convenience. Instead the use of elements of social constructionism and aspects of psychoanalytic theory in combination with the voice-centred relational method reported in Mauthner and Doucet (1998) has enabled a critique of the taken for granted and status quo (Hacking, 2003) and the language to describe a host of interpersonal processes (Turp, 2003). Without combining these approaches, the study would have been limited as a consequence, possibly mirroring Gough's (2004) critique.

This leads to the final two chapters of this thesis which are concerned with my own reflexive points which are offered to be interrogated by the reader and finally those issues which are prompted by completion of the study.

Chapter 9

A reflexive approach

The main body of this thesis has been divided into three sections, "*Going There,*" "*Being There*" and "*Being Here*" (Birch, 1998). This chapter relates to being here, it is where the practical research world is distanced, the text is created (Birch, 1998) and by nature of its focus, a retrospective consideration of the journey up to this point is warranted. To assist in this process Chapter 9 is structured around the sections highlighted above beginning with "*Being Here.*" The reason for this inverted order is that whilst, this chapter is retrospective, "*Being Here*" is the position I am currently in and therefore will be considered first.

Being Here (Birch, 1998)

"*For the constructionist, the point of social analysis is not, then, to "get it right" about what is happening to us. Rather, such analysis should enable us to reflect and create.*" (Gergen, 2000 p195).

Whilst previous discussion has highlighted perspectives from social constructionism within the study, I am not a constructionist. However, I have found this approach to be useful, liberating and energising and it has enabled me to consider the stories in a different way than I might otherwise have done. That said the crucial part of Gergen's quote for me, is the final sentence. I have been able to reflect and create and whilst I hope that this is apparent throughout the thesis, I would like to offer further insight in this respect.

This study has emerged as one with relationships at its core. These include the tellers of the stories and their characters within it, but also relationships with the self and me as the researcher. Undoubtedly, my ability to reflect and create has been dependent upon the time I spent with Celia, Margaret, Ellie and Riordan, not just in the sense of our physical proximity during the interviews but also in the time I have spent thinking about them and their stories. This has occurred at a particular place and time in my life and has caused me to be contemplative in a way I might not otherwise have been, and for me, relates to events which took place whilst I was on three months writing leave.

A week into this leave I received a telephone call from my distraught mum telling me that my aunty, her younger sister, was in a life threatening condition as a consequence of a deterioration in her health during a current hospital admission. Over the next three months this was a recurrent occurrence as my

aunty seemed to improve slightly only to become gravely ill once more. The resonance with the stories of family and survival shared with me by Celia, Margaret, Ellie and Riordan struck me throughout this painful period and I was also forced to contemplate issues of death, contrary to the intended pursuit of my research study.

However, in retrospect as the study has progressed I have moved from this somewhat dichotomous position of regarding death and survival as poles and have become increasingly mindful of the fragility and elasticity of life and death and the way in which both permeates the other. The notion that the physicality of death kills us and the idea saves us (Yalom, 1980) struck me. Whilst loss, the quest to survive despite it and the overwhelming existential dilemma that faces all of us, given that we and our loved ones will ultimately die (Yalom, 1980), pervades the stories of Celia, Margaret, Ellie and Riordan and also my story as I journeyed through this work.

My three months writing leave was characterised by a sense of urgency not only in relation to staying on track with my study but with regard to the events surrounding us as a family. My aunty died and her debilitating illness ceased. I was reminded how loss, be it through bereavement or the loss of a loved one or object, whilst painful, can also be positive. This resonated with the changes seemingly brought about by a loss, despair or desperation within Celia, Margaret, Ellie and Riordan's stories as reflected in the various shifts all four participants shared following their attendance at A&E. These included relating in different ways to family members and having something to live for.

The issue of loss as having both positive and negative consequences relates not just to this event for me. There is also a sense of loss related to being at this point in my doctorate studies and whilst this brings me closer to completion than I have been before and which is a relief, it is also anxiety provoking because I know judgments are to be made of it.

At different times in my journey, my PhD supervisors have commented on my voice in the work, or the discussion being reflective of me. Clearly, using the approaches I have, I took this to be positive and as Etherington (2002) remarks, the use of a personal voice in writing offers an opportunity for growth and development. However, she goes on to say that there is also a risk associated with self disclosure to ourselves and others. For me this relates to the judgments which have, and will be made in relation to this study and my ability to portray the stories in such a way that does Celia, Margaret, Ellie and Riordan's narratives justice. As such, being at this point brings me closer to completion than I have been before and I have to take responsibility for the choices, decisions and omissions made in relation

to the study and this contrasts with *"Going There"* which was characterised by a host of opportunity and possibility.

Going There (Birch, 1998)

At this point options were available to me, I could have pursued this study in a number of ways and whilst I stand by the journey I have taken. I am also aware that through this process I have gained new knowledge and experience which has changed me as a consequence (Etherington, 2002). This means that the work as it is presented now is different to how it was a year ago, and arguably how it would be a year from now. That is not to undermine the study, but to acknowledge my development through the process.

My discussion in Chapters 1 and 2 illustrates how I was drawn to particular approaches and perspectives. Yet by proposing to use critical approaches as an underpinning to the study and in particular, those deriving from feminist theory I experienced a degree of discomfort. Burman (1999) states that it is often said that naming work as *"feminist"* alienates those who need to hear the arguments. Clearly this was not my intention and my discomfort resided not in this context, but with a related concern. Identity is clearly inherent in any undertaking which espouses to use such a critical stance and it troubled me as to whether identification as a *"feminist"* was a prerequisite to adopting a method of research which draws on feminist theory.

Having never identified to myself or others as a feminist, I wondered if I was making fraudulent claims. This led to consideration whether I was a victim of my own petard, having taken a critical approach to the evidence base pertaining to self harm perhaps I was guilty of using theory in a disingenuous way.

However, I think my lack of identity as a feminist is more to do with the need not having arisen as opposed to my belief system not reflecting that of a feminist persuasion. Additionally, I could wholeheartedly say that I identified with Stanley and Wise's (2002 p189) arguments that there are a number of areas where the precepts from feminist epistemology are integrated within research. In considering these points I have been able to reflect on their relation for me not only through my research but in what I believe to be important in every day life. This includes the nature and importance of relationships, my emotional state and that of others, that there are multiple ways of understanding and making sense of something. That at its most fundamental, power is a dynamic which pervades the fabric of society and which needs to be made explicit. Finally, that as a woman, I internalise and project

my response to this in a way that can not be separate from my identity which may be considered to be supportive of a feminist ideology. Having metaphorically found myself in this sense, the next challenge was in finding Celia, Margaret, Ellie and Riordan.

Being There (Birch, 1998)

One of the issues which emerged throughout the study was why Celia, Margaret, Ellie and Riordan chose to be interviewed. I have proposed a number of possibilities for this within previous discussion, but I am also mindful that one part in the process has not been considered.

In an effort to remove myself from approaching potential participants in A&E, and in doing so, minimise the risk of *"peddling"* my study, practitioners who worked in this environment initiated contact. I know this to be sporadic as when I went to the service to see if anyone had consented for me to contact them, I would engage in conversation about how busy the service had been and why people had not been approached as frequently as I would have liked. Given this sense of inconsistency it suggests that there must have been something about Celia, Margaret, Ellie and Riordan which made them approachable in this sense.

Having posed this as a discussion point, I do not have an answer to it, but having completed the interviews know regardless of how they came to be, I could not have asked for more engaging and thought provoking people and narratives and I would not change anything about it. The time I spent with Celia, Margaret, Ellie and Riordan, both in a physical and reflective sense as I thought about their stories provoked further points for consideration and in an attempt to assist in their presentation I have split them into two sections as follows.

Relationships, hardships and an occasional mishap

Relationships have been a key theme throughout this study and the overwhelming feeling for me in relation to Celia, Margaret, Ellie and Riordan is that the duration of an encounter or longevity of a relationship does not necessarily make it meaningful, but rather what passes between those involved. I have carried all four of the participants in this study in my head since we met, I have thought about their stories and how best to present them and my relationship with Celia, Margaret, Ellie and Riordan has been sustained because of this.

However, this does not mean that I experienced the participants and their stories in a similar manner.

For instance, whilst I stand by my point regarding duration, I have thought about why Riordan's interview and the first draft of his chapter were longer than the others. It may be that being the fourth interview I had benefited from reflection on previous interviews and developed a greater sense and confidence in what I was trying to achieve. It may also be that Riordan's story was representative of those I expected to hear when I first thought about the research. In the postscript of Riordan's chapter I present the notion of a walking textbook bringing the detail to life and this is how it felt. At times I was excited by the things he talked about as it related to my existing knowledge base and in a way fulfilled my expectations.

Conversely, Ellie's narrative highlighted some tensions for me. At this point I had interviewed Celia and Margaret both of whom did not fit with my expectations as discussed previously and which related to notions of wanting to end their lives. Ellie was also representative of this and which contrasted to my conception of self harm and that which informed my research. On asking Ellie about her understanding of self harm I hoped to assuage my intrigue but in fact what this did was reveal my desire to couch Ellie's overdose as self harm as it fitted better with my study, whilst acknowledging the danger of misrepresenting her.

In this respect I am mindful of Stenner's (1993) points in relation to the ethics of interpretation and being painfully aware of having control over other people's words. Clearly what has occurred within the interview situation can not be changed. However, by taking ownership and trying to be honest about my intentions, I can be reassured that my transparency within the process (or bias depending on one's viewpoint) is laid bare.

In keeping with this transparent approach I was determined to distance myself from the criticisms I had made in relation to pursuing objectivity and was clear that benefit would be derived from being positioned as clearly as possible in the research. That said, I have acknowledged the need to balance the pursuit of transparency with not becoming self indulgent, which I hope has enabled an open appraisal of the process taken to identify the emerging ideas as discussed in Chapter 8.

However, this has its own risks and I was mindful of Davison's (2004) proposals regarding the potential for personal harm and distress for researchers. This author contends that whilst empathising and achieving emotional resonance with research participants is likely to lead to rich data, it may also accentuate researcher vulnerability or distress.

I was willing to accept the potential for this as to be detached in an attempt to avoid vulnerability would have been extremely difficult for me to achieve. It could also have been perceived as disrespectful to the participants and the powerful and painful experiences they disclosed. Therefore I regarded remaining detached as potentially destructive and damaging and was something I endeavoured to avoid.

That is not to say that listening to the stories was not without difficulty. On reviewing the postscripts written at the end of Chapters 4-7 I am instantly transported back to that situation and the feelings associated with it, some of which was painful and upsetting. Additionally, the differences in the postscripts following the first interview with Celia and the last with Riordan are telling to me. There is a sense of distance gradually being extended from myself as someone with experience of working in A&E with people following self harm, to one in which I feel I shed that persona, became more in touch with my feelings in relation to the story, and less concerned with the technicalities of it.

As stated, there were aspects in all four stories which were hard to listen to and relive when I was transcribing and working on the interviews. I also became increasingly aware of issues associated with transference and projection as I progressed through the interviews. In this sense I feel I observed a transition as I became more a part of the story as I have recreated it. I have also reflected on whether the distance from the technicalities of interviewing people in A&E which involves having to make decisions based on assumed levels of risk, and trying to the balance the needs of the individual against those of the organisation, which sometimes clash, have enabled me to acknowledge my transference and projections more readily.

This is an issue which has potential implications for practice as being attuned to one's counter transference and projective identifications can assist in productive work with people who use services (Rayner et al, 2005) yet my reflection here implies that barriers may exist to deter this.

A further example of my transition, which could be likened to a sense of progressing from constraint to increased liberty, was in relation to my decision not to consult the clinical notes following interviews and choosing not to follow the semi-structured interview schedule. Having carefully devised this with questions which ranged from facts and demographic information to more difficult, interpersonal issues and which finished on a potentially positive note. The semi-structured interview schedule was largely abandoned from the beginning and whilst this may have been a mishap of a sort, the postscript which follows Celia's interview contains suggestions as to why I did this.

However, I am also aware that my reluctance to intervene was as a consequence of feeling grateful that Celia had agreed to be interviewed and a sense of relief that I had my first participant. I also feel this may have influenced my refraining from asking the difficult question which played on my mind as to whether she had felt any sexual attraction towards her daughter's partner. Including comments such as this opens them up to scrutiny and this presents a quandary as Celia is not able to answer this. As such, my intention here is in trying to reflect something of myself rather than induce the reader to scrutinise Celia's story for signs to confirm or deny this.

The semi structured-interview schedule represented a further tension for me in relation to Ellie's story and whilst I have presented my lack of reliance on it as indicative of my progression from constraint to increased liberty. I also said it was only largely abandoned and as Ellie's chapter reveals, I did refer back to this. I suggested that one of the proposed reasons may have been my initial discomfort concerning Ellie's description of her sexual orientation which might have impacted on the relationship we forged.

On reflection this represents an interesting power dynamic juxtaposed with that of researched and researcher. Warnings such as that offered by Stenner (1993) with regard to the ethics of interpreting another person's words clearly place the power dynamic in favour of the researcher. However, the exchange between Ellie and I shifted this balance by virtue of a *"heterosexual hegemony"* (Burkitt, 1999 p73) which Burkitt uses to denote how sexualities are demarcated into normal and abnormal. As such, it is not simply the roles people play but what they bring of themselves which can exert an effect on the research relationship.

What did I notice?

Much of what I noticed was concerned with relationships within the research context. These included the relationships Celia, Margaret, Ellie and Riordan had with the characters in their stories, and with me, but also with themselves and how this related to the areas I wished to pursue through the research. These areas were made explicit in Chapters 1-3 and discussed in Chapters 4-8, what I now reflect on is the relationship I have with myself as researcher.

In reviewing my journey through this research I can identify feeling less constrained and more liberated by the purpose of the study and an increasing confidence in what I was trying achieve without needing the safety of a (pseudo)scientific approach. This is one of the main points for me having got to this stage in my doctorate studies. At the beginning of this journey I was clear that my research inquiry, as

couched within a historical, cultural and political context, should dictate how and why I gathered the information and made sense of it in the way I did. For me, this has been reinforced and whilst my confidence has grown and my reliance on a (pseudo)scientific safety net has lessened, it is perhaps not completely resolved. I know the way in which I have tried to make sense of the interviews to derive a useable meaning for wider consideration still has remnants of this.

Chapters 4-7 reveal my endeavour to urge the reader to appraise the information not solely on what else I could have included, as there are a multitude of readings which could have been derived from the narratives, but whether that which is commented upon is "*methodologically, rhetorically and clinically convincing*" (Miller and Crabtree, 2000 p623) in conjunction with my addendum, theoretically credible. In many ways these chapters were the hardest to complete and this part of the research process reminded me of Taylor and White's (2000) reference to the messy and complex business of professional practice. As such, the quote below resonated, loudly at times.

"*Data analysis is our most vulnerable spot. It is the area of our research where we are most open to criticism. Writing about data analysis is exposing ourselves for scrutiny. Perhaps it is for these reasons that data analysis fails to receive the attention and details it deserves.* Mauthner and Doucet (1998 p123).

I know that this undermined my confidence in the approaches I had taken to make sense of the narratives and initially, inclusion of the voice-centred relational method of data analysis (Mauthner and Doucet, 1998) was an attempt to assuage this concern. However, once I had completed the process it seemed to reinforce the importance of the themes I had identified in the stories and I felt more able to justify what I had noticed.

Whether I have been able to articulate how and what I noticed in such a way that it adds to the body of knowledge presents the next challenge as discussed in the following chapter. Clandinin and Connelly (2000) urge reflection as to whether an inquiry goes beyond personal interest or is seen as merely trivial and whether the inquiry makes a difference. These contentions have been an ever present consideration throughout the study and being in the position of sharing someone's story in the way I have, is one of privilege, but also carries a weight of responsibility to ensure that an effective outcome for their and my efforts is realised.

Chapter 10

Thoughts from here

Being here at Chapter 10 I am nearing completion of this thesis and in the preceding chapter, I referred to Clandinin and Connelly's (2000) urge to consider whether an inquiry makes a difference, and this is the focus of the following discussion. In this context the authors ask "*Who cares? And so what?*" (Clandinin and Connelly, 2000 p120). The question of *"so what"* has been ever present for me throughout my doctorate studies and I will use it to frame the first section of this chapter. I will then consider my proposals for "*now what*" and in doing so conclude this part of my journey.

So what?

This journey began with the formulation of two main questions which centred on exploring the health promoting function of self harm as a survival strategy and evolved into a study concerned with the love, loss and concerns of four people. In answering "*so what*" the discussion will reflect the evolution of the study and centre on a number of key issues which emerged through its completion. These relate to current service provision and the need to extend consideration beyond issues of risk (Heyno, 2008; Seager, 2008), the importance of relationships in stories concerning harm to the self (Bell, 2000), the need to search beyond rationalisation and the expression of self harm to underlying states of mind (Bell, 2000; Turp, 2003), the benefit of using stories to gain a cogent understanding (Etherington, 2006: Frank, 1997; McAllister, 1991 and Yalom, 1991; 1994) and the fluidity of ideas concerning death and survival (Hale, 2008; Seager, 2008).

The findings relate to these key issues, they are concerned with enhancing the response to people who attend A&E following self harm and derive from the mixed theoretical underpinnings, methodologies and methods used. These have engendered a critique of the taken for granted using perspectives from social constructionism and a proposal of meaning by applying elements of psychoanalytic theory and relational methods to understand the stories. Without this approach, the findings would have been limited, as evidenced by previous attempts to analyse the stories and which mirrors the contention of Gough (2004). These issues will now be explored in detail and a coherent rationale offered.

Praxis, it is not just what you teach

A limitation of this study may be seen to derive from the fact that it rests on the stories of four participants but the benefit of using stories in research to impact on practice has already been dealt with in Chapter 8. There is also the issue that research concerning self harm largely centres on people who attend hospital (Hawton et al, 2004) and this applies to the study being reported here but despite this, there are aspects of this study which add to the existing knowledge base.

Favazza and Conterio (1988; 1989) proclaimed that the mean age of someone who self harms is 28 although Shaw (2002) suggests that statistics may be skewed towards white middle class women in North America and the UK where most research into self harm takes place. Whilst bearing Shaw's contention in mind, there is a pattern reported in the literature which loosely concurs with Favazza and Conterio's finding (1988; 1989).

Klonsky (2007) reports on 18 empirical studies concerning self harm of which 16 reported average age to range from 15-37 years (2 did not include such details). In other examples such as Maghsoudi et al (2004), Solano et al (2005) and Zarghami and Khalilian (2002) the average age was between 22-27 years and interestingly concerned populations which were not North American or derived from the UK. Other studies such as Kapur et al (2008) state a median age of 30 in their study whilst Hawton et al (2007) state that 62.9% of the 7311 participants in their study were under 35 years old, with numbers more or less decreasing with age.

As women in their 50's this suggests that the inclusion of Celia and Margaret in this study is comparatively unusual based on the figures above and underlines the importance of their input in adding to the existing body of knowledge. Additionally, using a narrative approach as opposed to information being collapsed into a questionnaire or solely relying on demographic information reinforces this contribution. This has been discussed previously in Chapter 8 where the potential impact that individuals' and their stories can have on practice is posited (Etherington, 2006; Frank, 1997; McAllister, 1991; Spandler and Warner, 2007 and Yalom, 1991; 1994).

A related area which would have been a useful addition to the study concerns recruitment. Exploring how individuals were identified by clinicians involved in recruiting to the study, how many people were approached but declined to participate and who the study was not broached with at all, could have enabled further information to be gathered. This may have helped build a more comprehensive picture regarding recruitment to the study and led to interesting insights.

Much has been made in the study with regard to language and shared meaning, particularly in relation to terms such as self harm and attempted suicide. However, the four stories in this thesis illustrate that this is not straight forward and is couched in a host of other complexities. These include, whose meaning takes precedence, how meaning may be interpreted by others and can be used to either secure what is desired or protect from that which is not.

The implications of this can be highlighted using the assessment of an individual's needs. If the terminology used to describe something is not shared then meaning becomes blurred. The outcome of which may be that an individual's specific needs are poorly defined and met only in a limited way, if at all. This discrepancy between what people need after self harm and what the service offers was also recognised by Lilley et al (2008). As such, focusing on self harm when its meaning is far from universally agreed complicates the existing complexities further. In this respect there is an argument for not relying on terms such as self harm and attempted suicide, and as an alternative, shifting focus to what lies beneath. That is, what brought the person to the point at which they harmed themselves and concentrating efforts in this respect.

Turp (2003) progresses aspects of this argument by stating that the term self harm can conjure up images of cutting, scalding or overdosing but that this characterisation is too narrow a focus. She goes on to say that self harm finds expression in many different ways and thinking about these health impairing behaviours can perhaps be best understood through consideration of broadly similar underlying states of mind.

As an implication for practice Turp's (2003) contentions that focus should not be on the physical manifestation of self harm, is supported and taken further in my study. There is a body of literature which delineates a clear distinction between suicide and self harm (McAllister, 2003; Turp, 2003) with the basic difference being that in the former the person wants to kill themselves and in the latter they do not (McAllister, 2003), this distinction also features in my critique of the literature. Yet this was not reflected in Celia, Margaret and Ellie's stories as they agreed to be part of a study concerning self harm yet at times expressed suicidal thoughts and acts through stories where issues of death and survival intermingled.

This reflects the work of Bell (2000), Klein (1935) and Menninger (1935) all of whom regard harm to the self as also having a positive intention. This makes the distinction between self harm and suicide less clear and terms such as attempted suicide and self harm may be required as a way of acknowledging harm, but the limitations of terminology also need to be kept in mind and overcome.

This has implications for practice and in trying to gain clarity, the individual's interpretation should be made explicit and consideration of the underlying state of mind as urged by Turp (2003).

Turp (2003) states that while it is possible to keep self harm hidden the individual is unlikely to seek help at an early stage. In relation to Celia, Margaret and Ellie this is interesting as all stated their attendance at A&E was the first of this nature. However, it could be that the three women in the study do not fit Turp's (2003) contention and the first time they engaged in such activity it resulted in a visit to hospital. Alternatively they may have used other forms of less conspicuous self harm such as alcohol use, over work or even putting others needs first to the detriment of one's own. Equally, self harm might have been used previously but explained as accidental or this was not the first time risky activity had been engaged in, but previously attendance at A&E was not required. That a number of possibilities existed may relate to how I phrased the question and in the pursuit of understanding, illustrates the importance of asking the right questions.

With Riordan I asked him what led to his use of the service and his story transpired from there, with the three women in the study I asked them all a version of "*was this the first time you've used that service*" and whilst I also asked about the events leading up to the visit to A&E during the interviews, I took confirmation of first time use to imply the first time they had self harmed. Despite my insistence of its importance, it seems that I was not as attentive to language as I could have been and which has implications for practice.

Hale (2008) contends that he does not distinguish between suicide and attempted suicide as he understands suicidal acts as a spectrum with the wish to kill the body and desire to survive being present in all suicidal acts. This illustrates the need to be mindful of the language used to clarify events and meaning and the importance of this was successfully demonstrated in Shea (1999).

During assessment the client was asked if they have any thoughts of wanting to hurt themselves to which they replied they did not. The assessor continued but felt the picture they were building up of the individual did not fit with their denial of such thoughts. This issue was returned to and the person conceded that they did wish to kill themselves but not to feel pain, hence their initial response (Shea, 1999). As such, the use and interpretation of language has implications in clinical practice and is concerned with a need to establish a shared understanding and identification of the person's specific needs (Allen, 2007).

In attempting to meet such needs it may be that offering follow up after the initial attendance at A&E could allow time to reflect and may prove useful in this respect. Some might argue that those who

attend A&E following self harm are unlikely to attend follow up, but this study shows that people will engage at a later date. This leads to consideration whether the configuration of current service provision available to people is entirely fit for purpose.

Early Intervention

The need for services aimed at early intervention for those who experience psychosis is well established, the NHS plan (Department of Health, 2000) contains specific mention of this and the NICE guidelines on schizophrenia (2009) stress the need to urgently refer people who first present in primary care with psychotic symptoms to secondary mental health services. For a full assessment to be carried out, a care plan written with the service user including crisis plan and risk assessment and to offer early intervention regardless of age or duration of the psychosis. Conversely the NICE guidelines on self harm (2004) make mention of early management which seems concerned with immediate after effects as opposed to offering early intervention as an ongoing process. Given NICE's (2004) remit to focus on the short term management of self harm, this may seem reasonable. However, there is also an emphasis on prevention in the guideline and in this respect early intervention may be as relevant as it is for people experiencing psychosis.

Turp (2003) states that disclosure becomes inevitable by the time self harm has become an entrenched coping strategy with therapeutic intervention being much more difficult. Conversely an early intervention unit could start to address some of the problems experienced by those people whose self harm has not yet "*taken over*" (Turp 2003 p 219). In this respect counselling interventions are said to provide a good response with unstructured psychodynamic and narrative approaches being more helpful than structured cognitive behavioural interventions (Turp, 2003). This is in contrast to the NICE guidelines on self harm (2004) which proposes the use of dialectical behavioural therapy (DBT) and the observation by McAndrew and Warne (2005) that there is widespread reliance on cognitive behavioural approaches as the treatment of choice in the UK for many conditions.

Early intervention can prevent suffering and contribute to best practice according to Turp (2003) who further contends it is likely to be cost effective if associated with a shorter period of treatment and an improved success rate. Whilst Kapur et al (2005) comment on access to relatively scarce interventions following self harm and Lilley et al (2008) suggest there is a discrepancy between what people need after self harm and what the service offers. Such evidence suggests there is a need to consider current service provision and the findings from the study being reported here concur with this.

The three women in this study were discharged from A&E but could alternatively have been seen as requiring early intervention. NICE (2004) states that discharge from emergency departments without follow up should not solely be on the basis of low risk of repetition of self harm or attempted suicide and no mental illness, but does not sufficiently detail what should be done in this instance. In this respect, there may be a case for early intervention and people who attend services under similar circumstances to Celia, Margaret and Ellie could be seen as first presentation and requiring urgent attention in a similar way to people experiencing psychotic experiences described above.

The notion of early intervention is also supported by Cooper et al (2005) who say that suicide rates were highest in the first 6 months after the index self harm and that these results highlight the importance of early intervention following self harm in a suicide prevention strategy. Whilst Hale (2008) contends that focusing on secondary mental health services in relation to suicide prevention may be ill advised, and that strategies might be better focused on the education and support of GPs and counsellors in primary care. As primary care services are those most likely to provide longevity of support to the individual, Hale's proposal is reinforced by reference to his previous work documented in Jenkins et al (2002). These authors examined the rate of suicide 22 years after an episode of parasuicide in the 1970s. It reports that of the original 223 people, 140 could be traced and were followed up until 2000. During this period, 25 died and of these the death certificate revealed three suicides, four open verdicts and five accidental deaths, the latter nine being referred to as probable suicides (Jenkins et al, 2002).

Previous comments regarding the use of statistics are also applicable in relation to Jenkins et al (2002) as of those people who had died nearly half had done so through suicide and "*probable suicide.*" However, of those who had been followed up, this represented 9% over this 22 year period thereby conversely meaning that 91% of people who were traced had not died through suicide or "*probable suicide.*" It is also pertinent to say that a more apt term might be untimely death rather than probable suicide given the difficulties associated with ascertaining motivation. This is an issue recognised in Cooper (1999) who refers to the preferred term "*sudden death*" as relatives of the bereaved in her study did not believe their death to be suicide.

In returning to Jenkins et al (2002) it does mean that there are 12 people who may be considered as having an untimely death and it is stated that the risk of suicide for people with a history of parasuicide persists over many years thereby stressing the need for clinicians to intervene after such an episode. In making reference to Jenkins et al (2002) the intention is not to suggest that one would be able to predict who is most at risk in this context but rather to say that services have an

opportunity to intervene in a timely fashion by not solely focusing on current risk and evidence of mental illness, but seeing the opportunity for early intervention.

A risky business

Despite the comment above, risk remains a key consideration in contemporary clinical practice but by making sense of the four stories in the way I have in this study, I have been able to provide a depth and breadth of possible issues requiring attention from the perspective of the story teller. These might not otherwise have been identified if the inquiry had not extended beyond whether someone poses a risk of suicide or is using self harm to cope with distress.

There is a further point to make in relation to an original contribution to the evidence base. Attempts to apply self selection as detailed in previous chapters enabled a host of insights and complexities concerning self harm and suicide to be revealed which may not have been highlighted otherwise. Particularly as fixed criteria and definition of self harm may have resulted in Celia, Margaret and Ellie being excluded from the study.

The notion of risk also applies to the original approach used to gather information in this study. The use of seemingly divergent perspectives may be seen as a risk and potentially undermining academic rigour. However, justification for this approach has been outlined and the benefit of using an eclectic or bricolage approach is also brought to mind here. Turp (2003) contends that theories are not made up of incontestable facts but rather are a tool for thinking and it is the process of meaning making not formulaic explanation that has the potential to be therapeutic and this is an implication for practice.

Turp (2003) further says that theory as a tool for thinking rather than statement of facts or underlying realities allows for the co-existence of various concepts, and given this author's background in psychoanalysis it seems that its use in conjunction with perspectives from social constructionism are not so alien. A further practical example of where such perspectives collide is in meaning making.

As previously discussed, social constructionism contends that knowledge is not something people have, but is something people do together (Burr, 2005) and this relates to Turp's (2003) description of the therapeutic process. As such, Turp regards the transitional space as an area of shared experience that is contributed to and drawn upon by both the client and therapist. Embracing such notions in practice may assist in liberation from unhelpful ways of being where the professional assumes the expert role (Johnstone, 1997) to acknowledgment of the need to pursue shared meaning. This also appeared to be a motivation for all four participants who attended the research

interview as illustrated by their discussion of being helped and wanting to help.

In this pursuit, Fonagy (2008) contends that psychoanalysis is the most sophisticated discipline devoted to studying the subjective experience. Those familiar with his work might not be surprised by this declaration, but there is a point to be made here and as McAndrew and Warne (2005) state, psychoanalytic perspectives can enable those working in practice to hear clients' stories and respond in appropriate ways.

This view contrasts with the use of structured cognitive behavioural interventions (Turp, 2003), the NICE guidelines on self harm (2004) support for DBT and McAndrew and Warne's (2005) observation of the widespread reliance on cognitive behavioural approaches in the UK. The intention here is not to berate such approaches but to urge consideration of Turp's (2003) proposition of using tools for thinking. By engendering this notion at the heart of one's clinical practice recognition of the part that culture and history have in the generation of knowledge can be acknowledged. This may enable a critical approach to be taken where clinicians work on the basis of doing the best they can and setting high standards to achieve it (Cooper and Lousada, 2005).

In keeping with McAndrew and Warne's (2005) contention of the importance of hearing client's stories and responding in appropriate ways. One of the major issues throughout all the stories in this thesis was that of relationships. Previous mention has been made of David Bell's work and his contention that all suicidal acts occur within the context of real or imagined human relationships, and this is reiterated in a later publication (Bell, 2008). The stories reported in this thesis have relationships as a central theme with key characters being present in conjunction with the self. In this respect the part that psychoanalytic theory has to play in proposing one meaning behind the stories has been invaluable and enabled proposals as to what lies beneath the self harm (Turp, 2003).

In this respect, McAndrew and Warne (2005) highlighted the utility of psychoanalytic theory in relation to self harm. This can also be seen to go beyond reductionist approaches which pathologise the complexities of this issue and is more than simply an exercise in risk management. It is the opportunity to engage in meaningful joint discussion to highlight and potentially make sense of the issues for the benefit of the individual.

However, there is the argument posed by those who stress the need to extend inquiry beyond the personal. Johnstone (1997) stated that the effect of locating a problem within an individual prevents acknowledgment that as a culture, self harm pervades and that we are all involved in these dynamics. A further related consequence of individualising problems in this way is that experiences,

such as trauma, are diminished as the self harm becomes the focus of attention (Pembroke, 2007; Shaw and Shaw, 2007).

If attempts to enhance understanding and provide support are to be achieved, the above arguments need to be considered. These emphasise the need to consider the issues associated with self harm by taking into account the individual, their narrative, significant others and the historical, cultural and political context of their lives. In this way focus on the meaning behind distress rather than sole concern with the symptom may be enabled and as a pursuit is the hall mark of psychoanalytic practice (Turp, 2003).

The strategies used to propose meaning in the stories in this thesis have also enabled me to go beyond the taken for granted. The benefits of which were largely gleaned from using a narrative approach which facilitated the telling of the person's story as opposed to sole focus on the reasons for their self harm. This point relates to taking a needs led, rather than risk focused approach and can also be a means to an end in its own right. Celia, Margaret, Ellie and Riordan have been testament to securing a type of help through the telling of their stories. The therapeutic benefit of narrative has also been highlighted by authors including McAdams, (1993), Sque (2000) and with specific reference to the research situation, Hart and Crawford-Wright (1999).

In terms of implications for practice there is an important point to be made in this context and it is as Bell (2008) states that aside from the usual areas of concern, an accurate assessment of the inner situation of the client is crucial in order to provide what he refers to as "*rational management of these patients*" (Bell 2008 p52). Seager (2008) echoes these sentiments by stating that the NHS culture is permeated by a preoccupation with risk and generic toolkits which consider previous suicide attempts, current intent, diagnostic factors, epidemiological factors and various stress factors but are relatively blind to the quality of attachment, relationship and containment afforded by the service.

Ladame's (2008) supposition that a suicidal crisis is a trauma which ruptures previous experiences of containment is pertinent here. This argument is progressed with the proposition that containment needs to go beyond the mindful support available to the person. It must also extend to clinicians through good quality attachments to skilled and supportive supervisors, managers and policies and is an issue to be discussed more thoroughly later in this chapter. Yet in contrast Seager (2008) states that risk in mental health services has traditionally been concrete and focused almost exclusively on physical danger. He states that very little conscious attention has been afforded to the relational and social factors which give rise to dangerous feelings, thoughts and acts or to those which give rise to an atmosphere of safety. Arguably the approaches used in this thesis may assist

in this pursuit by urging consideration of the co-existence of destructive and survival properties associated with harm to the self. These have been illustrated in Celia, Margaret, Ellie and Riordan's stories and by Yalom's (1980) small death, Bell (2000) and Klein's (1935) contentions that some acts of suicide are aimed at preserving what is good.

Seager (2008) further contends that psychoanalytic thinking can be extended from the clinical level to include the whole culture or ethos in which mental health services are provided and this is vital in order to promote a culture of *"psychological safety."* To achieve this, Seager stresses the need for a wider concept of risk assessment which goes beyond medicalised examination of the stability of personality to explore actual attachments and relationships available to the individual including those the service is, or is not, providing. As such, it may be reasonable to suggest that using the narrative approach as illustrated in this study may help to engender Seager's wider concept of risk assessment thereby enabling exploration of psychological as well as physical safety.

A safe pair of hands?

As discussed in Allen (2007) a critical approach can be taken to the way in which statistics have been used to make links between self harm and suicide and whilst self harm may be the best predictor of suicide (Hawton et al, 2004) (or more aptly, untimely death where a definitive conclusion can not be reached) it does not mean it is accurate, it simply means it is the best available. There is a need for policy directives to acknowledge the complexities associated with the prediction of risk. In doing so this may impact on organisational culture to minimise the pressure practitioners are placed under due to potential consequences of getting risk assessment and management wrong, as illustrated by Bell (2000). This reflects Ladame's (2008) comments concerning containment extending to clinicians through good quality attachments with skilled and supportive supervisors, managers and policies, as discussed above.

To explore this further, Bell's (2000) comments enliven Gergen's (2000) contention that as we are metaphorically asked to explain ourselves in terms of the dominant ideology we gradually and unconsciously come to reproduce the dominant order in words and deeds. It is only in having a sense of distance from clinical practice that I have truly had the opportunity to consider the untenable task assigned to practitioners in the prevention of suicide. Untenable because it can engender a sense of responsibility to the organisation rather than the individual's care (Bell, 2000) and as such, flout the core task of supporting those who use services.

That said there are occasions where a suicide is preventable and clearly those instances require interrogation and any issues requiring attention to be addressed. However, there are also occasions where accidents happen during self harm or where it is extremely difficult to predict suicide and under these circumstances one has to question whether these comparatively rare events should dictate the way in which self harm is responded to by service provision to the extent it does. As such there is a requirement for policies to be implemented whose primary function is to support the individual rather than the needs of the service to avoid litigation and in doing so enable practitioners to fulfil the task to care.

Bell's (2008) comments resonate here that toleration of the possibility of suicide is not the same as collusion with it. A shift towards this mentality may be difficult to effect even though the literature is supportive. An example of this is Seager (2008) who states that where professionals' minds are linked to a general surveillance mentality derived from risk-focused government policies and performance driven managerial styles, anxious, defensive and paranoid professional practice thrives, although this does not need to be the case. In considering the issue of suicide prevention and self harm in this thesis, I have been able to argue the importance of interrogating the taken for granted and in considering knowledge as culturally and historically specific, local and provisional, and have come to see dominate discourses as vulnerable and change possible.

Cooper and Lousada (2005) contend that individual, organisational and societal states of being have socially constructed and historical properties that are central to their nature but also patterned according to deep structural generative principles. Therefore in using perspectives from social constructionism and psychoanalytic theory one may propose that fertile ground in the respect of effecting change may be propagated.

Use of the evidence in this respect is crucial and according to Briggs (2008) there is a risk that a target setting culture degenerates into omnipotent organisations. Additionally, ritualised practices such as form filling and completing checklists displace anxiety from the pain of the work itself on to the ritualised task of monitoring risk. These organisational practices tend to be risk aversive and the aim of suicide prevention becomes suicide elimination. Yet Cooper and Lousada (2005) contend that traditional health and welfare organisations were intended to function as a container for the complex risky and emotionally demanding exchanges between professionals and local populations. However, it is also their contention that political processes have impacted and using risk management systems as an example, state that these obscure how individual and collective anxieties create climates of risk that become indistinguishable from risk itself. These authors state that there is a complex

interplay between a publically driven movement to govern risk in the professions and the capacity of professionals and professions to withstand the consequences of public exposure for failure to assess or manage risk.

Using student counselling services as an example, Heyno (2008) illustrates the contentions of Cooper and Lousada (2005) by discussing the disproportionate media interest when a student kills themselves and the wish to apportion blame. She goes on to state that blame and projected guilt is problematic for universities and other public institutions. This, Heyno states can lead to a climate of fear and caution in discussing and thinking about suicide and if infected by the fear of being blamed then risk and suicidal thoughts become difficult to talk about. This may also lead to the omnipotent fantasy that all suicide is preventable and the task with keeping students alive lies with the university and in particular, student counselling services (Heyno, 2008).

There is clearly a parallel process in terms of the responsibility to keep people alive occurring in mental health services as described by Bell (2000). Further progression of this argument is proposed by Cooper and Lousada (2005) who state that there is a considerable shift in mentality from a service concerned with the prevention of risk where clinicians work on the basis of doing the best they can and setting high standards to achieve it and one where failure to prevent can result in exposure, interrogation and censure. They go on to contend that contemporary interpretations of prevention mean practice that is driven by the anxiety that clinicians will be found culpable in not protecting the individual, organisation or community.

The consequences of such anxiety are explored by Hinshelwood and Chiesa (2004) who state that under such conditions nurses function in a way which keeps emotional distance from patients and this can harm the quality of the work. In Menzies classic 1959 study of the nursing service of a general hospital (Menzies-Lyth, 1997) one of the ways that intolerable anxiety was avoided, as opposed to confronted, was by displacing responsibility. In a way the experiences of all four participants in my study may be seen to illustrate this proposition and Seager's (2008) contentions of "*discharging responsibility*" are brought to mind. In Riordan's story, his referral by the GP for crisis intervention may be seen as the GP discharging responsibility onto secondary services which was prompted by fear for his life and the comment pertaining to coroner's court. Whilst for the women in the study, service providers discharged responsibility onto others such as family. However this should not replace professional support yet Kapur et al's (2005) contention of the scarcity of interventions following self harm and Lilley et al's (2008) suggestion of a discrepancy between what people need after self harm and what service offers, are brought to mind.

Hinshelwood and Skogstad (2005) contend that despite there being evidence for an alternative, the way things are done is perpetuated because of unacknowledged or even unconscious anxieties. In Rayner et al (2005) we made a case for the importance of supervision and attention to issues of counter transference when working with people who self harm and this may assist in illuminating the anxiety Hinshelwood and Skogstad (2005) speak of. In this respect and with specific reference to student counselling services, Heyno (2008) contends that the organisational expectation is that counselling services carry the concern regarding suicide risk and while they have to accept this, they do not need to act it out, but rather be affected by the projections but not infected by them (Heyno, 2008). This notion can also be applied to clinical settings and echoes the contention of Cooper and Lousada (2005) around the indistinguishable nature of risk when anxieties prevail. As Heyno (2008) goes on to say, risk can be minimised by accepting it is always there and if counsellors can bear this level of useful anxiety, pick up cues in the counter transference and resist being infected by the organisational fantasy that counsellors are responsible for all student suicide, then they can be free to be affected by the useful anxiety that accompanies students with suicidal thoughts (Heyno, 2008).

Unravelling such complexity would best be pursued in supervision with a like minded supervisor but may also be explored in debriefing sessions and critical incident reviews. Completing this study has urged reinforcement of this implication for practice but also goes beyond it. To explain further, rather than solely undertaking critical incident reviews when things have gone wrong, a forum could be implemented where the reasons why decisions are taken is routinely reviewed. In doing so it would be possible to build up a picture of who gets referred to which service and on what basis. This could assist in identifying gaps in service delivery or best practice initiatives and could be used as evidence underpinning the need for developments in service provision.

Clearly, the delivery of a quality mental health service is only as good as those who deliver it and their ability to collaboratively identify needs from the perspective of the individual, informed by organisational culture and the policies which influence it. The previous discussion has taken account of practice at an individual, organisational and policy level and urged taken for granted knowledge to be examined using aspects of social constructionism. It is argued that from this position critical appraisal of theory and practices is facilitated and in engendering the notion of looking beneath observable behaviour as inspired by psychoanalytic perspectives, I aspire to join in Turp's (2003) quest to leave the reader better equipped to remain thoughtful and compassionate in interactions with people who self harm. This is surely a key point in terms of implications for practice and the benefit of using individual stories to bring alive the issues has been posited. As such, this study has placed the people at the heart of consideration, not as "*self harmers*" but as individuals whose

experiences have the power to inform practice and thereby benefit others.

Now what?

Clearly research which argues a need for change requires dissemination and aspects of the study have been presented at conferences and some of the underpinning arguments, published in Allen (2007). However, there is now a need for me to increase these efforts and disseminate as widely as possible.

I am in the fortunate position of working at The University of Salford where self harm is firmly couched within the pre registration and post qualifying/graduate portfolios. This has, and will, enable the study to be discussed and interrogated through teaching and learning and is indicative of my desire to use as many channels as possible to present the information.

Additionally, as part of ethical approval I am required to feedback to those who participated in the study and the wider community. Clearly in keeping with the construction of the study this will not be in person, but will involve information being disseminated to GP surgeries and has the added benefit of focussing on primary care services, which is in keeping with Hale's (2008) contention of the need to focus efforts within this arena.

As such, my hope is that I will be able to disseminate aspects of this thesis with a view to continuing interrogation of seemingly taken for granted and established "*facts.*" To challenge established modes of being and relating to those who self harm, to encourage acceptance that we create and construct knowledge and truth, and to highlight that behind every instance of self harm there is a story to be shared. This is not solely for the potential benefit of the story teller but in the pursuit of enhanced understanding and responses by those for whom self harm feels too alien or indeed too close to engage with. Clearly at this point in the thesis there is a clear sense of heading to conclusion, however there is an issue to consider first.

The death of the author (Rolfe, 2006)

I am prompted to make a further reference to relationships at this juncture, and whilst previous comment has been in the context of past and present relationships, here I consider those associated with the future. Etherington (2001) stated that story telling is a social process which is interactive and through which learning takes place. She further describes that as she writes she needs to imagine being in a relationship with future readers.

Clearly this has been a consideration throughout my journey as I thought about the judgements to be made, whether I had represented the stories in an ethical manner, how the work would be received and whether I had included enough of myself to ensure an understanding of my intellectual autobiography without it becoming a self indulgent pursuit. However, at this point, those future relationships feel more real than before and I am conscious that the work will soon no longer be mine but will enter the wider arena for discussion and interrogation.

In this respect I am minded of Rolfe (2006) who states that a research report is likely to be written differently depending on which self is writing it and with which other internal selves it is in dialogue with at the time. I have experience of this in reviewing my thesis during this editing period and for me this confirms Rolfe's (2006) argument that the self of the author that later reviews the earlier writing is likely to regard it differently from the self that wrote it. As such, this means that the authorial voice is no more privileged than the interpretation by its readers. Meaning is therefore created by the reader not the writer and in this sense the author as the creative force, is dead (Rolfe, 2006).

With this in mind and having had the opportunity to present my interpretation of the journey I have taken through doctorate studies. My hope is that self harm is regarded as just one part of Celia, Margaret, Ellie and Riordan's narratives and that each individual can be seen as defined by and defining their stories. That I have been able to articulate a cogent argument for the claims I have made in the thesis and that I have offered an answer to the "*so what*" question posed by Clandinin and Connelly (2000 p120). As such, the last say, in keeping with Stanley and Wise's (2002) contention now belongs to you, the reader.

Appendix (i)

Ethical Considerations and Management

Informed Consent

Participants included those who are not involved with in-patient provision and information pertaining to the study was provided in advance in the form of a participant information sheet which also requests consent for me to contact the potential participant to discuss their possible inclusion in more detail.

Capacity to give consent was determined by ensuring the participant understood the participant information sheet, believes it, can consider the benefits/risks and make a decision whether to participate in the study or not and thereby chooses to give informed consent in writing or not.

Confidentiality

No identifying details were attached to the recorded interviews and subsequent transcripts other than a pseudonym and The Caldicott principles were adhered to as follows;

Principle 1 Justify the purpose(s).

Principle 2 Do not use patient identifiable information unless it is absolute necessary.

Principle 3 Use the minimum necessary patient identifiable information.

Principle 4 Access to patient identifiable information should be on a strict need to know basis.

Principle 5 Everyone should be aware of their responsibilities.

Principle 6 Understand and comply with the law.

Data storage

The information I collected was subject to The Data Protection Act (1998) and as such I ensured it was;

1. Fairly and lawfully processed
2. Processed for limited purposes
3. Adequate, relevant and not excessive
4. Accurate
5. Not kept for longer that is necessary
6. Processed in line with rights
7. Secure
8. Not transferred to countries without adequate protection.

Information was stored within The University of Salford where the interviews took place. This ensured the information remained within the building and immediately secured in non-portable locked storage.

On one occasion, the mental health service notes were used following interviews as an additional form of information and remained stored as usual for the service.

Protection of participants' interests

Participants were people who had used a particular mental health service via A&E, had the capacity to give informed consent and had done so in writing. It was envisaged that some material discussed would be painful and as I have previous experience of supporting people through this process I was able to use my skills in collaboration with the participant in an attempt to promote their best interests. It was also specified in the Participant Information Sheet that should significant harm to self or others be disclosed, my professional code of conduct means I would have to take action in response to this, the exact course of which was discussed prior to the interview commencing.

If support was required following the interview, this could be accessed referring to the plan previously discussed with a practitioner from the mental health service during the participant's initial contact in A&E. It was also envisaged that using accommodation within The University of Salford would minimise any potential stigma the participant may feel from attending mental health services.

Safety of the proposed researcher

Confidential interviews took place within The University of Salford and I notified a designated person independent of the study what time the interview was due to commence and again on completion of the interview.

Appendix (ii)

Shelly Allen
Lecturer in Mental Health Nursing
School of Nursing
The University of Salford
Allerton Building,
Frederick Road Campus
Salford
M6 6PU, United Kingdom
0161 295 7128
s.l.allen@salford.ac.uk

To Whom It May
Concern:

My name is Shelly Allen; I am a Lecturer in Mental Health Nursing at The University of Salford and previously worked here in (name deleted) as a Mental Health Nurse.

I am currently undertaking a study to gain insight into self-harm and how it can help people to cope with their experiences.

The Participant Information Sheet will provide further details of what this entails and may I take this opportunity to thank you for taking time to read and consider this information.

Sincerely

Shelly Allen
Lecturer in Mental Health Nursing
The University of Salford

Appendix (ii)

Participant Information Sheet

Study title ~ "Coping and Self -Harm"

Researcher ~ Shelly Allen

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear, or if you would like more information. Take time to decide whether or not you wish to take part. **Thank you for reading this**

- **What is the purpose of the study?**

The study aims to find out whether self-harm has helped you to cope with your experiences and is planned for completion in 2007.

- **Why have I been chosen?**

You have been chosen due to your recent contact with (name deleted) following self-harm and will be one among a number of others who will contribute to this study.

- **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 withdraw at any time and 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 take part?**

I will contact you to arrange a mutually convenient time to meet. This will be a confidential meeting usually within The University of Salford, but you can suggest an alternative if you prefer. You will then be asked a series of questions through interview with me, which will be noted using a tape recorder. When the study is over the audio tapes will be destroyed. You will only be interviewed once in the study and your (name deleted) notes will be looked at. If you have receipts of travel costs to the site these can be reimbursed taking into account your return journey.

- **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. If you reveal you are of significant risk of hurting yourself or someone else, under the rules which govern my professional code of conduct I will discuss with you any appropriate action, which may need to involve a breach of confidentiality.

- **What are the possible benefits of taking part?**

The information from this study may lead to a better understanding of self-harm and may help to improve the services offered to people.

- **What if something goes wrong?**

Appendix (ii)

If you are unhappy about any aspect of the study or your participation in it please feel free to make a complaint through: Debbie Livesey Research Institute Administrator, Institute for Health and Social Care Research, The University of Salford, Salford M6 6PU. Telephone number 0161 295 7006.

- **Will my taking part in this study be kept confidential?**

Information which is collected about you during the course of the research will be kept strictly confidential.

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 report or publication.

- **Who is organising and funding the research?**

The research study is being undertaken through The University of Salford as part of a PhD and at present no funding has been sought. However your travel and the study's administration costs will be met through application to one of the university funding schemes.

- **Who has reviewed the study?**

The study has been reviewed by Bolton 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, questions or concerns you might have**

Shelly Allen, Lecturer in Mental Health Nursing, School of Nursing, The University of Salford, Allerton Building, Frederick Road Campus, Salford, M6 6PU, United Kingdom

Telephone Number -0161 295 7128

e-mail- s.l.allen@salford.ac.uk

Should you decide to participate you will be asked to sign below giving consent to be contacted by me.

Thank you for taking the time to read this information and please take one copy to keep

I agree to the researcher Shelly Allen, contacting me on this telephone number: ....to discuss the study further with a view to my possible inclusion in it

- Signed:..Date:......................................

Full Name in Capitals:..

- Signature of witness:..Date:......................................

Full name in capitals:..

Appendix (iii)

Informed Consent Form

Study title ~ "Coping and Self-Harm" Researcher ~ Shelly Allen

PLEASE GIVE YOUR RESPONSE TO EACH OF THE QUESTIONS BY TICKING ONE OF THE BOXES	YES	NO
Have you read the Participant Information Sheet?		
Has the research study been explained to you orally?		
Have you had the opportunity to ask questions and discuss the study?		
Have you received satisfactory answers to all your questions?		
Have you received enough information about the study? Who have you spoken to...		
Do you understand the purpose of the research study and how you will be involved?		
Do you understand that participation in the study is voluntary and you are free to withdraw at any stage without giving any reason and without your medical care or legal rights being affected?		
Do you agree that the interview can be taped using a tape recorder and typed up? (At the end of the study the audio tapes and typed transcripts will be destroyed)		
Do you give permission for the researcher to look at and have access to your (name deleted) notes?		
Do you agree with the publication of the results from this study in an appropriate outlet(s)?		
Do you understand that any information you provide is confidential and that no identification of any individual will be disclosed in any reports or publications from the study?		

I agree to take part in the above research study

- Signed:...

Full Name in Capitals...Date...................

- Signature of witness:..

Full Name in Capitals...Date...................

Appendix (iv)

Semi Structured Interview Schedule

Demographic Information Age Gender Sexual orientation Ethnicity

Mental Health Service involvement

1. How many times have you used The (name deleted)?
2. Have you been involved with other mental health services, if so was this community or in-patient provision?
3. Are you currently involved with mental health services? If so is this community or in-patient provision?
4. What have your experiences of using mental health services been like? Why?
5. How do you explain your experiences of using mental health services?

Early experiences

6. As a child did you feel you could confide in people, if so anyone in particular?
7. Growing up did you feel you were treated fairly and can you give any examples?
8. What punishments were given and were they appropriate and reasonable?
9. How much freedom did you have?
10. Were your thoughts feelings and opinions valued at home and were you encouraged to express them?
11. Who made the decisions at home, were you consulted, your opinions valued and your input acknowledge and welcomed?

Recent experiences

12. What's your occupational status?
13. Have you had jobs since school, how many?
14. Any disputes with work colleagues if so what about and was their reaction understandable?
15. Are you in a relationship?
16. Do you have close friends to confide in and do you use this?
17. When you are upset or distressed is it understandable?

The meaning of self-harm and suicide

18. What does self-harm mean to you?
19. How would you describe its function?
20. If for some reason this was not an option what other strategies would you use to cope?
21. How does self-harm differ from suicide?
22. Have you ever had thoughts of suicide, if so what has prevented you from acting on these thoughts?

Coping, achievements and meaningful activity

23. What are your achievements to date and what are you proud of?
24. What enjoyable activities do you do?
25. How do you function in social situations?
26. What helps when you feel stressed?

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